INTRODUCTION

WICKED PROBLEMS

Sometimes the first duty of intelligent men is the restatement of the obvious.
—George Orwell

During the years compiling the research for this book, we shopped our project to numerous outlets. We heard time and time again of a "saturated market" of parenting books that examined how cell phones and social media are hurting our kids. Many of these books were written by mental health professionals like us and offer solutions to the wicked problems we are facing. We insisted we offered a different approach, but still, we faced multiple rejections. Like Orwell's quote above, we wanted to state the shockingly obvious—to say what so many of us know but can't quite face. We also allowed space in our research for narratives hidden behind mainstream headlines to provide a fuller picture of what's going on with kids these days. We felt a book that stated the obvious would be, in a very literal sense, refreshing. In this book, we consider the complexity adults are faced with when trying to protect kids or families, and we question how we can best help in the face of uncooperative systems.

Crisis in Plain Sight

In 2021, the eight-episode miniseries *Dopesick* premiered on streaming services across the world. Inspired by Beth Macy's bestseller *Dopesick: Dealers, Doctors, and the Drug Company that Addicted America*, the series, starring Michael Keaton and Kaitlyn Dever, focused on America's opioid crisis and the conflicts of interest among Purdue Pharma, the Food and Drug Administration (FDA), the US Department of Justice, and professionals associated with the medical industry. Millions streamed the show about how the very people presumed to care about our health broke our trust. Many paid the price with the death of loved ones.

Purdue Pharma was a privately owned pharmaceutical company primarily producing medications for pain management. Owned by the Sackler family, Purdue's most notable contribution to medicine was the development of the painkiller OxyContin, made up of the semisynthetic opioid called oxycodone, a derivative of opium. The highly addictive and dangerous pain medication, initially designed for cancer patients, was rebranded and pushed for chronic pain management. The Sacklers, described publicly as the worst drug dealers and most evil family in American history,[1] provided "incentive trips" for doctors to attend pain-management seminars, which were basically expenses-paid, all-inclusive vacations for those prescribing opioids to their patients.

Swayed by evidence from Purdue Pharma-funded studies and ignoring the absence of long-term research into potential side effects, the FDA approved the use of OxyContin in 1995. The addictive qualities of the opioid were not investigated. OxyContin was marketed as not only more effective, but safer than its competition. At about the same time, the American Pain Society also campaigned for pain to be understood as the *fifth vital sign*,[2] along with body temperature, pulse rates, breathing rates, and blood pressure. Their campaign produced those cute pain scales

with smiling faces doctors use when they ask you to rate your pain from 1 to 10.

Lobbying efforts effectively conflated chronic pain with post-operative pain, and the checklist and treatment protocols they advocated for led many doctors to prescribe even more potent opiates—those produced with fentanyl.[3] To put the strength of this chemical in perspective, fentanyl is about fifty times stronger than heroin, and one hundred times stronger than morphine.

To get their product on the market, Purdue organized a team of one thousand representatives for a three-week training session.[4] The plan was to create a workforce of salespeople to broaden the use of OxyContin for all types of pain, not only for post-surgery or those living with chronic pain. Purdue Pharma's goal was antithetical to just about every public health initiative—to prescribe the least amount of any drug to the least amount of people. However, the Sackler family's team of sales reps easily convinced doctors that their pharmaceutical was safe for broad use and not addictive. The evidence showed otherwise.

From 1999, opioid deaths rose from fewer than 3,500 per year to more than 17,000 in 2017.[5] Sadly, most of those overdoses began with the prescription pad. In 2007, Purdue Pharma was sued for the largest sum in pharmaceutical history. They were accused of misleading the public about the addictive qualities of OxyContin. While some senior leaders at Purdue took the fall, no Sacklers were implicated in the one-hundred-plus pages of court documents.

Two years later, in 2009, Pfizer paid out an even higher settlement, $2.3 billion, for fraudulent marketing and promotion of their pain medication, making them the largest healthcare felons of the day.[6] Purdue, however, continued to sell opioids until they ultimately filed for Chapter 11 bankruptcy in 2019. The American Pain Society closed that same year when faced with allegations of colluding with opioid producers. Many knew

about the damage, but not enough people spoke out against the harmful overprescription of the drug. In January 2025, the Sackler family agreed to pay up to 6.5 billion dollars and give up ownership of Purdue Pharma in order to settle the lawsuits from numerous local, state, and tribal governments.[7]

Shows similar to *Dopesick* were soon seen on other channels. The limited drama series *Painkiller* became one of Netflix's most streamed shows, providing yet another exposé on the Sacklers and America's opioid crisis that displaced pain with addiction. This was a regrettable substitution.

The opioid epidemic in North America and other nations is well-known. (Though it is worth noting that in the media it is now often linked with problems with fentanyl and other synthetic opioids laced into more common prescription and street drugs). Overdose and fatality are not uncommon.

Judging by the success of Macy's *Dopesick* and the popularity of the related television shows, most of you will be familiar with this story. But our book isn't about OxyContin or Big Pharma. It's about youth—teenagers and young adults—and the adults in their lives. From youth suicide to the overprescription of psychiatric medications to the poorer outcomes from the education system to, yes, the phones and social media, we want to examine what's going on with kids (and adults) these days. We see how bad it is, and we know how shockingly obvious it is to most of you.

OxyContin is a case study. It's just one example of the ways adults impact our health and well-being. There are many more. Here, we give just a few examples.

