Attention deficit/hyperactivity disorder and ethnicity

K N Dwivedi, R G Banhatti

Despite the large volume of research dedicated to attention deficit/hyperactivity disorder (ADHD), the influence of ethnicity on the condition is still to be adequately addressed. Previous studies have shown differing rates of ADHD between different countries (although this can be affected by the assessment tool used). Cultural environment may affect a child’s behaviour, but the differing attitudes of parents, clinicians, and society around the world towards acceptable behaviour may also influence diagnosis. If assessment criteria could be consistently applied across different ethnic groups, the prevalence of ADHD would probably be similar.

Attention deficit/hyperactivity disorder (ADHD) is among the most frequent, intensely researched, and yet diagnostically controversial conditions of childhood. There is extensive literature on ADHD, but relatively little emphasis has been placed on cultural differences, and diversity variables, such as ethnicity, have been rather neglected in ADHD research.

INFLUENCE OF RATING SCALES ON PREVALENCE

Large variations exist in the reported rates of ADHD for different countries (tables 1 and 2), which likely reflect the difference in diagnostic schemes used. However, a review of 50 studies from around the world suggests that ADHD is at least as high in many non-US children as in US children.

There seem to be differing views about the distinction between hyperactivity and conduct disorders, as well as about the necessary severity for defining a case. The classification of disruptive behaviour disorders of childhood therefore continues to be controversial. Taylor and Sandberg highlighted a 20-fold variation in the diagnostic rate between USA and UK. This may reflect differences in the definition of the condition, rather than the behaviour of the children. Prendergast et al studied the differences in US and UK clinicians’ rating of the case histories of actual child psychiatric patients and found that the diagnostic scheme and clinician training both contributed to the difference in the reported cases. They concluded that cross cultural studies will have to be based upon better means of identifying cases than is yielded by clinical diagnosis.

Baumgaertel et al compared teacher reported prevalence rates for disruptive behaviour disorders in a German elementary school sample using DSM-III, DSM-III-R, and DSM-IV criteria. They found that the application of DSM-IV criteria increased total ADHD prevalence rates by 64%. A study of professionals from Italy and the US did not differ significantly in diagnosing case descriptions, but did so in the reported use of assessment to diagnose ADHD in routine clinical practice. Americans were found to use more assessment procedures than Italians.

Wolraich et al evaluated a measurement model of ADHD in a study where elementary school teachers rated 21 161 children in four locations: Spain, Germany, urban USA, and suburban USA and found that the two factor model (inattention, hyperactivity/impulsivity) was the best fit for all four samples in the two continents.

INFLUENCE OF ETHNICITY

Culture influences the very same areas that are central to mental health, such as behavioural expectations and tolerance, language, emotion, attention, attachment, traumatic experiences, conduct, personality, motivation, setting limits and other aspects of parenting and child rearing, and so on. Undoubtedly, cultural context plays an important role not only in structuring the environment in which an ADHD individual functions, but also in the way such an individual is understood and treated.

In order to understand the phenomenon of ADHD, it is important to explore the complex interaction between organic, environmental and cultural factors. Psychodynamic and attachment factors in the genesis of ADHD have not so far received the attention that they merit. Traumatised children exhibit patterns of symptom clusters that resemble ADHD, conduct disorders, and anxiety disorders. Sustained traumatic experiences, such as child abuse and neglect, or failure to form a secure attachment in the early years of life, can create a chronic state of hyper arousal in a child that alters the neuroendocrine activities of the brain with cognitive, emotional, and behavioural changes.

Block argued that children prone to hyperactivity may be “suffering from a culturally-induced stimulus overload”. A disproportionate number of ethnic minority families live in highly stressful environments, thus making their children more vulnerable to hyperactivity.

