“The Mental Health Epidemic: How Real Is It?”

SALLY LEE: We’re now going to hear from Dr. Harold Koplewicz. Dr. Koplewicz is the Founder and the Director of the New York University Child Study Center, which is actually celebrating its tenth anniversary this year. He also serves as the Vice Chairman at the Department of Psychiatry, the Arnold & Debbie Simon Professor of Child and Adolescent Psychiatry, and Professor of Clinical Pediatrics at the New York University School of Medicine, the Director of the Division of Child and Adolescent Psychiatry at the Bellevue Hospital Center – and I have at least one more – and Director of the Nathan Klein Institute for Psychiatric Research. I probably left some out. He’s a national expert on adolescent depression, attention deficit hyperactivity disorder, and anxiety disorders in kids; and he’s a tireless advocate for the rights of children with mental illness. Please welcome Dr. Harold Koplewicz.

[APPLAUSE]

HAROLD KOPLEWICZ: It’s about ten years ago that Random House decided to publish a book that I was going to write. And for those of you who have been in academic medicine or in academics – Kathleen was talking about publishing an article – you know how hard it is, that you have to do research, it takes years to get the data, you finally get it organized, write it up, you submit it to a journal, if you’re lucky they send it back and say they accept it with minor revisions, you make the minor revisions, you send it back – and maybe eight months or nine months later it gets published. And it gets published in a journal that might even have a circulation of 3,000 people and 200 people will read it. It’s so much better when a publishing house comes to you and says we’re going to give you lots of money to write your thoughts down, whether they’re data-driven or not. So that was good news that Random House was willing to do that. The book was called It’s Nobody’s Fault and even better, they were going to get me on Good Morning, America, which was very good because back in those days, no one wanted to talk to Katie Couric, they wanted to talk to Joan Lunden. And even better, I was on between seven and eight, which was the time you always want to be on early morning TV before everyone goes to work. And at the very last minute I got bumped by the late Itzhak Rabin’s granddaughter, who had written a book about her dead grandfather. Her book, by the way, never did as well as mine. Nevertheless...

[LAUGHTER]

I have no bitter feelings. But anyway there was a silver lining to the cloud, and that was that at the time I was the Chief of Child Psychiatry out at Long Island Jewish, and so I was commuting from Manhattan to go to work. So I got to walk my youngest son, who was seven at the time, to school. And as we were walking to school on a city block here in New York on the Upper Eastside, two of his two big friends, who were eight-years old, were having a very animated discussion with each other. And so Sam and I eavesdropped, and the first boy said to the second “You’ll never guess what I found this weekend.” And the second boy said, “What?” He said, “I found a condom on the patio.” And the second boy said, “Really? What’s a patio?”

[LAUGHTER]

So all of you who are parents and take care of parents and children outside of New York, I want you to know it’s just a little bit more difficult here in New York City. Now I have a follow-up on this, by the way. A few years later I actually got an award for starting school-based mental health programs in Nassau County. For those of you – child mental health has the highest no-show rates in our clinics. So you have a lot of people sitting there ready to see the patient, and the kids don’t come. So if you start putting mental health clinics in schools you get passed the stigma, people will have very high show rates. It’s very convenient. Anyway, they gave me an award for this. The meeting was being held in Toronto.
It was a great excuse for my three kids to play hooky. My wife’s a teacher – she got to play hooky. So we go up to Toronto, the original seven-year old is now about nine years old. So we’re with my nine-year old, my 11-year old, and my almost 13-year old son, and we’re walking on King Street or Queen Street in this funky little area of Toronto, and as we’re walking, the five of us, I see a big store that says Condom Shop. And I say, “We have to go in there. It’s impossible that they just sell condoms because I don’t see how you can make a living just selling condoms.” And my almost 13-year old says, “Dad, if you say condom one more time I’m just crossing the street. I just can’t...” And I said, “Joshua, I just want to go in for a quick look to see what else they’re selling.” And he said, “That’s it. I’m crossing the street.” And so Sam, who was seven and now nine, says, “Joshua, condoms aren’t dirty. Patios are.”

