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## Case study review of Caucasian and Latino boys diagnosed with ADHD

M. Johanna Mayorga  
*San Jose State University*

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Case study review of  
Caucasian and Latino boys diagnosed with ADHD

by

M. Johanna Mayorga

Presented to  
The faculty of the  
College of Social Work  
San Jose State University

Partial fulfillment  
of the requirement for  
Masters Degree of Social Work

Michael Gorman, Ph.D., Chairperson  
Josie Romero, LCSW Faculty Field Liason  
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## Acknowledgement

I thank the Lord Jesus Christ for guiding and providing me with the strength and perseverance needed to succeed in graduate school. Without Him, I could not have accomplished this milestone.

**Commit to the Lord whatever you do,  
and your plans will succeed**

**Proverbs 16:3**

I also thank my family for their continued support, understanding, and love.

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## INTRODUCTION

The project is a case study which looks at the presenting problems and comorbid disorders for Latino and Caucasian boys diagnosed with Attention Deficit Hyperactivity Disorder and seek mental health services from an outpatient mental health clinic. The project will take place at Kaiser Permanente Santa Teresa Department of Child and Adolescent Psychiatry. The department provides mental health services to children, teens, and the families.

The case study addresses issues with regard to Latino and Caucasian boys from the ages of 6-11 years old referred to a mental health outpatient clinic and diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). The primary audience is the staff at the Child and Adolescent (C & A) Psychiatry Department. The intended purpose of the project is to inform the staff about the findings and present what the literature has discovered. This project is a summative evaluation. The data details the findings of the clientele at Kaiser Santa Teresa Department of Child and Adolescent Psychiatry.

## CONTEXT OF SERVICES

### Description of Agency:

The Child and Adolescent department provides services to children, teens, and families for mental health services. Bicultural and bilingual (Spanish/English) services are offered. The clients reside in Santa Clara County. Most of the clients live within the San Jose City limits. In addition, some clients live in Morgan Hill or Milpitas and are seen at Kaiser Santa Teresa because child and adolescent psychiatry services are not available in the respective cities. The Department of C & A is set up in two different sites because of the growing staff. One site is located on Bernal Road and Santa Teresa, and the other is situated on Cottle Road and Beswick.

A person in this clinic is eligible for health insurance usually via one's employment. A small percentage, approximately 10% are Medical insured. The Child and Adolescent Psychiatry Department offers a variety of psychiatric services to the clients. The range of services consists of a twenty-four hour emergency service call-line, crisis intervention, and psychoeducational parenting groups, for the preschool, latency, and teen developmental stages. There also is a Spanish-speaking group for parents to discuss acculturation and discipline issues in a culturally competent environment. In addition, the menu of services further includes consultation, advice, information and referral therapy, and psychotherapy, such as Intensive Outpatient Program (IOP) to prevent hospitalization. Additional services

are individual/family/group therapy, psychological testing, and medication evaluation with follow-up casemangement.

Two parent child specialty groups are offered. They are the Families in Transition, designed to discuss divorce and separation issues, and Family Anger Management class designed to develop new communication tools and discover ways to cool down. C&A works in collaboration with other Kaiser departments, such as Health Education, and community based organizations. The first program is Shapedown, with an emphasis on appropriate food intake to help with weight reduction and maintenance, as well as instill the importance of following through on an exercise program. Parenting the Attention Deficit Hyperactivity Disorder (ADHD) child in conjunction with Parents Helping Parents community organization are also offered. The other departments that C&A Psychiatry collaborates with are Adults & Couples Services Psychiatry and Chemical dependency for Adults & Adolescents.

The C & A Psychiatry department has a multi-disciplinary team consisting of 4 Child Psychiatrists, 7 Clinical Psychologists, 8 Licensed Clinical Social Workers, 1 Licensed Marriage, Family, Child Counselor, 1 Psychiatric Registered Nurse, and a 6 member support staff. The intern program consists of 2 MSW interns, 1 post doctorate psychologist, and 3 post doctorate psychiatrists. The male/female distribution is close to equal; however, women do slightly outnumber the men.

