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Correspondence

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TREATMENT FOR HYPERACTIVE BOYS

DEAR SIR,

The paper by Drs August, Stewart and Holmes (*Journal*, August, 1983, **143**, 192–98) is consistent with what we already know, due in part to more recent work of Stewart and his group, on the differential prognosis of hyperactivity with and without aggression in children of normal intelligence. Childhood aggressive behaviour is a fairly stable predictor of later behaviour problems. Attentional deficit disorder without conduct problems is indicative of a higher risk of educational problems, due to accumulating learning deficits in the school career.

However, I disagree with the last two sentences in which the authors suggest different types of treatment for the two groups, i.e. social-skills training for conduct disordered children together with self-instructional training and, on the other hand, educational programs with stimulant medication for those without conduct disorder.

It is a truism if it is implied that identified individual deficits and behaviour excesses have to be dealt with in a problem-specific way. From all we know, it is not an umbrella term like 'social-skill training' or 'social problem-solving training' which, despite serious efforts to systematically organize and define their scope and the ingredients involved (Ladd and Mize, 1983), can provide a meaningful boundary for different treatment recommendations to be made. Social problem-solving programs, with self-instructional training as an alleged major agent, have been, by and large, equally effective for both groups, provided the procedures were highly individualized (e.g. Douglas, 1980; Eisert *et al*, 1982).

More important, I can see no empirical foundation for their belief in stimulant drug treatment being especially suited for hyperactive children without conduct disorder. In the light of the fascinating but frustrating search for responder characteristics, which has filled the literature with purported indicators of drug response which have rarely stood the test of time or replication, we should be hesitant in giving such a general view. This is especially so, as it is easily transformed into a treatment recommendation that stimulant drug treatment is of no avail for children with 'additional' conduct problems. The findings that normal children react similarly to dextroamphetamine as do hyperactive children (Rapoport *et al*, 1980), or that there is comparability of methylphenidate effects for 'borderline' hyperactive children, those with some 'hyperactive' symptoms, and severely (cross-situational) hyperactive patients (Klorman *et al*, 1983), seem to lend support to the more parsimonious conception of stimulant drugs being a relatively non-specific treatment. Let us not even inadvertently revive the 'treatment-etiology fallacy' that methylphenidate-related gains confirm the presence of some form of physiological dysfunction.

This is a minor criticism, and should not detract from the major thrust of the findings by August *et al:* it makes a difference if hyperactive children also show aggressive and antisocial behaviour, and should make a difference in the treatment provided.

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