[LAUGHTER]

So first and foremost among all my jobs I’m a dad. So we’re going to talk about the kids mental health epidemic. David Sature was one of the best Surgeon Generals we’ve ever had. He was not a child psychiatrist, he was a family practitioner, and he did the most unbelievable thing in this nation, he finally gave us a Surgeon General’s report on mental health. And he said, “Mental health is a critical component of children’s learning and general health. Fostering social and emotional health in children is part of healthy child development. It must, therefore, be a national priority.”

Well, there was very bad news in that report and the news hasn’t gotten much better in the last seven years. In this country if you are a white child you have a one out of three chance of getting any kind of help – forget about quality treatment, but any kind of intervention if you have a psychiatric disorder. And if you are black it is one out of five; and if you are Hispanic it is one out of seven. And there are many, many different barriers for why you don’t get it, but there are many, many different disorders. And somewhere between 12 million and 15 million children in the United States have a serious psychiatric disorder. That’s about 12 percent of the population. Some of them have more than one disorder.

So I thought we should look at some of the more common disorders. This is adapted actually from Time magazine. So if we look at infancy to five years, we have disorders like autism and attention deficit hyperactivity disorder. And, by the way, we have lots of people out there who like to fight us on these disorders – that these are not real disorders. I mean, I’ve been on The Today Show many times where I have colleagues who come on and say, “ADHD, that’s not real. That’s Huckleberry Finn or that’s Pippi Longstocking.” Well, unfortunately, these are not fictional characters. There are 2 million children in the United States who have the very, very real disorder of having a shorter attention span, being more impulsive, being more hyperactive than the average child their age. Which means being in school is nearly impossible. They cannot sit. And take away their glasses, if they can’t see they can’t function in school. Take away these kids’ medications and they cannot function.

And if we don’t treat kids with ADHD, ten times more often they drop out of high school, and if they drop out of high school they are more likely to go to jail. And when we look at these groups of disorders, they come in three big buckets. There’s a bucket of kids who have these disruptive disorders and learning disorders, and overwhelmingly they get ignored. And when they fail at school, they end up in the juvenile justice system. 50 percent of kids in juvenile justice have dyslexia. I mean, that’s outrageous. If you think about the only two things that Bush and Clinton had in common was they both wanted us to have all our children reading by third grade. Well, if you have dyslexia and you just read normally, you can’t hear the phonemes of our language if you don’t identify those kids early, they’re not going to read by third grade. When you feel frustrated and yelled at on a regular basis, you quit your job, you drop out of school – that’s more likely that you’re going to go to jail. And that group of kids with HDHD conduct disorders and dyslexia, they end up going to jail.
We have another big bucket of kids who have anxiety disorders and depression, and that big bucket of kids – not only do they tend to self-medicate, those kids with selective mutism or social phobia, those pathologically self-conscious kids, they’re not just shy, but they just can’t speak because they’re afraid – they’re so afraid you’re going to judge them. So I’m not going to raise my hand and answer a question because it’d be better to be silent than to be wrong; I’m not going to eat in front of you because I may choke on my food. Those kids start to drink much more often with alcohol than the bad boys.

So we can show you the trajectory of leaving social phobics untreated, they’re more likely to abuse alcohol. And kids with social phobia and with depression and generalized anxiety disorders, that second big bucket of kids, well, they not only are going to be more self-medicating, they also are going to visit the internists and the other doctors significantly more, also. So they’re going to cost a lot more money. By the way, they go most often misdiagnosed and undiagnosed.