One of the most popular questionnaires used in the medical industry to "detect" depression is the Patient-Health Questionnaire-9 (PHQ-9). (It is found easily online; you can rate yourself and see how your doctor would be instructed to respond to your total score.) The PHQ-9 was created by *marketers* for the antidepressant Zoloft (Sertraline),[8] which was produced by Pfizer, who funded the development of the questionnaire. Even though

it was commercially backed, the PHQ-9 has been cited in over 11,000 scientific papers.[9] The PHQ-9 lowered the bar for doctors to prescribe antidepressant medications[10] with one large study finding 79.1% of people assessed by the PHQ-9 were given a prescription for an antidepressant.[11]

The stimulant Ritalin (methylphenidate hydrochloride, by Novartis) was not originally developed for treating attention-related issues in youth. Chemist Leandro Panizzon developed the drug to test his discovery of synthesized methylphenidate on his wife Marguerite in 1944. He wanted his wife, nicknamed Rita, to have more energy and focus—and to slim her waistline. He named his success after her: *Ritalin*.[12]

It wasn't until the so-called godfather of medication for ADHD (attention-deficit hyperactivity disorder), Dr. Keith Conners, tested the drugs in the late 1960s and early 1970s that stimulants became everyday treatments for youth described as distracted, troubled, or unable to sit still at school.[13]

In the 1990s, Roger Griggs purchased a small pharmaceutical company known for producing Obetrol, a weight-loss pill he suspected might help children diagnosed with ADD. The drug would require a rebrand, however, and Griggs started putting words together. ADD. For all. *Adderall*. Griggs said, "It was meant to be kind of an inclusive thing." Adderall and Ritalin were now competing for the market share.[14]

Griggs strongly opposed the direct-to-consumer pharmaceutical marketing after introducing Adderall, and Conners is said to have regretted the overuse of stimulant medications. But they aren't solely to blame. Overuse was driven by decades of aggressive marketing by manufacturers, including industry-funded campaigns like the one just mentioned for depression.[15]

And, of course, there's more. Cell phones and social media have been correlated with drastic effects on youth mental health and education outcomes. They interfere with child and youth development in several ways, yet it is challenging to protect children from digital interference or put them down ourselves.[16] Despite having

more therapists, counselors, educators, experts, and medications than ever, today appears to be a really difficult time for young people. "Why?" is what we are asking.

Wicked Problems

A term first coined by design and urban planning professors Horst Rittel and Melvin Webber[17] at the University of California, Berkeley in 1973, *wicked problems* are those with no definitive solution. There is no way to know if a particular solution will be decisive, and it is almost impossible to say when or if wicked problems are properly solved. Sounds complex? It is.

Consider a cracked foundation in your home or a math equation; both have a solution or even an ideal resolution. Wicked problems do not. The experience of today's youth is dynamic and multifaceted. Problems may require several interventions, with many consequences and numerous possible outcomes over time. What may at first appear to be a good solution may turn out to be the next phase of the problem. Maybe without end. There is no quick fix for these problems.

Rittel and Webber suggested, "There is no rule or procedure to determine the correct explanation or combination of them." We assess situations, make choices, and take actions we believe will alleviate the negative consequences of a problem. We know there is no one correct solution to increased concerns about youth mental health, so let's apply this idea of wicked problems to understand kids these days.

Best-selling books have tried to propose a single cause for the youth mental health crisis. Abigail Shrier's *Bad Therapy* blamed mental health experts. Jonathan Haidt's *The Anxious Generation* took on phones. Lenore Skenazy's *Free-Range Kids* focused on overprotective parenting, while Leonard Sax's *The Collapse of Parenting* suggested a lack of parental authority was responsible. And we agree with all of them, to some extent, but we do not believe any single facet is causal. Solving just one of these problems is not an antidote to this wicked problem.

Addressing wicked problems requires innovative approaches that acknowledge and embrace complexity because they lack clear boundaries and are often deeply ingrained in societal structures and behaviors. Unlike simple (or even complicated) problems, wicked problems cannot be successfully addressed using straightforward analysis or expertise. Attempts to solve one aspect of a wicked problem may inadvertently exacerbate other problems or create unintended consequences.

One classic example of a wicked problem being addressed as easily solvable was the introduction of the cane toad to Australia to control cane beetles, which were wreaking havoc on sugarcane crops. It backfired royally.

The cane toad, native to Hawaii and Puerto Rico, was brought to Australia in the 1930s. They ran amok.[18] With no predators to control their proliferation, the giant toad population skyrocketed, initiating numerous unintended consequences, with environmental disruption being the foremost issue. The toads decimated other species of frogs, lizards, small mammals, and even livestock, which upset the balance of natural predators and competitors. These other species had no adaptation to counter the toad's toxins. Each species affected had a knock-on effect, causing further disruptions to the ecosystem. Biodiversity was compromised.

Some species were driven to extinction. Others faced significant declines in their numbers. The fallout from attempting this simple solution to a wicked problem also had significant economic impacts for many years as humans attempted to restore nature's balance. So, in this case, the desire to control pests led to widespread ecological imbalances, which led to new problems to deal with. As is too often the case, intervention caused even more significant complications. This example underscores the importance of carefully considering the potential consequences of interfering and intervening in complex systems *before* implementation.

While we agree with Jonathan Haidt about the effects of smartphones on mental health, with Abigail Shrier about diag-

noses, medication, and social-emotional training, and with Lenore Skenazy about the need for more outdoor, unstructured, independent, and unsupervised play, these factors are only parts of a complex story. Decline in youth mental health is a wicked problem, and we know of numerous aspects that need to be addressed from multiple angles. We also know there is no one solution or panacea. Remove the phones? OK. And then what?

