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. 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 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.
culture, as there are no specific cognitive, metabolic, or environmental causes. The widespread propagation of the ADHD construct in modern Western society has produced the ideal cultural precondition for the birth of this condition.

Parents, clinicians, setting, however, emerging functional neuroimaging and neuropsychological 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.

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>
</tr>
<tr>
<td>China</td>
<td>1.9–13</td>
<td>Range of studies</td>
<td>Li et al.</td>
</tr>
<tr>
<td></td>
<td>3.0</td>
<td>Primary school children; Tao et al.</td>
<td></td>
</tr>
<tr>
<td>Israel</td>
<td>5.0</td>
<td>CTRS</td>
<td>Margalit et al.</td>
</tr>
<tr>
<td>Italy</td>
<td>3.9 (&quot;likely cases&quot;)</td>
<td>DSM-III R</td>
<td>Gallucci et al.</td>
</tr>
<tr>
<td></td>
<td>6.9 (&quot;possible cases&quot;)</td>
<td>CTRS</td>
<td>O’Leary et al.</td>
</tr>
<tr>
<td>Spain</td>
<td>12.0</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>Israel</td>
<td>5.7</td>
<td>School; DSM-IV</td>
<td>Magnussen et al.</td>
</tr>
<tr>
<td>Scotland</td>
<td>4.5</td>
<td>CTRS</td>
<td>Gleeson &amp; Parker et al.</td>
</tr>
<tr>
<td>UK</td>
<td>16.6</td>
<td>DSM-III</td>
<td>Taylor et al.</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>9.5</td>
<td>DSM-III</td>
<td>Verhulst et al.</td>
</tr>
<tr>
<td>Canada</td>
<td>5.8 (boys)</td>
<td>Ontario, multiple checklists</td>
<td>Szatmari et al.</td>
</tr>
<tr>
<td>USA</td>
<td>9.1–12.0</td>
<td>DSM-III (4 studies)</td>
<td>Studies reviewed by Faraone et al.</td>
</tr>
<tr>
<td></td>
<td>7.1–12.8</td>
<td>DSM-III R (6 studies)</td>
<td>Faraone et al.</td>
</tr>
<tr>
<td></td>
<td>11.4–16.1</td>
<td>DSM-N (4 studies)</td>
<td>Faraone et al.</td>
</tr>
<tr>
<td>Columbia</td>
<td>16.0</td>
<td>Children in the general population; DSM-IV</td>
<td>Pineau et al.</td>
</tr>
<tr>
<td>Brazil</td>
<td>5.8</td>
<td>School; DSM-IV</td>
<td>Roade et al.</td>
</tr>
<tr>
<td>Australia</td>
<td>12.0</td>
<td>Queensland; CTRS</td>
<td>Halbrow et al.</td>
</tr>
<tr>
<td>New Zealand</td>
<td>15.0</td>
<td>CTRS</td>
<td>Werry &amp; Haworth et al.</td>
</tr>
</tbody>
</table>

CTRS, Conners' Teacher Rating Scale.

US) differed in their ratings, and found that perceptions of hyperactivity vary significantly across countries even if uniform rating criteria are applied.17 Chinese and Indonesian clinicians gave significantly higher scores for hyperactive disruptive behaviours than others. Clearly, parental perceptions of normative and deviant behaviour in children are influenced by their culture. Hackett and Hackett found that Gujarati-speaking parents had more stringent expectations of child behaviour and tolerated fewer behavioural difficulties.18 Indeed, children were found to display fewer behavioural problems in line with parental expectations. Thus, the differences in the rate of ADHD across cultures or over time could also be a reflection of the differences in social tolerance of behaviours that do not conform.19 However, it is not possible to standardise the cultural environment and the attitudes of parents, clinicians, and society towards acceptable behaviour.

According to Tamimi,20 a variety of social mediators appear to have produced the ideal cultural precondition for the birth and propagation of the ADHD construct in modern Western culture, as there are no specific cognitive, metabolic, or 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 neuropsychological 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.

Table 2: Clinic or other samples

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate (%)</th>
<th>Note</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>7.5</td>
<td>Child Guidance Clinic; DSM-IV</td>
<td>Mukhopadhyay et al.</td>
</tr>
<tr>
<td></td>
<td>11.2</td>
<td>Hospital OPD; DSM-III</td>
<td>Bhatia et al.</td>
</tr>
<tr>
<td></td>
<td>3.9</td>
<td>DSM-III R in army institutes (16–17 years)</td>
<td>Zohar et al.</td>
</tr>
<tr>
<td>Kenya</td>
<td>2.5</td>
<td>Nairobi Juvenile Court; ICD-10</td>
<td>Manu et al.</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1.1</td>
<td>Ibadan, paediatric primary care clinic; DSM-III R</td>
<td>Gureje et al.</td>
</tr>
<tr>
<td></td>
<td>5.0</td>
<td>Ibadan, child psychiatric clinic; DSM-IV</td>
<td>Omigbodun et al.</td>
</tr>
</tbody>
</table>

CTRS, Conners' Teacher Rating Scale.

References

39 Omigbodun OO. Personal communication. 2002.
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