

Identifying Treatments, Addressing Stigma

Gina Pera interviews Stephen Hinshaw, MD

IT WASN'T UNTIL STEPHEN HINSHAW WAS A PREMED STUDENT

at Harvard that his father revealed to him his long struggle with mental illness. Virgil Hinshaw was a well-regarded philosophy professor, but for long stretches at a time during his son's childhood, he would disappear. His children were simply told their father needed "rest."

As Stephen Hinshaw later learned, the treatments his father received were primitive at best, involving being tied to a bed or given electroshock therapy and experimental antipsychotic medications. It took another twenty years—after Hinshaw helped to correctly diagnose his father in the 1970s—for his father to receive appropriate treatment for bipolar disorder.

Inspired in part by his family's experience, Hinshaw went on to study clinical psychology, eventually becoming a professor, author, and highly regarded researcher, particularly in the area of ADHD.

As one of the chief investigators of the Multimodal Treatment Study of Children with Attention-Deficit/Hyperactivity Disorder (MTA), Hinshaw fulfilled a longstanding professional interest: identifying which treatments work best for which type of children with ADHD.

Hinshaw's other guiding interest is addressing what he calls the "last frontier" of mental illness: stigma. He has written a trilogy of books that focus on the topic. We talked about stigma and more.



Steve Hinshaw, PhD, is chair and professor of psychology at the University of California, Berkeley.

Do you recall your professional aspirations from childhood?

Our first-grade teacher asked us to draw a picture of what we wanted to do when we grew up. I asked permission to divide the picture in half. On the left, I drew an astronomer; on the right, a pro basketball player. Well, I switched psychologist for astronomer, but I still play basketball regularly!

What drew you from astronomy to clinical psychology, research, and academia?

My dad, as I've written in my books and shared in many public talks, was absent from time to time when I was young, but I was not allowed to know that he was in mental hospitals. The doctors ordered my parents to keep silent.

A chief focus of my work has been addressing this whole issue of stigma, silence, and shame around mental illness. Here's the bottom line: If children sense something is not going well at home but there's a gag order that prevents everyone from talking about it, what do they do? They internalize it. They think, What did I do wrong?

When my dad later began to

tell me about his life, that inspired me to work with children who had lost their way. I was probably identifying with the lonely and confused child I'd been. At roughly the same time, my volunteer work with summer camps increased my interest in this field.

Please tell us more about those experiences with summer camps.

During summers in college, I worked at residential schools and summer camps. But for three years before starting grad school, I directed a residential summer camp and coordinated an alternative school for children who'd been thrown out of the public schools. So that fueled my interest in understanding the many complex reasons for these children's problems. At the same time, I was learning that my father's mental illness is often genetic.

So, I was working with children who for a whole bunch of reasons—genetic, environmental, and so on—were having major problems in school or with the law. And I wanted to understand how these problems start. In my grandiose youthful way, I decided to study every possible contributing factor.

Given your personal, research, and clinical experience, do you have any advice for parents who have ADHD about how to explain their own symptoms to their children?

This is the sixty-four-jillion dollar question. The best model is in the mood-disorders field. It's essentially a family therapy with, of course, one of the goals being the parent receiving proper treatment. But parents also work with the therapist to develop an age-appropriate narrative that will explain to the child what's going on with mom or dad.

Randomized trials show that not only does this type of intervention reduce everyone's stress, but it also reduces the child's risk of developing depression. So, given that there is also a heritable factor with mood disorders, the idea is that honest and informed communication may be a preventive strategy for the child. That's very exciting.

How would you adapt this for ADHD? I think the same principle applies. If the child can begin to understand why the house is disorganized, why a parent is irritable, and so forth, it takes the blame off the child *and* the parent. Moreover, the parent's honest disclosure might help the child accept his own ADHD-related problems and aid longer-term adjustment.



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So, highly genetic conditions such as ADHD aren't all "nurture" or all "nature" but rather a mix of the two?

Yes, and historically, the shift between the two extremes has been fascinating. The clinical approach used to be, "I don't need to see your child to deal with your child's problems; it's a marital issue and we treat that with marital therapy." Then it went to the opposite extreme: "I don't need to see the couple; it's a child's genetically inherited issue, and we medically treat the child."

But, of course, the parents of children with ADHD often have ADHD themselves. And how are these parents going to help their children with ADHD if they can't get organized and be responsive parents? To be clear: It's not that disorganized parenting *causes* ADHD, but such parenting can maintain it and even exacerbate the child's challenges over time.

This points to a bigger scientific issue: All things being equal—meaning similar genetic influence and degree of symptoms—why do some children with ADHD remain challenged over time while others improve? Yes, ADHD may be entirely heritable, but parenting style might have everything to do with how those genes continue to be expressed and how the child does over time.

The bottom line: Multiple strategies, often including medication, are important. The metaphor with diabetes is that you might need insulin long-term, but how well is it going to work if you're still eating junk food, not exercising, and not taking care of yourself in other ways?

The first book in your trilogy devoted to destigmatizing mental illness was *The Years of Silence Are Past*. You wrote candidly about your father and your own concerns of inheriting bipolar disorder. Yet you also explained, to the lay reader, the historical and modern attitudes towards bipolar disorder. So, this book seems to embody your approach of combining research with personal narrative.

Education and knowledge about mental illness are good, but it's the kind of education about mental illness that is particularly crucial—meaning, far less about facts and statistics and far more about the potential for strength, resilience, and recovery.

Moreover, knowledge may be necessary to reduce negative attitudes and discrimination, but it's far from sufficient. Contact, empathy, and antidiscrimination policies are essential. I explore this further in the trilogy's other two books: *Breaking the Silence* and *The Mark of Shame*.

What has been the most enjoyable aspect of your work?

The blend of learning new things every day, trying to make a difference in lives of children and families, and teaching others about what we've learned—all of this is an exciting combination. 🍌