The staff is ethnically diverse. There is a bilingual-bicultural Spanish speaking Clinical Psychiatrist and

Licensed Clinical Social Worker. An African-American Clinical Psychologist and Licensed Clinical Social Worker are also employed there. There are two Asian American Licensed Clinical Social Workers. The rest of the staff is of Caucasian/European descent. Support staff consists of African-Americans and Latinas.

The Child and Adolescent Psychiatry Department is organized on the triage (on-call) system, in operation from 8am-5pm Mondays-Fridays. After hours and weekend calls are covered by emergency services. When a call comes into the department, the on-call staff person does an assessment of the presenting problem consisting of the child's age, familial, social, and educational history, as well as a mental status assessment. Based on the information the therapist receives, he/she may recommend one of the following: (1) inpatient hospitalization, (2) drop-in services, (3) urgent response, (4) high priority, (5) routine, or (6) recommendation to a group.



**POLICY CONTEXT**

Kaiser Foundation Health Plan & Hospital is the nation's largest Health Maintenance Organization (SJ Mercury Newspaper, 98, October 31). Individuals with medical coverage from Kaiser are eligible for mental health services. The treatment modality is brief therapy; a client may have up to 20 psychiatric visits per calendar year. Participation in an individual, family, or group therapy is counted as one visit. Clients are charged a co-payment ranging from \$0-\$20 based on the insurance policies. A non-Kaiser family member can be seen within the family therapy model. The person is assigned a medical record number and is required to pay the same co-payment as the insured family member.

The mental health services are not provided for mandated court ordered treatment, mediation, child custody evaluations and/or recommendations, educational testing, and long term psychotherapy for families or individuals.

The goal of the program is to provide up to twenty quality and culturally competent mental health services to the children, adolescents, and families insured through Kaiser.

**CURRENT EVALUATION PROCESS:**

Current evaluation process consists of the completion of the "Oscar" form, which details the status of the client and client system, i.e. initial, ongoing, or closed case, and individual, family, or group client. The therapist also identifies the client's mental health disorder and the respective global assessment of functioning (GAF) which "reflects the patient's

overall occupations, psychological, and social functioning" (Morrison, 1995, p.7). The Oscar form is a statistical tool to inform Northern California Regional Representatives of the clients and their presenting problem as seen at Kaiser Santa Teresa C&A.

Another evaluation methodology is the monthly quality assurance plan, or peer chart review. Charts are chosen randomly by the Department Chair, and staff reviews each other's documentations of client's therapy session. Factors evaluated are progress notes, treatment goal, and status.

**TARGET POPULATION:**

The latest figures for the total population served in the Santa Teresa facility of Kaiser Health Maintenance Organization reflect data for Fiscal Year '95-'96. The total population served was 129,619. From the aggregated total, 38,370 clients were 18 years old and younger. A small percentage of Kaiser patients have medical coverage through Medi-Cal. From this total population, 1,285 people were seen, and from the total, 690 from were children under the age of 18 years old (Child Psychiatry Best Practices Committee, 1997, p.6).

## **THEORETICAL FOUNDATIONS AND LITERATURE REVIEW**

The Diagnostic Statistical Manual (DSM-IV) assists mental health professionals to be aware of the predominant features and/or symptoms to diagnosis the mental health disorder from which a person suffers. The DSM IV follows a medical model of illness wherein scientific studies have been performed on groups of people who have similar symptoms, signs, and life course of their condition (Morrison, 1997, p.8).