And the last bucket of kids are these kids who have autism spectrum disorder, bipolar disorder, where we need a ton more of research to really understand what the best interventions are. And right now we throw a lot of money but a lot of bad or ineffective treatment at those kids, and those kids left untreated don’t ever get to function the way they deserve to. So not only do we have an epidemic, because look at the numbers here from the National Institute of Mental Health, from SAMSA – because we’re talking about anywhere from – this totals up to more than 20 million kids, but we’re talking about kids who by in large go untreated. In the wealthiest nation in the world we don’t take care of kids with psychiatric disorders. And we’re not talking about neurosis, we’re not talking about rich kids, we’re not talking about poor kids – we’re talking about all kids who are left untreated, left unidentified, and very often what happens is they hit the wall when they get to school.

Now, how severe is it? Well, 71 percent of adolescent deaths are from accidents, homicides, suicides, and other intentional injuries. In other words, you’re not supposed to die during adolescence. And the fact that consistently suicide is one of the leading causes in adolescence – in fact, 5,000 children continually kill themselves – it’s really teenagers between the ages of 14 and 24 – in this country every year since 1960. We’ve had one little dip, which we’ll talk about, and now we have an increase again, but by in large we have a group of children who suffer from depression mostly that goes untreated, and they at the end feel so much pain that they end their lives.

You also find that people who have more psychiatric illness are more likely to have more car accidents. In fact, kids who have attention deficit hyperactivity disorder not only have accidents more frequently with their cars, their car accidents are three times as expensive as the children who just have plain ordinary car accidents. So you can imagine what your insurance is like when you have a child – or your insurance doesn’t go up when your kid has ADHD, but how often you should think twice before giving your keys to your child who has ADHD.

The other piece is that we have 170 non-fatal medical serious suicide attempts. So, Irwin said it before, Katherine said it – it doesn’t really make a difference whether you believe this is the right thing to do or the wrong thing to do – it’s bad business for America not to take care of these kids, because if you think about how much money we’re wasting in our emergency rooms, how much money we waste by not graduating the right amount of kids from high school, how many givers – you don’t become a giver, you don’t contribute to society if you don’t graduate high school; you become a taker and more likely to be on the dole and get some kind of government assistance. It’s just bad business not to identify and take care of these children. Suicide remains the third leading cause of death even among 10-15 year olds, with accidents and cancers being first and second. And as I said, we’ll talk about the suicide rate.

So what else can we call it if not an epidemic? So certainly the biggest advance is that we have in-
creased recognition, and that accounts for most of the observed increases that we’ve been seeing. But it’s still epidemic in that there are these lifelong negative consequences. Something as simple as someone having – let’s just talk about depression for a second. First of all, in this country we still use the word depression to mean demoralization. So when most of us have had a bad day we say, “Boy, I’m very depressed.” And you should be depressed if your boss yelled at you, if you had a fight with your wife, if you are a kid and you got rejected from the baseball team or you didn’t get the grade you wanted. But that’s demoralization, that’s not true depression. And we have trouble understanding that children could be depressed or that teenagers could be depressed. And a lot of this misunderstanding has a lot to do with previous investigators and clinicians.

Anna Freud actually, who’s quoted a lot, has always said that it’s abnormal not to be depressed during adolescence. That that adolescent turmoil that you have is a normal part of adolescence. Well, she was incorrect. Yes, it’s right to be moody, it makes sense that adolescence is a time of turmoil – you have five developmental tasks that you have to accomplish. You have to get used to puberty, you have to separate from mom and dad, you have to develop a social network, you have to get vocational skills or goals or educational goals, and you have to get your sexual orientation, comfortable with that. That would make most people a little moody.

[LAUGHTER]

But we also know – and you’re supposed to finish it by the time you’re 22. So we also know that the brain changes. And that’s one of the big advantages. Jay Geed at the National Institute of Mental Health has been doing beautiful work over the past decade looking at the brains of normal kids. And he has found that at the age of 13 your brain actually goes through a wonderful renovation. It starts to become more efficient, which is perfect timing since 8th grade and 9th grade education is much more comprehensive and more complex. Now if you think about it, before 13, at 10 or 11, you have a brain that kind of has circuitous country roads. You have a road to learn Italian, a road to play golf. If you learn to play golf at nine you’ll get a natural swing. You stop for a few years, you start again, the natural swing comes back. If you start when you’re 30, stop for a few years, you look at the golf club, you have to start remembering to squeeze it, do this, do that. It doesn’t come back. But you still can learn these things, it’s just that from country roads we now go to super highways. Because the brain basically says at 13, you haven’t used it, you lose it.

