

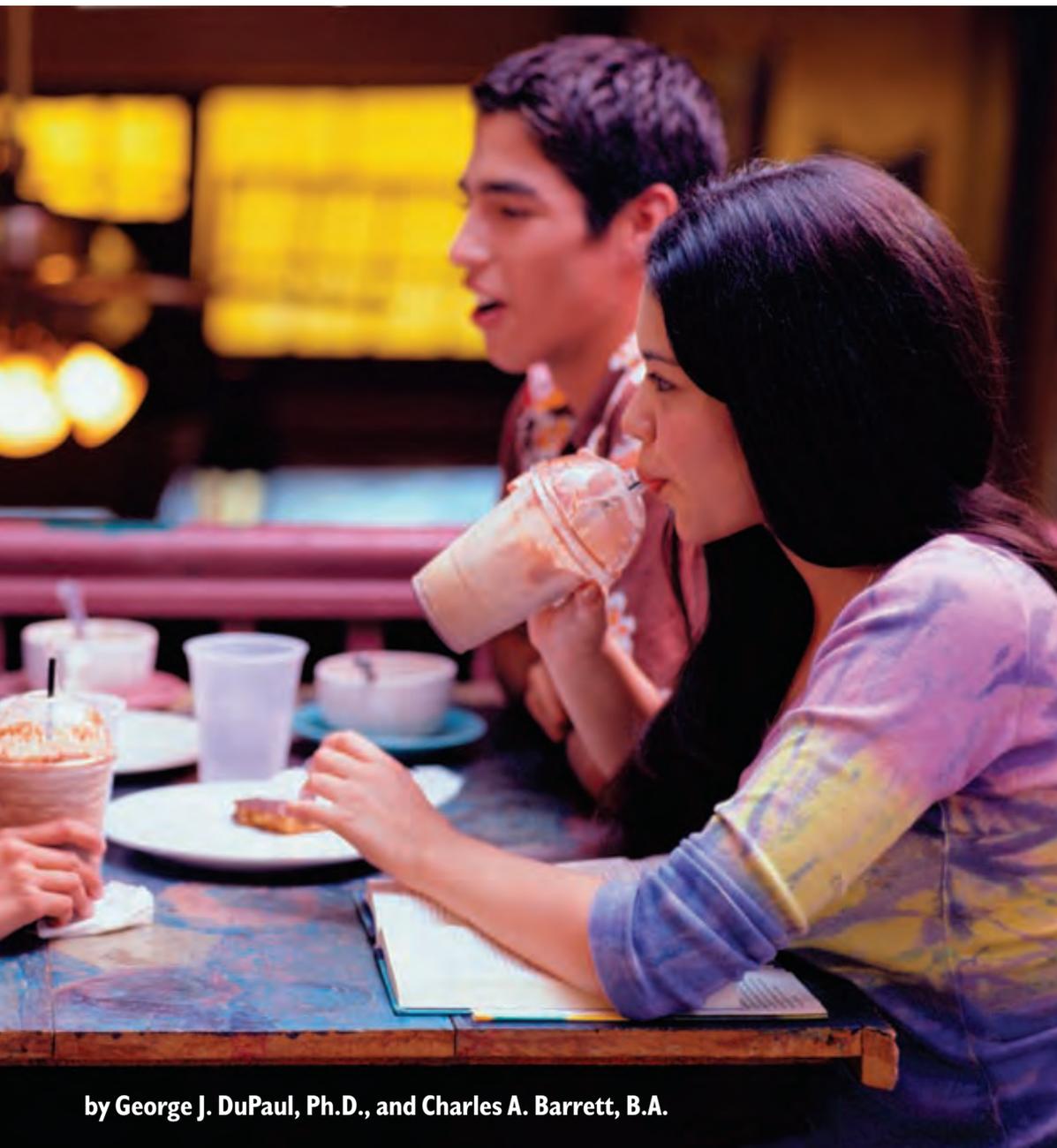
# Diagnosing AD/HD in Minorities

THE COMPREHENSIVE ASSESSMENT of AD/HD in children and adolescents involves the use of diagnostic interviews with parents and teachers, their completion of behavior rating scales, as well as classroom observations, educational testing and other assessment measures (e.g., adolescent self-report) when necessary (Barkley, 1998). Behavior rating scales are particularly critical components of an AD/HD evaluation because these measures can help indicate how different a child's AD/HD symptoms are relative to others of the same age and gender, at least through the eyes of the parent or teacher.