This is why we approach this problem with breadth, even knowing that we, too, will miss parts of the story. No one can see all of it. But, putting our thoughts and research to paper, we realized the importance of zooming out and observing kids these days from forty thousand feet. What we sought was an approach that could prepare readers to decide for themselves how to preserve and protect the spirit of youth based on the best available evidence we could find.

In doing so, we found ourselves getting fired up, as we hope you do too. We found ourselves asking how the research literature and mainstream depictions of harm (such as *Dopesick*) are so visible, yet the harm still persists. This book is about standing up for a pragmatic approach to protesting harmful fads and ideologies harming young people today.

The longer adults stay complacent in waiting for *someone* (governments, corporations, politicians, etc.) to make it all better, the easier it becomes for those addicted to power (such as governments or corporations) to grab it, hold onto it, and never let it go.

The Adventure Ahead

> *Until the lion learns how to write, every story will glorify the hunter.*
>
> —Chinua Achebe (Things Fall Apart, 1958)

The critical reader will ask who we are to write this book, and they may question the absence of a youth voice. Fair questions. Youth voice makes for an important follow-up, but this book

is for adults. We want to show how adults can advocate—even protest—for youth's health and well-being in the face of uncooperative systems, the attention economy, and simply bad ideas. Sometimes this requires deviating from dominant narratives and cultural norms and bucking the mainstream. We hope our readers will become *positive deviants* who will attempt to find what works when it comes to supporting youth mental health.

The two of us have worked with youth in many circumstances: some in corrections, some eager to abandon school or run away from home, and some were teens referred for self-harm, drug use, abuse, and family conflict. We've spent our careers as youth-serving educators, therapists, and academics, and we've talked with thousands of adolescents over the years. We've learned from working in underprivileged communities, including rural, remote, vulnerable, refugee, and Indigenous populations, as well as in our therapeutic work with the more affluent. Our experiences and interventions with families and the environments they inhabit eventually led us to research and study what helps young people thrive. Alongside our clinical work, we collectively teach social work, counseling, recreation, health, and leadership, and yet we still ask ourselves: *Why aren't we doing better for kids these days*? We keep coming back to questions about whether our careers as researchers and therapists are helping, especially now, when so many youth are suffering.

We originally connected over a shared interest in outdoor therapies. We are good friends and maintain a productive academic working relationship. We are fierce advocates for practicing therapy outside of the counseling room and do not shy away from difficult conversations, even in our own professional circles.

Our research on improving youth experience is often met with resistance. We've fielded accusations from industry-funded researchers of misrepresenting data and have had to endure slanderous comments from our colleagues. Outdoor

therapy is a small field of practice, so when we speak out, trouble ensues. We are speaking particularly about our efforts to fight an industry that has sprung up in the last forty years: America's *troubled teen industry,* and *wilderness therapy programs* in particular. Often using the guise of "healing in nature," these mostly for-profit organizations provide involuntary, residential treatment to struggling adolescents. Under the supervision of qualified mental health professionals, these particular wilderness therapy programs operate in ways that are contradictory to just about everything we know about psychotherapy and child care. Additionally, their research claims are misleading and seldom disclose unethical practices and experiences of harm.

We've interviewed many youth who have been harmed—in various ways—by practitioners of outdoor therapy in these settings, and we've written extensively on the trauma, danger, harm, and infringements on human rights caused by these residential treatments. We've begged our professional communities to stand up against harmful practices associated with this industry. Unsurprisingly, we've found that earning the respect of youth and young adults who were harmed by these programs was much easier than influencing the academics and licensed professionals endorsing (and/or accepting funding from) an industry saddled with a laundry list of unethical principles and harmful practices.

You may have seen recent Netflix documentaries such as *Hell Camp*[19] or *The Program*,[20] or Paris Hilton's YouTube 2020 documentary about her horrifying experience in one of these residential treatment programs.[21] After we published a paper in 2022 that questioned the ethics of licensed and certified mental health professionals advocating for the legalized kidnapping of troubled youth in the name of therapy,[22] industry researchers asked that we retract our article. The journal editor scoffed at their request, denied the plea, and commended our work in

protecting kids from adults promoting harmful and traumatic interventions.

Advocating for adolescents requires adults who will listen and act on the research evidence. In this sense, we are comfortable with the approach we took. Much of our book is about adults who stand up for kids in the face of uncooperative systems impacting the environments youth grow up in.

Throughout, we deal with contentious topics. We take an analytical swing at the rising use of medications, psychotherapy's effectiveness and shortcomings, the changing educational system, overprotection, and sociopolitical debates impacting youth today. We don't approach these issues to gain rank in the popularity contest of controversy. We focus on *what works* and *who it works for*. To do so, we wanted to find the voices of those who are on the frontlines and working to make change. As you'll read, we talked to many experts to hear what they have to say about kids these days.

Some may find our approach overly critical. We assure you as researchers, therapists, husbands, and parents, that we wrote this book because so much is at stake for today's youth.