Now that’s a very efficient way of working. The problem is, think of a big Long Island Expressway. That’s our expressway that goes form here out to the Hamptons. Well, imagine you have construction on that brain. Well, it takes a while to make a new highway. And so during that time period is when you’re going to have more turmoil, which makes sense that we have our first peak of depression when we’re 13 and 14; we have a big peak in schizophrenia and bipolar disorder at 18 and 19; and, amazingly, the brain calms down and the road is all finished at 25, which is when Hertz will let you rent a car.

[LAUGHTER]

Didn’t you ever wonder why Hertz doesn’t let you rent a car at 20? They didn’t know about the brain, but they knew about the rates of accidents. And 25 is not a bad time to fall in love, also, because you’re less moody, you’re also calmer. So as we start to learn more about the brain, we start to recognize that these aren’t caused by moms who didn’t wipe you the right way or a mom who worked versus a mom who stayed – for some of us, because our mom stayed home. You know, it really isn’t a mother who did this, but that it really is a matter of understanding the brain, genetics, and the combination of how environment plays into that.
So what can we do? The number one thing we have to do is make sure that the public understands that these are real disorders. That they’re common but they’re treatable as well. And we can’t change what we don’t measure. So the current approaches are fundamentally inadequate. We have about 6,300 practicing child and adolescent psychiatrists in the United States. Now we have more child psychiatrists – we have about 7,000 child psychiatrists, but it’s not an easy job. So to become a child psychiatrist you do four years of medical school, you do at least one year of internship, you do two years minimum of general psychiatry, sometimes three, and then two years of child psychiatry. You can become a neurosurgeon in the same amount of time, and you can make significantly more money. But, more importantly, taking care of children is not as lucrative as taking care of adults.

Now how does that happen? Well, if any of you got depressed – for the men in the room, it’s very hard to get you to see a psychiatrist. The reason you’ll come to see a psychiatrist is all of a sudden your libido goes. As soon as your libido goes, trust me, you’re in my office so fast it’s unbelievable.

[LAUGHTER]

And on top of that you’ll be very compliant. If I tell you that it’s depression and I write a prescription, you will take the pill, you’ll give a very comprehensive history, and you will come back the next week – we’ll spend 45 minutes together and if everything goes well, very quickly you’ll be coming in once a month for 20 minutes and it’s very easy. I get reimbursed by the insurance company very well.

Well, if you’re 15-years old and you’re depressed, which means you’re irritable – you’re not classically depressed like an adult – you’re moody, you may be overeating, oversleeping, you’re sleeping during the afternoon, you’re skipping meals at night, you’re not going to school in the morning. And your parents finally drag you to see a psychiatrist – first of all, the interaction between us is not all that pleasant. I’m more like a dentist than a child psychiatrist – I’m pulling teeth to get the kid to talk. I think have to talk to the parents, I have to call the school. I’m not getting reimbursed for all those other things. And so what happens is that over time, child psychiatrists frequently stop practicing child psychiatry and start to practice general psychiatry. So currently we only have 6,300 practicing child psychiatrists. So we’re never going to have enough child psychiatrists to meet the need, which means that we’re going to have to educate pediatricians on how to be the first line of attack for these disorders; we’re going to have to use nurse practitioners; we’re going to have to have better screening in schools to understand what is rambunctious behavior versus what is worrisome behavior that needs more help; and we’re going to have to do prevention on high-risk kids as well.

