Australian Aboriginal Perspectives of Attention Deficit Hyperactivity Disorder

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The diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) has been based on a western concept of health, a concern when considering a non-western culture such as Australian Aboriginal and Torres Strait Islander peoples. The lack of statistical data on the extent of ADHD in the Aboriginal community is another concern, a situation similar to many other mental health problems in the Indigenous population. Further, no Australian studies have mentioned specific information on the prevalence of ADHD in Aboriginal communities. The WA Aboriginal Child Health Survey, however, reported that Aboriginal children had a higher risk of hyperactivity problems (15.8%) when compared to 9.7% for non-Aboriginal children (Zubrick et al., 2005).

The diagnostic methodology for ADHD is based on a western concept of health. This raises the issue of cultural sensitivity and appropriateness in identifying ADHD in a non-western culture like that of Australian Aboriginal people. Unlike their western counterparts, health to the Aboriginal people is not simply just the physical wellbeing of an individual but is connected to social, emotional and cultural wellbeing of the whole community (National Aboriginal Health Strategy, 1989). These relationships can influence how people understand illness, and in turn impact on their decisions about help-seeking behaviour and accessing services. Moreover, Hunter (2007) asserted that the narrowly focused mental health services that lack cultural sensitivity were inadequate in managing Indigenous psychological and behavioural problems, with children being particularly vulnerable. In view of the detrimental effect of ADHD, it is imperative to understand how Aboriginal culture views ADHD, a disorder based on a western health concept, and its impact on early detection and help-seeking behaviour for ADHD within the Aboriginal community. Hence, in order to ensure that future mental health services for the Aboriginal community will be effective, cultural factors need to

be adequately explored and a sound understanding of Aboriginal mental health belief systems gained. Such understanding is not only the first step to engaging the Aboriginal community by the mental health system but it also allows for the integration of such belief systems into the planning of strategy at all levels of mental health services in tackling ADHD and associated comorbidity issues.

Recent discussions with 27 parents from Aboriginal communities located in urban Perth, Western Australia were thematically analysed to identify key issues in relation to the concept of ADHD for Aboriginal people. These participants originally came from various urban and rural locations around Australia. Parents and caregivers of children with ADHD recognised that hyperactive behaviour was not desirable in a range of circumstances, and that this hyperactive behaviour was problematic in a variety of settings. The implications of this problematic behaviour extended beyond the individual with ADHD to those around them, and across domains in which the child resided. This is best conceptualised within an ecological systems perspective, which recognises the interactions of several domains central to the individual (Bronfenbrenner, 1992). On an individual level, parents and caregivers reported how the child's hyperactive behaviour was problematic for the hyperactive child, impacting their ability to concentrate and learn. The consequences of this hyperactive behaviour also extended to other microsystems such as teachers, peers, school, and caregivers. Parents and caregivers also provided valuable insight into how a child's hyperactive behaviour can have negative implications for the wellbeing of the caregiver.

Parents/caregivers of Aboriginal children with ADHD generally expressed a desire for a reduction in these hyperactive behaviours to improve the child's capacity to concentrate and learn in school, while also not causing disruption to others. A

frequently occurring term pertaining to this was the concept of 'respect'. Parents frequently used the term to encompass a range of desirable behaviours, and to represent the absence of undesirable (hyperactive) behaviours. While a reduction in hyperactive behaviours was desired, they also recognised that children should not be sedentary but should live active lives. There was consensus among those interviewed that certain situations required certain behaviours. While it is expected that children should play and be active, different circumstances warranted different behaviours. This reflects the general belief that children should be able to know how to behave appropriately in different contexts (e.g. concentrating in class, and playing in the playground), while making sure that respect for self and others is upheld at all times.

When discussing the treatment of ADHD, the participants expressed a range of views. They frequently discussed treatment for ADHD within the context of medical treatment involving drugs. While some shared some positive experiences with medical treatment for ADHD, experiences with medication were generally negative. The parents reported hesitancy towards medicating children with ADHD as they believed medication slowed these children down so that they would not be disruptive in class, but not in a way that was beneficial to their wellbeing. Motivated by this perception, parents often advocated for either a non-pharmacological intervention, or for medication to be coupled with other non-medical treatments.

Parents and caregivers also shared their experiences with accessing current services related to diagnosis and treatment of ADHD. They reported negative experiences with the current services available to them. This supports previous findings by Vicary and Westerman (2004). In their study with Aboriginal communities in the Perth metropolitan and Kimberley regions, the participants identified numerous factors

in relation to the processes used by some western therapists that were inappropriate. Although their study related to depression and suicidal ideation and not children with ADHD, it highlighted many similar issues in relation to culturally inappropriate processes.

Parents were cognisant of the differences between Indigenous and non-Indigenous Australian children, and often disclosed a need for intervention programs that also recognised these differences. This is best supported by one caregiver who supported the ineffectiveness of the current 'one-size fits all' approach to treatment of ADHD. The wider family was also implicated as an important target to maximise the effectiveness of treatment, particularly given the strong family values embedded within Indigenous Australian culture.

Another concern identified by the parents with their experience with the currently available resources was the lack of information about ADHD. Hyperactivity may be perceived as being mischievous, rather than by the presence of a disorder. Community members suggested more education within communities, perhaps even ADHD educators as is the case for illnesses such as diabetes. Difficulty accessing facilities relevant to the assessment and treatment of ADHD was frequently highlighted.

Further research is needed to understand ADHD from an Aboriginal perspective. Aboriginal parents/caregivers made it clear that present treatment approaches may be inappropriate, and more culturally appropriate intervention may be more successful for Aboriginal children with ADHD. Additionally, a lack of information about ADHD and the facilities and treatment available appear to be impacting on early identification and treatment. This has significant implications for policy makers when making decisions on resource allocation to meet the needs of Aboriginal people affected by ADHD.

Cultural understandings of ADHD symptomatology will direct interventions, making them better focused and better able to engage and retain Aboriginal people in treatment. This will lead to improved outcomes for the Aboriginal population in terms of ADHD and its associated comorbid issues.

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