We try not to *should* on people. We know most parents, educators, doctors, and therapists are trying their best. After all, we agree with our colleague, psychotherapist Dr. Daryl Chow, who wrote, "Parenting is an amateur sport. The moment you think you've turned pro, the rules change."[23] But today, youth need more adults in the room. Not for overprotection, but to create environments for them to thrive. As you will read herein, overprotection has become one of the problems. An ideology of safety interfered with and transformed a reasonable path to walk onto a precipitous cliff with loose footing. Like the impact of the PHQ-9, overprotection and ideologies of safety have interfered with youth development and inspired an increased medicalization of childhood.

To be clear, we aren't saying our careers as clinicians have not been a thrilling and rewarding journey, or that people

should not seek professional help. Of course, when all else fails, professional or medical help is important—and mostly effective. Some people *do* benefit from psychiatric medications; many people do *not* become addicted or overdose on OxyContin. But many experience irreversible harm. We care most about how people are impacted by these interventions, and we want all involved to know that universal applications of these somewhat extreme interventions are not solutions to wicked problems.

We live in a time where words such as *evidenced*, *scientific*, and *research-based* are used to market certain approaches to improving one's health, and one's *mental health*. Of course, reading any book is not a substitute for expert opinion because one expert might be totally unhelpful in a particular context and another might be incredibly helpful. People who think they have the answers can topple from the mantle of expert and descend to imposter quickly; we've been there—with the youth and families we failed to help.

Regarding the evidence, we know not every casual reader can access research articles (often stored behind preposterous peer-review journal paywalls), let alone interpret what is being published beyond mainstream headlines. While we all hope that the medical, political, and professional helpers we lean on are using the most up-to-date evidence about *what works*, keep in mind that there is a 15-to 20-year gap between the publication of research and when it actually becomes everyday practice.[24]

Our task was to make sense of and share the research in an engaging way. We remain surprised by some of the evidence we found, and we wonder why it is not more mainstream and in the public's consciousness. There is solid evidence of harm, yet it is often left in the dark. We are shining light into those dark corners and illuminating issues that could make for safer and healthier environments for our kids to grow up in.

We encourage readers to become the adults in the room that young people need, yet we remain humble in stating that even though we have explored a range of factors, there is always more to learn.

As you read on, you will see we are nonconformists; we continue to ask unscripted questions, interrogate our own work, and hold our professions and colleagues to a high standard. We always look for the trail of evidence that will help us improve as we move forward. In the Notes section at the book's end, you will find the sources informing our discussion. (After all, one cannot write a book such as this without showing one's receipts!) Additionally, you can visit www.kidsthesedaysbook.com to find links to the research we cite and additional resources for parents, educators, and therapists.

Many of the questions we raise do not condense. They often simply generate more questions. We encourage the curious reader to make their own decisions about the value of our exploration and its pragmatic meaning for themselves. In the end, our goal was to understand why so many young people are hurting, starved for connection, and lacking the autonomy to adventurously explore adolescence.

The book is organized by three types of harm needing to be addressed to promote healthy, positive child and youth development: *Interference*, *Intervention*, and *Ideology*.

Part I: Interference explores increased loneliness, loss of connection, digital interference, and the impact of environmental toxins on youth development. *Part II: Intervention* takes a critical look at the labeling of mental disorders, psychotherapy, the overprescription of psychiatric medications, and universal school-based programs teaching social-emotional learning. *Part III: Ideology* shows how the dogma of safety has led to an *extinction of experience* and how this impacts youth. We aim to show how adults can, at first, at least notice these shockingly obvious concerns, and more importantly, be courageous in addressing

them. We shouldn't be blaming kids these days. We should be listening, learning, and leading.

This book is about stepping up and assuming responsibility, especially when others are not. It's about becoming a stabilizing force and setting an example. It's doing or saying what others are unwilling and/or unprepared to do. This book is about being the "adult in the room"—an idiom used figuratively to encourage us to demonstrate maturity, responsibility, and leadership in the face of unhelpful and uncooperative systems or where others are acting irresponsibly, unethically, or immaturely. In the end, it's about giving today's youth something to imitate.

PART I

INTERFERENCE

1

THE KIDS THESE DAYS EFFECT

The children now love luxury; they have bad manners, contempt for authority; they show disrespect for elders and love chatter in place of exercise.

—K. J. Freeman

Often attributed to Socrates, the above quote is from an Oxford dissertation written in 1907.[1] Kenneth Freeman paraphrased lines from a caricatured version of Socrates in a play, *The Clouds*, written in 423 BC by Aristophanes. The play mocked prominent Greek intellectuals and is still considered one of the finest comedies of its time. Like many adults today, the famous Greek philosopher complained roughly 2,500 years ago about "*kids these days*."

So, it's not a new phenomenon. For millennia, young people have been labeled by adults as apathetic, arrogant, disrespectful, and self-absorbed. Each generation obtains a new label and stereotype. Millennials are the so-called *entitled generation*, assessed as lazy, self-obsessed, and uninspired. Baby boomers in their youth were viewed as pampered and neglectful of religious conventions—hippie kids pushing back on war and capitalism.

Although, those boomers are now old enough to be referred to as hardworking and innovative.

The youth of today consist of Generation Z (aka Zoomers) and Generation Alpha, the oldest members of which are 15 in 2025. These two are sometimes called *mini-millennials*. We don't yet know what the objections will be to the behavior of these new generations, though social psychologist Jonathan Haidt recently labeled today's youth the *Anxious Generation*. Inevitably, every young person survives twenty or so years as a member of the world's most criticized generation, until the next one arises. This is the *kids these days effect*. The first child born in 2026 will be the start of a new generation: Generation Beta. The jury is still out on how they will be categorized.

