

# Lessons Learned, Messages Received, Ideas Transmitted

by Stephen P. Hinshaw, Ph.D.

**Editor's Note:**  
The Spanish translation of this article begins on page 38.

FOR MORE THAN THREE DECADES, I have been privileged to work with children and adolescents who experience behavioral disorders, most often AD/HD.

When I entered graduate school at UCLA in the late 1970s, I began 25 years of work with children who were then diagnosed with “hyperactivity.” Over the years, my summer programs have provided me with wonderful opportunities to observe the social behaviors and enrich the lives of many children with AD/HD, to investigate a variety of influences on children’s development, and to build and evaluate powerful treatment strategies.

Recently, I have focused my research on girls with AD/HD, longitudinal research strategies, linkages between treatment research and theory, and the deep stigma related to mental illness in our society. My dual quest has been to understand and assist children and families and to tackle “big questions” of a conceptual and theoretical nature.

Reflecting on my journey, I have considered major scientific and clinical issues; trends in the field; and the question of what has been learned over the years, positively and negatively, in the quest to help advance our clinical and scientific efforts.

First, a major trend in past decades has been the increased focus on careful evaluation and accurate diagnosis. In earlier versions of the *Diagnostic and Statistical Manual of Mental Disorders* (i.e., *DSM-I*, 1952; *DSM-II*, 1968), diagnostic categories were described loosely at best. With the advent of *DSM-III*, in 1980, and continuing with *DSM-IV*, in 1994, evaluation became more precise—with specific symptom lists, periods of duration and degrees of impairment included in the criteria. In fact, the diagnosis of AD/HD

can be reliably made when well-normed rating scales, a careful history, and appropriate interviews and assessment tools are utilized.

Yet key problems exist. For one thing, the time required to make an accurate evaluation is far longer than the few minutes typically allotted in real-world practice. There are many reasons why a child or adult may display attentional difficulties and impulse control problems (e.g., abuse, stress, other medical conditions).

Without adequate time, and thus, a comprehensive evaluation, overdiagnosis may too easily occur. On the other hand, unless assessing clinicians realize that diagnosis cannot be made on the basis of office observations alone—or that girls as well as boys can have this condition—underdiagnosis is likely to occur.

To minimize risks for either problem, insurance coverage for evaluation must fund adequate efforts, education of medical and mental health professionals must be enhanced, and future diagnostic systems must transcend static lists of symptoms and take into account the development that occurs among individuals with attentional and other disorders.

Second, over the years the field has come to realize that the impairments associated with AD/HD go beyond the core symptoms of inattention, impulsivity and overactivity in terms of importance. Indeed, academic failure, peer rejection, family disharmony and serious risk for accidental injury frequently accompany AD/HD, as does a strong risk for comorbid psychiatric problems and conditions. Such impairments and disorders require not only careful evaluation but also specific treatment in their own right, as they are usually more predictive of problems in the long run than are the core AD/HD symptoms themselves. Such an understanding is essential, as AD/HD is not just a disorder of childhood but tends to persist across the lifespan, another major realization of the last decades.

Third, I have been impressed with the growing sophistication of the search for processes and mechanisms that underlie AD/HD. The candidates are many: dysregulated attentional processes, difficulties in inhibitory control mechanisms, deficits in “executive functions”—e.g., planning, set-maintenance and set-shifting, fighting distractions—subserved by the frontal lobes and their interconnections with other key brain regions, problems with time management, oversensitivity to reward, emotion dysregulation and deficits in modulating arousal.

Perhaps the most crucial question is how the precursors of AD/HD, such as problems in temperament early in life, develop across time and interact with family and school environments to shape symptoms and impairments. We are still far from having a truly unified and unifying theoretical account of AD/HD, probably signaling that the disorder is not just “one thing” but reflects different conditions that are the outcome of several disparate developmental processes. I have been dramatically influenced by wise investigators willing to take on the challenge of studying such complex and fluid developmental processes across time.



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Along this line, it is hard to escape the field’s increasing biological sophistication. Indeed, 30 years ago most theories of AD/HD were related to faulty parenting styles—or to rather vague neurological notions. Today, it is recognized clearly that the core symptoms are strongly heritable, meaning that the risk for problems in activity level, inattention and disinhibition across the population is shaped more by genes than environments. But too many otherwise-perceptive scientists assert that because individual differences in AD/HD are attributable largely to genes, families and school environments are not important in terms of ultimate outcome. Quite simply, such reasoning is wrong.

The genetic determinants of a given trait or condition do not rule out the possibility that family, school or cultural influences can shape and mold the course of the individual’s life. The brain is highly plastic: genes may require the effects of environmental influences to be expressed, and destiny does not reside wholly in genetic determinism (as is often asserted today) or in family child-rearing styles (as was the belief a generation ago).