### ***What is Attention Deficit Hyperactivity Disorder?***

The DSM-IV categorized Attention Deficit Hyperactivity Disorder (ADHD) under the Attention Deficit and Disruptive Behavior Disorder category. ADHD can be codified into three categories (1) Attention-Deficit Hyperactivity disorder, predominantly inattentive type. The patient has met the criteria for inattention but not for hyperactivity-impulsivity; (2) Attention-Deficit/Hyperactivity Disorder, predominantly Hyperactive-Impulsive type. The person has met the criteria for hyperactivity-impulsivity but not for inattention; and (3) Attention-Deficit/Hyperactivity Disorder, combined type. The individual has met the criteria for both inattention and hyperactivity-impulsivity. Most children have symptoms of the combined type.

The following describes the symptoms for both Inattention and Hyperactivity-Impulsivity:

*Inattention.* At least six of the following criteria must apply:

Fails to pay close attention to details or makes careless errors in schoolwork, work, or other activities;

- Has trouble keeping attention on tasks or play;
- Does not appear to listen when being told something
- Neither follows through on instructions nor completes chores, schoolwork, or jobs (not because of oppositional behavior or failure to understand)
- Has trouble organizing activities and tasks
- Dislikes or avoids tasks that involve sustained mental effort (homework, schoolwork)
- Loses materials needed for activities (assignments, books, pencils, tools, toys)
- Is easily distracted by external stimuli
- Is forgetful

Hyperactivity-impulsivity. At least six of the following often apply:

*Hyperactivity:*

- Squirms in seat or fidgets
- Inappropriately leaves seat
- Inappropriately runs or climbs (in adolescents or adults, this may be only a subjective feeling of restlessness)
- Has trouble quietly playing or engaging in leisure activity
- Appears driven or "on the go"
- Talks excessively

- Answers questions before they have been completely asked
- Has trouble awaiting turn
- Interrupts or intrudes on others

In order to diagnose a person with ADHD of any type, the symptoms must have been present for six months and be maladaptive and immature in nature (American Psychiatric Association, 1994, p.254).

The diagnosis of ADHD may be misdiagnosed or underdiagnosed; thus, it needs to be made by a trained professional (Best Practices, 1995,p. 81). Trained professionals such as a medical doctor, a licensed clinical social worker, a psychologist, psychiatrist, or a licensed marriage, family, child, counselor should be cognizant of certain stipulations and particular information about ADHD prior to diagnosing an individual with the disorder.

The important information to be aware of are: (1) some of the symptoms must have been present prior to the age of seven years old; (2) symptoms are revealed in at least two different settings, such as the school and home environment; (3) the disorder creates havoc in school, social, or occupational functioning; (4) the symptoms do not occur only during a pervasive developmental disorder or any psychotic disorder, such as Schizophrenia; and (5) the symptoms can be explained better by a mood, anxiety, dissociative, or personality disorder (Morrison, 1995,p.516).

**Measurements to diagnose ADHD:**

There have been various measurements and/or rating scales designed to identify symptoms of ADHD. The Kaiser Permanente/Santa Teresa Department of Child and Adolescent (C&A) Psychiatry uses questionnaires developed by Achenbach to identify ADHD. The three tools implemented in the screening phase to measure the strengths and weakness of the child are as follows: (1) Child Behavior Checklist (CBCL); (2) Teacher Report Form (TRF); and (3) Youth Self-Report (YSR) (Achenbach, 1991). Pediatricians rely on the parent and teacher reports in the diagnosis of ADHD (Kwasman, Tinsley, & Lepper, 1995) because the ADHD symptoms must be displayed both at home and the school setting (Nassbaum & Engler, 1990, p.9).

The CBCL is designed for the parents to describe their child's behavior. The Department of C&A recommends that both mother and father complete an individual questionnaire to obtain each parent's perspective regarding their child's psychological profile. The questionnaire is designed for a child between the ages of 4-18 years old. The total time to fill out the questionnaire is 20-25 minutes.

The CBCL scale is divided into two sections. The first section is the Competency Scale detailing a series of questions regarding the child's competencies and any parental concerns; the second section is the Behavior scales and contains 113 questions regarding problem behaviors scored on a three-point scale.