Although diagnostic interviews and rating scales appear "objective," these measures are only as accurate as the perceptions of the person completing them. The amount of subjectivity involved in assessing AD/HD symptoms becomes even more of a concern when evaluating children from minority backgrounds, especially given the potential for over-identification and misdiagnosis when cultural differences are not taken into account.



Although over-identification of AD/HD among children from minority backgrounds has not been studied extensively, there is clear evidence that this phenomenon occurs for special education placement. For example, according to the 2000 Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (IDEA, U.S. Department of Education, Office of Special Education Programs, 2000), African American students were 1.3 times as likely to be labeled as having a learning disability than were Caucasian students. Furthermore, although black students made up only 14.8 percent of the general population, they accounted for 20.2 percent of the special education population. These students are also less likely than their white counterparts to be returned to the general education classroom after



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being placed in special education. The reasons that may account for the disproportional placement of minority students in special education—ineffective and inappropriate procedures and processes used to refer and classify students—may also be related to assessing these children for AD/HD (National Association of Black School Educators [NABSE], 2002).

We will examine several misconceptions regarding the assessment of AD/HD in minority youths that could lead to misdiagnosis. Suggestions will be provided for parents of these children, as well as for clinicians who conduct evaluations of various populations.

### **Misconception #1** The assessment of AD/HD in minority youths has been studied extensively.

The vast majority of research on AD/HD has been conducted with samples of white boys between the ages of six and 11 years old with middle-class backgrounds. We have very little information on how AD/HD symptoms might be expressed as a function of cultural background, or as how to best account for diversity when evaluating children for this disorder. For example, Jarvinen and Sprague (1995) noted that only a few studies have been published with data on the screening of minority public school children for AD/HD. Bauermeister and colleagues (1990, as cited

in Reid et al., 1998) concluded that the concept of AD/HD and the instruments used to assess it were developed through a Western paradigm of what a disorder is and how to measure it. Furthermore, the degree to which factors such as socioeconomic status and place of residence (e.g., inner city) interact with the cultural background to influence AD/HD symptom ratings is unknown.

### **Misconception #2 There are no differences in behavior ratings between Caucasian and non-Caucasian youths.**

Several recent studies of randomly selected children (not clinical samples) have found teacher ratings of AD/HD symptoms to be higher for black children than for white children. (e.g., Epstein, 1998; Reid et al., 1998). There are several possible reasons for these group differences. First, since most teachers in the United States are white, there could be an inherent bias among raters evaluating children from different cultural backgrounds than the person completing the scale. More research is needed to determine whether ethnic group differences would also occur if the rater

and the children being rated came from the same racial background (e.g., in the case of parent ratings).

A second possibility involves differences due to the influence of socioeconomic status, since a higher percentage of black children live in poverty relative to white children. Once socioeconomic status is taken into account, ethnic group differences are somewhat reduced. However, economic factors are not the only reason for these discrepancies since group differences still exist.

A third possibility is that rating scales are “biased” with an inherent “pull” for higher AD/HD symptoms in certain ethnic groups due to the way items are worded or rated. There is some evidence for rating scale bias and it may be the combination of this inherent bias along with socioeconomic status that accounts for black/white differences on these measures.