To illustrate, I highlight findings from the *Multi-modal Treatment Study of Children with AD/HD*, also

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known as the MTA Study, a large-scale clinical trial—funded by the National Institute of Mental Health—comparing medication management, intensive behavioral intervention, the combination of the two and community care in the treatment of children with AD/HD (see the December 2003 issue of *Attention!*<sup>®</sup> for details). In an important secondary analysis of the MTA data, our team found that for children receiving the combination treatment, school-based disruptive behavior not only decreased, but was also brought within the normal range, if and only if parents showed clear improvements in their negative/ineffective discipline styles (this work is described in Hinshaw et al., 2000, *Journal of Abnormal Child Psychology*). Indeed, such improvement in parenting served to mediate or explain such benefits of the multimodal treatment condition. Despite the psychobiological reality of AD/HD, parenting still matters.



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Regarding treatments, progress has been made in several arenas. For one thing, medication has been increasingly recognized as an important—in many cases essential—intervention strategy for children, adolescents and adults with AD/HD. In fact, recent pharmacological advances have allowed for single-dose-daily formulations that span both school and after-school activities of treated individuals.

Careful research has also shown that a variety of behavioral interventions (e.g., parent training, school consultation, intensive child programming) are beneficial for individuals with AD/HD, although, on average, effects are somewhat smaller than those from medications. Crucially, combining medication and behavioral interventions has the greatest chance of producing clinically significant benefits, with the potential for lower dosage levels of medication than would be the case when medication is the sole treatment. Such research progress is welcome, given that several decades ago individual, insight-oriented therapies were touted as the treatment of choice for nearly all children with behavioral or emotional disorders.

Yet this is no time for the field to rest on its laurels regarding treatment. **There is still a major lack of training among practitioners in the use of empirically based medication and behavioral treatments; insurance coverage for evidence-based interventions is sorely lacking as well.** Even more fundamentally, both medications and behavioral treatments suffer from a key, parallel limitation, namely that the effects of each dissipate rapidly when the active intervention is stopped. Thus, current treatments are palliative in nature, easing the symptoms without actually curing the disorder. It will take strong conceptual and clinical efforts to develop treatments that will fulfill the promise of yielding lasting change.

Finally, what of future trends? I note a small but growing movement across the mental health fields with respect to the blending of scientific efforts and compassionate narrative accounts. Traditionally, it has been against their nature for scientists to disclose their own personal reasons for their work, for fear that such subjective rationales may taint their objectivity. Similarly, clinicians have been trained to be dispassionate, lest their own “issues” interfere with treatment. But how do scientists and clinicians get interested in their work in the first place? Personal and family experiences may be wholly appropriate sources of inspiration.

In terms of science, there is good reason to promote objectivity during latter phases of the research process, when hypotheses are put to the test; but



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disorders can inform a humane and responsive set of research and treatment-related efforts in the field and let the public know that mental health is a core priority. Stigma still exists regarding mental disorders, including AD/HD. Multiple efforts, at individual, familial and societal levels are required to reduce such bias and stigma and thereby increase the support and funding of research and treatment efforts. ■

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during earlier “discovery” phases of inquiry, personal or family experiences, as well as empathy and compassion, are legitimate sources when determining what to investigate. Similarly, clinicians often have key personal or family-related reasons for entering the field—this is perfectly fine, provided that treatment itself is delivered professionally and responsively.

In my own life and career, I have slowly taken steps toward understanding the reasons for my dual interests in the scientific underpinnings of child disorders and the search for effective treatments. Such reasons include my having grown up in a family in which serious mental disorder was and is quite present.

In telling the story of the life of my father—a philosopher who suffered from lifelong, misdiagnosed bipolar disorder—in *The Years of Silence are Past*, I have attempted to humanize serious mental disorders by portraying its reality and by discussing issues faced by families. My personal experience has, in fact, sensitized me to the utter importance of accurate diagnosis and responsive treatment, to the resilience and courage (as well as the pain and despair) that can accompany mental disorders, and to the need for communication and openness within families and across society about mental illness.

Overall, I ardently hope that the blending of personal, scientific and clinical accounts of mental

**Errata**

The editors regret that the following biographical information was not included in the **Just What Is Coaching?** article (December 2003).

Joel L. Young, M.D., is the medical director of the Rochester Center for Behavioral Medicine in Rochester Hills, Mich. He is board certified by the American Board of Psychiatry and Neurology and holds added qualifications in geriatric, forensic and adolescent psychiatry. Dr. Young has authored many chapters and articles about AD/HD and related disorders and served as primary investigator in many recent AD/HD and antidepressant medication field trials.

David Giwerc, MCC, International Coach Federation, is the founder/president of the ADD Coach Academy, a comprehensive AD/HD coach-training program. Giwerc is the president of the board of directors of Attention Deficit Disorder Association (ADDA). He leads the AD/HD SIG (Special Interest Group) monthly teleclass, sponsored by the International Coach Federation, which is designed to provide a platform for coaches to learn more about AD/HD coaching. He was the producer and co-director of the well-received AD/HD Coaching video and has been a featured speaker at previous ADDA, CHADD and International Coach Federation Conventions.