According to Margalit, the syndrome is stable across different cultures and similar proportions of children are defined as deviant. However, the extent of agreement among different countries regarding labelling, such as what is an impulsive behaviour or a concentration problem, needs to be studied further. Mann et al examined the degree to which mental health professionals in four countries (China, Indonesia, Japan, and the

Abbreviations: CTRS, Conners’ Teacher Rating Scale.
neurological markers and no medical tests for ADHD that are commonly used in current clinical practice. In the research setting, however, emerging functional neuroimaging and neuropathological data describe measurable differences. In essence, it appears that if consistent assessment criteria for ADHD are applied to differing ethnic groups of children, the prevalence of the condition would be similar between such groups.

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REFERENCES

Table 1 Community (usually school) samples

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate (%)</th>
<th>Note</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>7.7</td>
<td>School; DSM-III-R</td>
<td>Kanbayashi et al</td>
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<td>China</td>
<td>1.9–13</td>
<td>Range of studies</td>
<td>Li et al</td>
</tr>
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<td></td>
<td>3.0</td>
<td>Primary school children; Tao</td>
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<td>Israel</td>
<td>5.0</td>
<td>CTRS</td>
<td>Margalit</td>
</tr>
<tr>
<td>Italy</td>
<td>3.9 (“likely cases”)</td>
<td>Fourth graders; DSM-III R CTRS</td>
<td>O’Leary et al</td>
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<td></td>
<td>6.9 (“possible cases”)</td>
<td>DSM-III R</td>
<td>Gallucci et al</td>
</tr>
<tr>
<td></td>
<td>12.0</td>
<td></td>
<td></td>
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<tr>
<td>Spain</td>
<td>16.0</td>
<td>CTRS</td>
<td>Gingerich et al</td>
</tr>
<tr>
<td>Germany</td>
<td>8.0</td>
<td>CTRS</td>
<td>Gingerich et al</td>
</tr>
<tr>
<td>Iceland</td>
<td>5.7</td>
<td>School; DSM-IV</td>
<td>Magnusson et al</td>
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<td>Scotland</td>
<td>4.5</td>
<td>CTRS</td>
<td>Gleeson &amp; Parker</td>
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<td>UK</td>
<td>16.6</td>
<td>DSM-III</td>
<td>Taylor et al</td>
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<td>The Netherlands</td>
<td>9.5</td>
<td>DSM-III</td>
<td>Verhulst et al</td>
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<td>Canada</td>
<td>5.8 (boys 9%, girls 3.25%)</td>
<td>Ontario, multiple checklists</td>
<td>Szatmari et al</td>
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<td>Studies reviewed by Faraone et al</td>
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<td>7.1–12.8</td>
<td>DSM-III R (6 studies)</td>
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<td>11.4–16.1</td>
<td>DSM-IV (4 studies)</td>
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<td>Pineda et al</td>
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<td>Rohde et al</td>
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<td>Queensland, CTRS</td>
<td>Halbarov et al</td>
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<td>New Zealand</td>
<td>12.0</td>
<td>CTRS</td>
<td>Werry &amp; Hawthorne</td>
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CTRS, Conners’ Teacher Rating Scale.

Table 2 Clinic or other samples

<table>
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<th>Country</th>
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<td>India</td>
<td>7.2</td>
<td>Child Guidance Clinic; DSM-IV</td>
<td>Muthapaddayya et al</td>
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<td>Hospital OPD; DSM-III</td>
<td>Bhatia et al</td>
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<td>Zohar et al</td>
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<td>Muru et al</td>
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<td>Ibadan, paediatric primary care clinic; DSM-III R</td>
<td>Gureje et al</td>
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<td></td>
<td>5.0</td>
<td>Ibadan, child psychiatric clinic; DSM-IV</td>
<td>Omigbodun</td>
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</table>

CTRS, Conners’ Teacher Rating Scale.
39 Omigbodun OO. Personal communication. 2002.
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Arch Dis Child 2005 90: i10-i12
doi: 10.1136/adc.2004.058180

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