Parents, policymakers – it’s really quite interesting – I think the most effective – Allison is sitting here in the front – the most effective way of working with policymakers and the public is with autism. Autism Speaks has changed the way autism research is being done in this country, the way people are thinking about autism. It is truly nothing short of remarkable. It was 25 years ago, maybe 30 years ago that many people still believed that icebox moms, cold, refrigerator moms caused autism. It was a mother that didn’t pick up their child enough times – that’s why their child was this way. So not only did you have a child that wasn’t going to speak properly, wasn’t going to be able to be independent, but it was clearly your fault. And we couldn’t get rid of that misconception. And if you can’t get rid of that misconception, by the way, you’re less likely – you’re going to feel ashamed to go get help, you’re going to be ashamed to ask for insurance, you’re going to – certainly the government, you’re not running – how few people call the government to complain? You’re certainly not going to run to the government.

Autism Speaks not only pushed autism completely out of the closet, it started to look at it in a systematic way so that people can quote one out of 151 births, one out of 92 males births, of kids on this autism spectrum disorder. All of a sudden a President, who we’ve been bashing it seems the whole morning,
gave hundreds and hundreds of millions more dollars now for autism research. And that's only because you had public awareness and you had policy. But brought on by parents and family members who said, “I’m not to blame. I have a seriously ill child, and I need that help.” And we have to do that model for other disorders as well in mental health. HIV is another good example.

But we also have scientific breakthroughs that are emerging at increasing pace – and that's with genetics, that's brain imaging, which I mentioned about Jay Geed, neuroscience. And we’re developing new methods of advancing research which are really remarkable. So for those of you – I think for many of you, you’ll learn a new piece of information today. I want you to repeat after me: serotonin transporter gene. Come on.

AUDIENCE: Serotonin transporter gene.

HAROLD KOPLEWICZ: You all have a pair of them. Now, the good news is that they come in three different versions. You can either have two longs, two shorts, or a long and a short. And it turns out that if you have two long – and this study, which I’m going to show you right here, was done in New Zealand. Because now that you know you have a pair of serotonin transporter genes, which move the neurotransmitter of serotonin around in your body – and you want serotonin. If you have enough serotonin, you don’t get rageful, you don’t get depressed, you don’t get anxious. It’s good to have. By the way, if you don’t have enough serotonin, you take a little Prozac, that’s why when you get very depressed – that’s how serotonin reuptake inhibitors work. So you all have the ability to move serotonin around.

Well, you want to know if these genes mean anything. So you go off to an island where people don’t move around so you could follow them over many, many, many years. It turns out in New Zealand people don’t even move from the south island to the north island. They stay on one island. So they could find thousands of people who had lived on the south island for decades. And so you now have a group of people who are cohorts over 30 years and they’re all normal, right? They didn’t get identified as patients. You know how much they weighed, you know what kind of school they went to, you know if their parents got divorced, you know if their father beat them, you know if they had a high stress life, a low stress life, or a medium stress life. It turns out if you have two long serotonin genes and life is stressful, you still turn out okay. It turns out if you have two shorts and life is very stressful, you try to kill yourself six times more frequently. And if you have two shorts and life is sweet, you’ll end up just okay and just as fine as the guys with the longs. And if you have a long and a short, you’re somewhere in the middle.

By the way, I got to tell this story last year to Bill Clinton, and he says to me, “Which pair do I have?” I said, “I would bet you have a pair of longs.” And he said to me, “You really think so?” I said, “I think the way you deal with stress is nothing short of amazing.”

[LAUGHTER]

“But I would actually think Roger has two shorts.” And he said to me, “Don’t pick on Roger.” And I said, “That’s exactly the point.” As we learn more about these kinds of genes and parents are able to recognize which one of our kids has more resilience innately and which ones of our kids don’t, that’s the one – we’ll know which kids you could actually raise your voice to and which ones of our kids you have to be more careful with, and which kids need more tutoring, and which kids will need a different kind of interaction between mom and child. And so these kinds of genes are not scary – they actually are making life easier for us as we start to understand what’s going on.