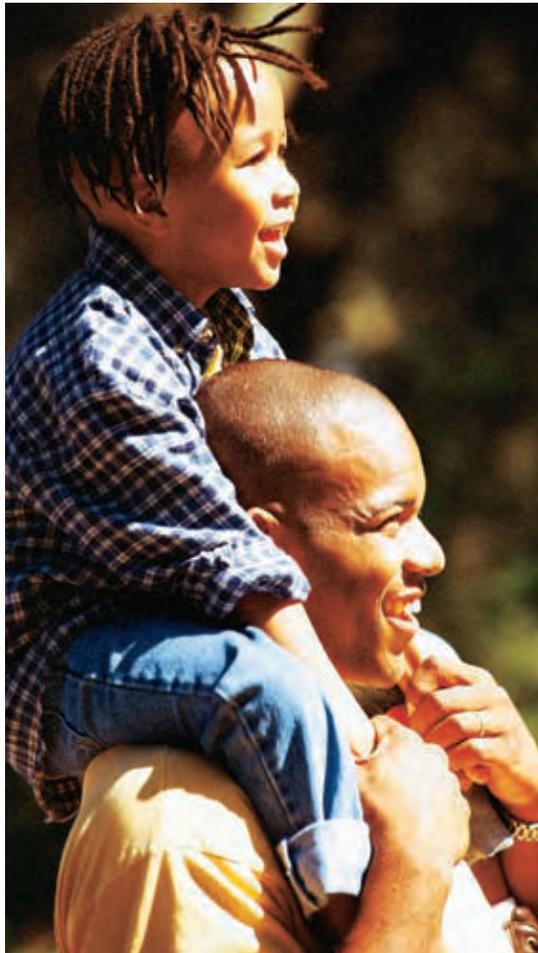
### **Misconception #3 Children from ethnic minority backgrounds are more likely than white children to be treated with stimulant medication.**

Since behavior ratings could lead to systematic over-identification of minority, particularly black children, concerns have been raised about the possible overuse of stimulant medication (e.g., methylphenidate) among non-white children. Yet, the few studies examining ethnic group differences in medication treatment for AD/HD actually found that black children were 2–2.5 times *less* likely than white youths to be treated with stimulants (Safer & Zito, 2000). The reasons behind the apparent underutilization of medical treatment in the black population are unclear, but perhaps this finding is related to difficulties that minority groups have in accessing health care due to a lack of health insurance or other financial issues.

### **Recommendations for Clinicians**

Special education regulations mandate the use of multiple assessment measures in a non-biased fashion for the identification of children with disabilities (NABSE, 2002). When assessing culturally different students for AD/HD, clinicians should apply these same principles. Assessment tools should be research-based, validated for the purpose for which they are being used, and standardized on populations similar to that of the child being evaluated (NABSE, 2002). Miranda (2002) suggests that viewing culturally different children from a multi-dimensional, rather than a one-dimensional, perspective is a key concept in a culturally sensitive assessment. For example, the clinician must determine the degree to which poverty,

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discrimination, immigration and social isolation account for behaviors that appear to be AD/HD symptoms.

The American Psychological Association (Fisher et al., 2002) presents guidelines for clinicians working with culturally diverse populations. Psychologists must be knowledgeable of research and practice issues that relate to the population being served. Clinicians must also consider the validity of a given instrument or procedure and cautiously interpret the resulting data, acknowledging the cultural characteristics of the person being assessed. Moreover, one must be aware of the test's reference population and the possible limitations of these instruments with other populations. We know that black children may get higher scores on behavior rating scales than white children. Thus, more conservative thresholds for diagnosis should be used when assessing black children for AD/HD. At the same time, clinicians should advocate for children to receive appropriate treatment services (e.g., stimulant medication) when it appears necessary.

### Recommendations for Parents

When a minority child is referred for an assessment of AD/HD, parents should seek an evaluation from a clinician who has experience working with culturally diverse populations. Furthermore, parents should ask questions about how the diagnosis was reached and how treatment-related decisions were made. For example, parents could ask what measures were used, whether scores on these measures were developed using a diverse group of children, and what threshold was used to determine whether the child had AD/HD or not. Finally, parents should advocate for their children to receive appropriate treatment services, including stimulant medication, when necessary. Advocacy is particularly effective when the parent is well informed about recommended assessment and treatment procedures (see, for example, Barkley, 2000).

Surprisingly little is known about the differences in AD/HD symptoms across ethnic groups. The few studies that have been conducted indicate that black children may receive higher ratings than white children, thus raising concerns about potential over-identification of AD/HD in this population. At the same time, appropriate treatment services (e.g., stimulant medication) appear to be less accessible to families of black children with AD/HD. Thus, parents and clinicians must advocate for the use of culturally sensitive and effective diagnostic practices, as well as for increased access to health care for impoverished and



ethnically diverse families. The research community must also expand efforts to develop and test assessment measures and procedures to reduce the effects of instrument and rater bias on the diagnostic process. ■

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