American psychologists John Protzko and Jonathan Schooler found prejudice against "kids these days" dates back even earlier than Socrates, to around 624 BC.[2] They put this bias against teens to the test in a series of studies involving 3,458 adults. First, they measured adults' levels of authoritarianism, such as how much they believe in the need for "old-fashioned values" and the honoring of their elders. The higher people ranked in authoritarianism, the more likely they were to believe youth of the day held less respect for older generations. The second study tested for intelligence, and smarter adults perceived kids today as less intelligent. The third study found well-read adults more likely to believe today's youth read less than generations before.

As it has through the centuries, the kids these days effect seems to say much more about us adults. The current state of this persistent tendency is impacting our approach to flattening the curve of what has been called a *youth mental health crisis*.[3] What follows in this book is our exploration of the impact of well-educated adults (those among the most likely to bemoan kids these days) and the troubling youth mental health trends we could no longer ignore in our work as clinicians, researchers, and parents. If anything, we propose that what is happening

with kids these days has more to do with the "adults these days" than the kids themselves.

In 2023, psychologist Dr. Jean M. Twenge published the book *Generations*, an illustration of how generations differ and what this means for the future of America.[4] Dr. Twenge showed that we often oversimplify how one generation differs from the next—pathologizing an entire generation as anxious, for example.

Adolescents and young adults today are diagnosed with mental disorders at rates higher than any other generation and are subject to the overprescription of psychiatric medications—meant to be quick fixes for a person's distress or challenging behavior. This approach comes with real risks, and overdiagnosing and overprescribing are becoming more and more widespread, despite the armies of psychiatrists, physicians, researchers, social workers, etc. offering expert opinions. What we've found is a shift away from what works in positive youth development toward increased interference, intervention, and ideology.

We argue that placing mental health *within* youth while ignoring social and environmental factors truly misses the mark. We are led to believe we can "fix" kids, when the truth is that kids develop in relationship to their surrounding environment. If youth *are* more anxious today than ever, what does this really say about the world and environments we are all living in?

Smells Like Teen Spirit

While we do speak about protecting childhood in the chapters that follow, our focus is on teenagers and young adults—those often referred to as *adolescents*. What do we mean when we say *adolescents* or *adolescence*?

Images of teen culture probably spring to mind, and, depending on your experience, may include particular fashion trends,

attitudes, behaviors, and language. Yes, yes, and yes. Still, definitions are important. As researchers, we are taught to define our terms clearly to avoid any distortion of language so readers can know exactly what we're talking about. We cannot tackle wicked problems with different understandings of the words we are using.

Take *climate change*, for example, another wicked problem. Many scientific studies use the term to refer specifically to changes in average global temperatures, while others use the term as a "catch-all" for all things environmentally related, be it erratic weather, rising tides, CO_2 levels, species adaptations, wildfires, extinctions, etc.

The climate change example provides an illustration of misunderstanding words. You can see how a debate among numerous people, each adopting distinct uses of a term, could become frustrating, or worse, futile. We experience this in our work with youth; terms such as *trauma*, *depression*, and *anxiety* often carry different meanings. Defining words is key to any successful communication of ideas. Without clear definitions, we can't move forward to develop and apply responses to wicked problems.

The origin of the word *adolescent* comes from the Latin *adolescere*, simply meaning *to mature*. Adolescence is the transition from childhood to adulthood. Of course, it's not a point in time where a person magically drops childish things and takes out a mortgage on their first house. (Actually, in terms of today's economy, we are sad to report that many youth, including our young university students, may struggle to *ever* get a mortgage on a house![5])

Adolescence is also considered a stage of development, but this is a pretty rough delineation. Is adolescence an age, the onset of puberty, or reaching a certain grade in school? This time of life can be so dramatically different for different people that it's hard to imagine defining adolescence beyond an abstract concept. There are, however, patterns of behavior and measurable

variables that provide enough rigidity for us to work with the concept of adolescence. We explore these briefly to ensure you know what we're talking about.

Giving Childhood Back

In the 1700s–1800s, factory owners preferred to hire children because they were cheaper, easier to manage, and too disorganized to go on strike. Children could work 12–18-hour days, with one day off, and come away with a single dollar after the week's work. According to an 1890 US Census report, more than 1.5 million children aged 10–15 were employed, which was about 20% of all children that age. Only 6% of 14–17-year-olds were in school. A decade later, the number of child laborers had risen to 1.75 million.

Teachers, pastors, labor groups, and social workers, including one of our superheroes, Jane Addams, were outraged. (We'll return to Addams's work and her influential contribution to the field of social work in chapter 8 in our discussion about youth and their spirit of adventure.) Addams was concerned about how adults, the juvenile courts, and the education system interfered with youth development. By 1920, collective efforts from Addams and other advocates helped 30% of 14–17-year-olds to be educated in schools. Child labor laws were revised, drastically changing the landscape for kids. Not everyone was thrilled by the shift.

Critics protested the removal of adult demands from teenage years. The first American to earn a PhD in psychology and cofounder of the American Psychological Association, G. Stanley Hall, described pre-adolescents as "savages" who needed adults to lead them to be God-fearing and country-loving and to develop strong working bodies. He believed adolescence was the time for children to overcome their animalistic and beastlike impulses. Corporal punishment and authoritarian discipline were necessary to burn the evil out of them. Hall saw adolescence as a time for "storm and stress." Society needed to break youth from their moodiness, conflict with parents, and

risk-taking behaviors.[6] He encouraged high school educators to lead youth to love discipline and authority and entice them toward military service.