Brain imaging is the other major advance. We’re going into really the next decade of the brain now, which is that we expect to be able to use brain imaging soon, not only for group differences but for
individual differences. Javier Castellano spent 12 years at the National Institute of Mental Health examining the brains of kids with attention deficit hyperactivity disorder versus normal controlled. The kids with ADHD never took medication. They were parents who refused to give their kids medication. And he found significant differences between the controlled and the ADHD kids. Their brains were 3-5 percent smaller in certain areas. The frontal area, which was executive functioning, the back area, which was balance and hyperactivity. When they became teenagers the back area became more normalized, they seemed to lose their hyperactivity. And that was only group differences.

As the machine gets more sophisticated, as we’re able to get better and better pictures, we’ll get closer and closer to the blood test. And you have to understand that if you think about polio, that was an epidemic. We had iron lungs. It was only until Salk and Sabin said, “Oh, we have a virus here” – you know, that’s when you get a vaccine, that’s when you start to measure something and you come up with an answer. And it’s only until we start to really look carefully at the differences between normals and kids who have these significant differences or these disorders. And so neurons only work by being connected to other neurons, and so these new techniques called DTI allow images to see the actual brain connections.

And here we’re actually looking at the brain at rest. So we always used to think that there was just a lot of noise going on in the brain – it turns out now that when we look at children while they’re doing nothing, when we’re just looking at their brains, we can actually think of it – think of it as a government office where there’s a whole bunch of people at the desk making requests, but there’s a whole bunch of government workers talking to each other. Well, that’s the brain at rest. You’re talking to yourself. And it turns out that certain disorders, that communication to yourself is affected. And so, therefore, we can actually see differences in tracks that we’re now being able to map.

We can do a lot today. We know, by the way, that we can improve depression treatment. Prozac and very specific types of talk therapy seem to be very effective. We need to know more about who needs what treatment. And we have to recognize that child mental health is the last unaddressed public health problem in America. And this is where the public can really be helpful. For those of you who read the Times on a regular basis, I would imagine you think that SSRIs like Prozac kill children. You would think that because the kids at Columbine supposedly took Luvox or a kind of SSRI. When we did autopsies on those kids, by the way, there wasn’t a drop of the medicine inside their brain or their spinal cord. They didn’t take the medicine. Just because you’re prescribed the medicine... But because of that bad publicity, the Food & Drug Administration made a decision to put a black box – a black box warning on these drugs that say it can cause “suicidality”. Never heard of the word before, but it’s been invented and now it’s called suicidality. It’s not suicide, it’s not suicide behavior – and, by the way, the 4,000 children who were tested on all these drugs, no one ever committed suicide. But they put the black box on it.

The reason why this is very significant is that if you look here, we finally had a decrease in the suicide rate in America in the last two decades among teenagers. And one of the reasons had to be SSRIs. They seem to finally have a medicine that you couldn’t kill yourself with. Tofranil, Elavil, the tricyclics, if you swallowed a lot of those pills, you died. With Prozac-like drugs the only way you killed yourself is the bottle had to fall off the shelf – it had to be a big bottle – and hit you in the head. But otherwise you couldn’t die from those medicines. But that black box changed a lot of things. Because with 6,300 child psychiatrists, we’re not writing the prescriptions. The prescriptions are being written by primary care physicians and pediatricians. And if there’s a warning label on a black box and I’m seeing a kid for seven to nine minutes, I’m not writing a prescription so fast. I’m going to think and wait. And so when you start looking, you see that the rates of prescriptions started to drop – you see to the right there? – young kids. The only place where it went up was kids over 60. And as the prescription rates dropped
since 2003, the rates of suicide have gone up.

So there’s no possible way that unless the public starts to recognize that we’re talking about real illness that sometimes needs medication, and that, unfortunately, the medicines we have currently are only okay, they’re not great, we will not be able to do what we’re supposed to do. But at the end of the day for everyone in this room, most of us who have been parents know that we don’t want our kids always to get A’s. I mean that’s not the goal. I like the metaphor of baseball. We don’t expect homeruns every time they get up at bat. But we want every child to be able to get up at bat and take a swing at the ball. And if they’re too depressed, or too confused, or too inattentive, or are hearing voices, or they can’t read the signs, they never get that chance to swing at the ball. And without that we’re really leaving a very large part of America out of the game. Thank you.

[APPLAUSE]

BRIAN WALKER: First of all, any question or comments? We’ll take them kind of both at the same time. The first hand I saw right there. Mary, if you turn to the left – there we go.

CONNIE DIEKMAN: [OFF-MIC] Hi, Connie – I don’t think this is on. Connie Diekman, President of the American Diabetic Association. I have a very loud voice. As you talked in terms of the brain... [FEEDBACK] ...size and its impact on ADHD, do we know, is that a function of development during pregnancy? [FEEDBACK, UNINTEL - PHRASE] ...or do we not know what that [UNINTEL - PHRASE]?

HAROLD KOPLEWICZ: So it’s not that the whole brain is smaller. It’s actually specific sizes. And so these kind of brain differences are most probably – we’re going to hear this word again and again – it’s genetics. And so most probably the message is that somehow a message is being sent to the brain while the baby is being made, that the brain is significantly different. And those sections of the brain which are interesting, seem to have a lot to do with dopamine. And it’s, again, interesting, that the medicines that we give for this treatment increase dopamine but only temporarily. So if you want to talk about a need for improvement, we have medicines for ADHD that only improve dopamine levels for four hours to maybe ten hours. And at the end of those ten hours you’re right back to where you started. So these are not cures by any stretch of the imagination – these are treatments that make dopamine go up, which, therefore, decrease the symptoms that cause the most distress and dysfunction. But until we get another quantum leap in the next decade to understand this better, we’re doing patchwork.

We’re not anywhere near that vaccine that I’m talking about. I think the best way to go is prevention. We were talking before about early childhood. We have a study that’s been going on for ten years now at the Child Study Center trying to prevent conduct disorder. So conduct disorder is one of the worst things we have in psychiatry. These are the bad seeds, so to speak. You know, the kids who set fires, they beat up other children, they torture animals, and they don’t have a conscience. They don’t feel bad about what they’re doing, they feel bad about being caught. So we have, God, so many theories about what mothers did wrong with those kids, and it turns out, again, that it’s not a mother’s fault. But how do you turn this around?

So we started a study about 11 years ago with a group of children who were three and four, and whose big brothers and sisters had already become adjudicated adolescents. So mom was about 15 when she had her first child, and she was maybe shy of 30 when she had the fourth or the fifth. So we’re notified by the court system when a child was convicted and if they had a three or four-year old sibling. And we invited them all to come to the Child Study Center. We got 100 of these kids into the study. Ever child was given a free evaluation. Very low IQ – 85 average IQ. Families from poverty, families with histories of abuse, substance abuse, physical abuse, really very, very challenged families. 50 percent of the
families were just treated nicely. We were just very pleasant and nurturing to them. And 50 percent of the families, the mothers all received intensive training in something called parent core. How to play with their kids and how to discipline their kids. But very systematic with videotaping.

After 28 sessions each child was – blind observers came in, they found the kids whose parents got this, that the kids were certainly more attentive, more ready to read, more compliant to commands. And, most interestingly, we took each child one-by-one to a new nursery school. And we said we’re taking you to a nursery school where you’re going to meet new kids and you’re going to see new toys. And as we walked into the nursery school we gave them a lollypop so we could get some saliva, and we took some saliva to get cortisol to measure their stress hormones. And the children whose mothers got parent core, their anxiety level, their stress hormone went up, and after the nursery school, it came down. Which is good, because you’re supposed to get stressed before a new environment. The kids whose parents didn’t get it, it stayed flat. They were stressed out the whole time. So we changed a biological – this is Laurie Miller Bratman’s work – she changed the biological finding without giving a kid a pill, without actually working with the kid but by working with the parent.