In those days, children were still being beaten at school for noncompliance with rules. While times have changed, Nevin recalls getting the strap in his northern Alberta school in the 1980s. The school principal, Mr. Teed, applied the first of three strikes of the leather strap on Nevin's outreached hand. When it didn't have the intended effect, Mr. Teed asked the much-feared vice-principal, Mr. Watson, a large and jovial Englishman, to apply the next two strikes to encourage a more desirable outcome.

G. Stanley Hall's ideas about adolescence went relatively uncontested until the 1950s, when the psychology, counseling, and social work professions grew in popularity. One of the new voices was Erik Erikson, the German-American analyst who became famous for his theories of psychological development, arguing that adolescents struggled between forming their identity and finding their place in society. He called this *role confusion*, and for him, the sole purpose of adolescence was to shape an identity—to discover where one fits in the world. This sounded like the field was on the right track. But an influential contemporary of Erikson, Sigmund Freud's youngest child, the British psychoanalyst Anna Freud, believed the problems associated with youth were universal across cultures and biologically based. She described adolescence as a *developmental disturbance* difficult to distinguish from psychopathology or neurosis. Based on her criteria, just about every adolescent could be called mentally ill.

While this sounds like a practical joke, it seems to have been adopted as the prevailing guideline. In 2024, The US National Institute of Health estimated the lifetime prevalence of mental illness for adolescents is an astonishing 49.5%.[7] That is, in their estimation, around half of today's youth will experience what

could be labeled a diagnosable mental disorder. Over the past century, we've continued to play along with medicalizing and labeling youth's journey of finding themselves, all while constantly shifting the social, political, and emotional environments they navigate.

Changes in child labor laws had surprisingly big consequences beyond the protection of children. These laws delayed young people's entry into the workforce, and teenagers in urban settings became people of leisure. They had free time and money to spend. Corporations paid attention. So much so, that the term "teenager" became popularized in the 1940s as advertisers targeted marketing to the spending power of this specific, and very visible, consumer age group. By the end of World War II, *teenager* had become an established international buzzword. In fact, American teens came to epitomize all things "cool."

Not surprisingly, the new, outsized influence of teenagers frustrated and even frightened adults (more of the kids these days effect). In 1953, the director of the FBI, J. Edgar Hoover, warned citizens to expect an "appalling increase in the number of crimes that will be committed by teenagers in the years ahead."[8] Despite their contributions to the global economy, teenagers were labeled an issue of concern, primarily due to fear of crime and disorderliness.[9] President Eisenhower used his 1955 State of the Union address to ask for legislation to "assist the states in dealing with this nationwide problem." We find ourselves today agreeing there is a worrying trend among teens, not related to crime specifically, though youth crime in some metropolitan areas is currently on the rise.[10]

What emerged over the last century are movements to either *fix* the teenager or *aid in positive development*. If a youth's propensity was toward crime, correctional approaches were applied; if a youth's conduct and motivations were seen as outside of the norm of regular "teen" behavior, mental health treatments were recommended. At the same time, if teens stayed

within the boundaries of normative behavior (whatever that is for a teenager) they were ignored by interventionists, even if there were signs of undue stress or struggle.

How we perceive adolescents, their behavior, and their emotional lives comes with consequences. If we label them as "savages" as G. Stanley Hall did, we are likely to think of them as such. When anxiety and depression are focused on, the likelihood of the youth being placed on the pharmaceutical treadmill increases. Understanding the kids these days effect can help us do more of what matters in helping youth, especially when they are struggling.

Recognizing Humanity Amongst Symptom Checklists

Medical professionals conduct biopsies and imaging tests for heart issues and cancers. We don't routinely do the same for emotional distress and well-being. Most so-called mental illnesses are identified by subjective groupings of symptoms, some of which are contradictory or vague (such as with the PHQ-9). For major depressive disorder, symptoms are loss of interest or pleasure, weight loss *or* gain, and insomnia *or* fatigue. For attention-deficit disorder, symptoms are persistent inattention lasting longer than six months or simply not listening when spoken to—something we know all teenagers will do at some point or another. Symptoms may be useful to a medical professional, but common symptoms such as headaches, fevers, muscle tightness, fatigue, or dizziness tell us little. Are they the result of the body's natural reaction to a virus? Or something more sinister? We are skeptical of diagnoses based solely on a list of symptoms. Search your own symptoms on WebMD, and you'll fear you have a host of possible illnesses.

Most clinicians diagnosing mental illnesses rely on the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This book is often described as psychiatry's bible.[11] Before they will reimburse for therapeutic services, insurance companies in the US require the

assignment of a code associated with a diagnosed mental disorder. The codes are assigned based on lists of symptoms that are often quite general, like those found on WebMD. Researchers use the lists of mental disorders in the DSM to study whether psychotherapy and medications attack the symptoms of said disorder, as antibiotics do with infections. As the DSM evolved into its fifth edition, we were left asking how this book—so central to many Western countries' healthcare systems—reflects the realities of the current state of youth mental health.

The history of psychiatry's bible is rife with uncertainty, political conflict, and economic motivations. One study found that 90% of psychologists reported actively using the DSM despite having serious concerns about its effectiveness and ethics.[12] The culturally bound nature of the classification of mental disorders is often shockingly obvious, and at times troubling.