More interestingly, it’s now 11 years later, the kids are 13-15 years old. 20 percent of the kids whose mothers got parent core are obese. 75 percent of the kids whose parents didn’t get parent core are obese. Now, this is an unintended finding. We would never have gone to the federal government and say, give me 28 sessions – it’s not an anti-obesity program. But the fact that early – because you asked the question before, isn’t there a group of very high-risk kids that we have to do something special for at a very early age? But clearly, it makes perfect sense that the earlier we get to these kids, especially the ones at risk, there’s tremendous benefits later on. And so now there’s 30 different preschools, we’ve taken it down to 11 sessions. I mean, we’re trying to titrate this more and more.

BRIAN WALKER: A question there?

MICHAEL THOMPSON: Michael Thompson. I want to ask about both the underdiagnosis of ADHD and the overdiagnosis. Because I see it being overdiagnosed in middle class and upper middle class families, especially among boys, which is a concern of mine. How do you see the way ADHD is playing out in the treatment of it in the United States?

HAROLD KOPLEWICZ: Overriding, we’re still – if you look everywhere, we’re still underdiagnosing it. Because every study will tell you we’re somewhere between 5 percent, 8 percent of the population, clearly more boys than girls, but overwhelmingly we don’t treat it. Now, you’re right, if we do treat it, we treat it among white middle class boys. And it’s very much directed by pediatricians’ attitudes to the disorder and to the treatment. So does anyone want to guess where you’re most likely going to get a prescription for this medication? Let’s do Northeast, Southeast, Midwest, West – where are you most likely going to get a prescription?

[AUDIENCE RESPONDS]

Northeast private schools? Well, that’s a myth, right? So the best place to get it if you want to walk into a pediatrician’s office, is the southeast of this country. And that’s where you’re going to get it. Savanna, Atlanta, Birmingham. And it’s quite interesting that the next place you’re most likely to get it is the Midwest. So you get it where there are less child psychiatrists. So it’s clearly driven by pediatricians’ attitudes.

I think that there’s a tremendous amount of education still needed out there. You can’t make the diagnosis on one visit because moms are terrible at making this diagnosis. You need teacher input. Teacher
input requires at least sending a Connors Form, sending a teacher questionnaire to a teacher, getting a teacher to complete it, getting a teacher to send it back, getting you to score it so you at least have a baseline before you do some intervention. And, also, if you think about ADHD, the symptoms of inattention, hyperactivity and impulsivity, if they didn’t start before the age of six, if they just had a sudden onset, is it because mom and dad are getting divorced? Is it because the kid is anxious? Is it because the kid’s learning disabled? Or is it because the kid’s gifted and has a boring teacher? I mean, there are so many reasons why you could have this set of symptoms.

So diagnosis takes time. And the problem we have with most pediatricians, in my opinion, is they don’t have the time to do it. And for many of them, they haven’t been given the skills to do this effectively and efficiently, and so they’re in a jam. Parents are coming in complaining, they try to fix it, and so some of them are giving medicine. The saddest part is when you start looking at these medications – they have to be renewed every 30 days. When you start tracking how these medicines are given in most parts of the country, people get one prescription and then they don’t renew. So, you know, that doesn’t work. So he took 30 days of it, obviously it didn’t work because if something works, believe me, they call you back and they ask for more or they say it’s making the kid weepy, give me less, or it’s not helping. But that takes time. I tell you, until insurance companies and managed care are willing to pay pediatricians for more of their time, this problem is not going to disappear.

BRIAN WALKER: I’m afraid we have to cut it here. So, first of all, thank you very much, Doctor.

HAROLD KOPLEWICZ: Thank you.

[APPLAUSE]

BRIAN WALKER: I know there are more questions. Please don’t lose them. We’ll hopefully get back to them this afternoon. But do right them down so that you don’t lose that thought. And we have another videotape from another Presidential candidate and then we’ll move into our next presentation. So roll tape.

[END OF SEGMENT]