For example, in the DSM's first edition in 1952, homosexuality was described as "sexual deviation." Worse, the classification remained under the umbrella of "sociopathic personality disturbance," along with sexual sadism, pedophilia, transvestism, and fetishism. In the 1968 edition, the APA expanded sexual deviation to include voyeurism and masochism, and homosexuality was labeled a "mental disorder." In the 1970s, gay rights activists organized to get homosexuality reclassified. The next edition of the DSM did rebrand homosexuality as a "sexual orientation disturbance," and it included a short line of descriptive text stating that homosexuality "by itself does not constitute a psychiatric disorder." Activists considered this a major victory. Still, the term *homosexuality* wasn't removed from psychiatry's bible until 1987.

This history of psychiatry and homosexuality reveals a troubling tale about how we view mental health, our culture, and people in general. Cancer, diabetes, and arthritis objectively exist whether your doctor finds it or not, and our understanding of these diseases evolves as we investigate and research them. But a mental disorder can be seen as a culturally informed con-

struct—one that can disappear when culture shifts and/or if definition changes are demanded when those impacted the most by the label push back and speak out about what is affecting them. These kinds of changes are an uphill battle.

Like the lion to the hunter, it is not the underdog who usually gets to control mental health narratives. In this case, it is controlled by what could be called the *mental health industrial complex*, which perpetuates biomedical explanations for human suffering. In essence, the prevailing attitude toward mental health is that problems lie within the person and are independent of environment. We question that attitude. And we question what the youth mental health crisis really is. How much of it is a subjective myth, and how much of it is really about something going on inside the minds of kids these days?[13] Who benefits the most from these declines in mental health? Looking at one "new" mental disorder is particularly telling.

The revision of the fifth edition, the 2022 *DSM-5-TR*, introduced a new mental disorder: *prolonged grief disorder*. While the American Psychiatric Association acknowledges grief is a natural response to losing a loved one, according to them, the "symptoms" of grief should decrease over time. When we stepped back and asked ourselves why grief—one of the most natural and ancient human emotions—was included in the DSM as a disorder, we found ourselves also asking who might be behind its inclusion. Who would want grief to be documented as a disorder? Is it something the general public was campaigning for? No. Were therapists and social workers demanding something more be done about a grief epidemic? No. We think the answer is capitalism. Digging deeper, we found that there were nine "expert" psychiatrists tasked with creating the mood disorder guidelines in this DSM revision. Six of them had financial interests tied to pharmaceutical companies (a 21% increase since the DSM-4), and three had been paid to conduct clinical trials on the antidepressant use for grief.[14] A recent study found 60% of the doctors serving on the DSM-5-TR "received more

than $14 million in publicly undisclosed industry funding."[15] Because of these conflicts of interest, we feel healthcare providers should be questioning the faith they put in the ubiquitous DSM. Are the labels and codes helpful in improving well-being? Or are they the result of capitalist intervention in the healthcare system and society as a whole?

Spikes in mental health diagnoses and prescriptions may suggest something is plaguing our youth. However, by medicalizing adolescent distress—which might be misinterpreted as adolescent exploration—we place the responsibility of change on the neurological, the biological, the so-called chemical imbalance all while the adolescent brain undergoes drastic developmental changes. We make the problem something *within* the child (aligning with Anna Freud's theories about the biological basis of adolescence). This keeps the *kids these days* fiction alive and well.

What if it is something else? What if it is simply that humans cannot adequately cope with the amount of information we now have access to today? What if we are reacting to the lack of community and cultural cohesion? Currently, most environmental and social factors are not taken into account; often, they are even off-limits in discourses about mental health. This results in a skewed sense of societal improvement. Medical interventions, clean drinking water, and better sewage systems improve life expectancy, yes, but the identification (or label) of a mental health condition has no correlation to improved quality of life. Continuing down this path of labeling youth distress and nonconforming behavior—the very hallmark of adolescence—has one certain outcome. Our responsibility as adults is removed. We blame biology, genes, chemical imbalances, and neurochemical deficiencies for the suffering of kids these days.

Again, our concern is not about what works in each specific context. If medication helps, fantastic. We care most about what works for each youth and their families, and know we can't provide an across-the-board answer of what is right for whom. At

a macro level, observing the current trends and evidence from forty thousand feet tells us something is not quite right. Homogenizing people into the best-marketed and most easily administered intervention falls short nearly every time. What works for one does not work for all, but labeling and medicating are efficient and profitable.

Across the Western world, there are more psychologists, social workers, and counselors than ever, though positive psychotherapy outcomes for youth and adults have remained flatlined for fifty years.[16] That's right, not one percentage of improvement. In 1993, psychologist James Hillman and journalist Michael Ventura took a critical swing at the field of psychotherapy—the talking cure—illustrated well by their book's title alone, *We've Had a Hundred Years of Psychotherapy—and the World's Getting Worse*.[17] For the authors, therapy had become overly focused on the individual, contending that mental illness resided *within* the patient. Of course, some people going to therapy have real and legitimate histories of trauma, attachment issues, and neuroticism. But the authors accurately predicted a tragic vision of the future if we continue to ignore societal and environmental factors. Tracking another thirty years of trends and outcomes confirms their prediction.

One of our concerns in discussing the rising rates of mental disorders are the proposed consequences that often follow. Our current theories of pathology—that is, what is wrong with kids these days—glorify *interference* from an ideology that mental health is most effectively treated by medicine and behavioral intervention. The statistics portrayed below do suggest youth mental health is a growing concern, especially as it relates to the tragic rates of youth suicide. However, if we respond with more of the same, we are likely to continue labeling youth and inspiring further disconnection.

The US Centers for Disease Control and Prevention (CDC) began exploring the leading causes of morbidity and mortality in youth in the late 1980s.[18] Nearly 70% of all child and young

adult deaths were attributed to four causes. Car accidents, unintentional injury, and homicides made up the majority, but 10% of deaths at the time were caused by suicide. (Drug use was associated with many deaths, and alcohol factored in roughly 50% of vehicle-related deaths, murders, and suicides.) In an attempt to bring these numbers down, the CDC established the *Youth Risk Behavior Surveillance System*, a survey designed to monitor 9th- and 12th-grade students across the US.

In 2023, the American Psychological Association reviewed the CDC's data.[19] The results were less than encouraging. The number of youth reporting hopelessness, persistent sadness, suicidal thoughts, and suicidal behaviors increased by about 40% in the decade leading up to the pandemic.

The COVID-19 pandemic ushered in a further 20% increase. Social isolation, uncertainty, and unpredictability are not recommended for improving one's well-being, no matter the context, but the trend of worsening mental health existed well before mandates, house arrests, social isolation, and lockdowns exacerbated the fear and unpredictability of 2020. While it is tempting to discuss youth well-being and mental health in the context of how detrimental some COVID-19 mitigation strategies were, this is not our focus. Blaming the pandemic for our current state is only part of the story. If anything, the pandemic threw gasoline on a fire already growing out of control. Let's take a deeper look at data from across the globe. (The reader will notice, though, that the way data is collected can lead to differences in what is reported.)

According to *Statistics Canada*, in 2023 intentional self-harm (suicide) was the second leading cause of death for adolescents and young adults in Canada—behind accidents, but ahead of cancer.[20] The World Health Organization's (WHO) 2019 report, using slightly different metrics, showed self-harm as the leading cause of death for 10–19-year-old Canadians. The order they gave was as follows: (1) self-harm, (2) road injury, (3) drug use disorders, (4) interpersonal violence, and (5) cancer. The

WHO's reporting on fatalities in the US found self-harm was second only to car accidents. Interpersonal violence and drug use were third and fourth.

In Australia, Russia, Japan, Germany, Ireland, Norway, Finland, Sweden, Belarus, and Iceland, self-harm is the leading cause of death for adolescents; in dozens of other countries, it came in second to car accidents as of 2023.[21]

In a 2020 study of 1.5 million 11-to-17-year-olds, more than 50% described thinking about suicide or self-harm "nearly every day."[22] The US CDC reported that 2022 saw the highest peak of suicide since 1941.[23] As therapists, educators, and parents, we find these numbers alarming, to say the least. As researchers, we have questions.

Teens should be excited for the adventure of life ahead, instead of living in the emotional states evidenced by these statistics. We asked ourselves, and the experts, why kids, who should be getting ready to take on the world, would instead want to turn their world off.

High rates of suicide tell of a wicked problem. According to the WHO, depression and anxiety diagnoses—the two most common mental health labels—increased by nearly 50% from 1990 to 2013, contributing a one-trillion-US-dollar dent in the global economy.[24] According to the National Institute of Health, depression and anxiety, along with pain, are the most common causes of disability. Mental and substance abuse disorders are more than 20–35% higher for 15–25 year-olds than any other condition.[25] Meanwhile, the average government spends less than 2% of their health expenditure on mental health.[26] Hardly the response we'd expect to a so-called crisis.

In 2020, the WHO reported only 51% of their 194 Member States had policies or plans for mental health in line with treaties and legal standards set out to protect human rights, falling well short of the WHO's target of 80%.[27] The WHO reported reaching only one of their 2013 targets of reducing suicide by 10% by 2020, though only thirty-five member countries main-

tained any stand-alone prevention strategy, policy, or plan to prevent these tragic deaths. Of the limited financial resources available for mental health, 70% of government expenditure in middle-income countries went to mental hospitals, and in countries identified as high-income, 35% went to hospitals. Institutional inpatient care and the mental hospital are centralized; this type of service is often only used for the most difficult of situations. Prevention and community-based care are second to the medicalization of our well-being and mental health, all of which is evidenced by the stopgap approaches of disorder labeling, prescription medication, and institutionalization.

In 2021, 8.5% of all children in the US were taking medication to address difficulties with concentration, behavior, and emotion.[28] 1.2% of them were preschool-aged, and one in eight young people aged 12–17 were medicated. Antidepressant use from 2015 to 2021 had a 10% annual growth. Prescriptions for antipsychotics and drugs used for ADHD saw the most yearly increase in this time (7.9 and 12.7%, respectively)—*for preschoolers*! In the UK, antidepressant use increased 26% for children younger than 17 from 2015 to 2020. Again, this started happening before the pandemic. Every country is experiencing a steady increase in the use of medication for youth. But the biggest and fastest increases are in the US, the UK, and Australia.

These trends continue despite numerous large-scale studies, such as one published in the *Cochrane Review* in 2021.[29] Cochrane is a global, independent network of researchers and healthcare professionals. They use explicit, rigorous methods to minimize bias and improve decision-making, which produces more reliable findings. Cochrane is recognized globally as the highest standard of evidence-based health care.[30] In a systematic analysis of the available evidence, researchers found that although antidepressants may, indeed, reduce depressive symptoms, their impacts are statistically small, and, to quote the researchers, "unimportant" when compared directly to placebos—pills inherently designed to be ineffective.