The Competency scale provides information on the child's abilities with general activities defined as chores, social skills, and schoolwork. The Behavior scale is further divided into two subsections to measure (1) Internalizing behaviors, and (2) Externalizing behaviors along with eight subscales like withdrawn, somatic, anxious/depressed, social, thought disorder, attention, aggressive, and delinquent. The scores are produced on a graph and fall within the continuum of normal, borderline, or clinical range (Kaiser Permanente, 1995, p. 29).

The second questionnaire is the TRF designed for a child between the ages of 6-16 years old and is completed by a teacher who has had the child in his/her classroom for at least three months. The required time to fill out the form is 15-20 minutes. This questionnaire is similar to the CBCL; however, it is designed for a teacher and not the parent of the child. The TRF also has the Competence and Behavior sections. The former measures competence behavior based on school performance and effort. The Behavior section has similar subscales as the CBCL (Ibid, 1995, p.30).

The third questionnaire is the YSR designed for the adolescent between the ages of 11-18 years old to complete. The time to fill out the form is 15-20 minutes. The questions are similar to the CBCL and the TRF. The Competence scale has two subscales: (1) Activities and (2) Social. The Behavior scale is similar to the CBCL and TRF (Ibid, 1995, p. 31).

In addition, the teacher completes the SKAMP and SCLAM forms. The SKAMP measures attention and deportment areas. The SCLAM form measures aggression and a combination of attention, hyperactivity, and inattention. The parent fills out a behaviors checklist for the associated disorders of ADHD, such as oppositional defiant disorder, conduct disorder, general anxiety disorder, major depression, dysthymia, and SAD.

### **HISTORY OF ADHD**

The first medical attempt of ADHD may have been in 1854, when a German physician named Heinrich Hofman diagnosed the hyperactive child, as "Figidity Phil" (Barkley, 1992). However, children were not formally diagnosed with ADHD until the early 1900s. Ross (1976) details that from 1902-WWII an English pediatrician named Still attributed the child's hyperactive behavior to brain injuries, such as lesions in the brain and/or a myriad of acute diseases and conditions.

In 1918, there was an encephalitis epidemic, and this medical event was used to link the child's brain injury to the hyperactive behavior. Studies performed by Hohman in 1922, Ebaugh in 1923, and Strecker and Ebaugh in 1924 revealed children who recovered from the encephalitis disease showed "'catastrophic change'; they became hyperactive, distractible, irritable, antisocial, destructive, unruly, and unmanageable in the classroom environment (Ross, 1976, p.15). Thus the disorder was termed *minimal brain damage*.



From WWII to the middle 1960s, the term minimal brain damage was replaced by *minimal brain dysfunction* because the symptoms (hyperactivity, distractibility, and impulsivity) could not be inferred solely from behavioral signs. Maternal, fetal, and behavioral factors were proven interrelated via fetal and animal tests (Ibid, 1976, p. 17).

From the middle 1960s to 1970s, hyperactivity no longer was viewed as a syndrome of brain damage but as a "part of the complex syndrome of behavior in which a small number of cases had demonstrable brain damage" (Ibid, 1976, p. 19). The name changed from minimal brain dysfunction to *hyperkinetic (excessive motion) syndrome* by the World Health Organization in the '60s.

In the early '70s, the focus of the disorder was removed from motor activity to the individual's attention span and the resulting problems. The psychologist Virginia Douglas at McGill University led the paradigm shift. Douglas (cited in Ingersoll, 1988) stated, "it is not really excessive activity that brings the child into conflict with others; rather, the problem lies in his short attention span, his impulsiveness, and his inability to 'stop, and look, and listen' before taking action" (p.4).

The focus in the early 80s was on the child's attention and impulsivity, which resulted in a new name- *Attention Deficit Disorder (ADD), with or without Hyperactivity*, per the DSM IV. The phrase denotes that attentional problems are prominent in the child. In addition, "some children who are not hyperactive or

disruptive can have severe difficulties with attention and concentration" (Ingress, 1988, p.5).

In 1987, the disorder was renamed to *Attention Deficit-Hyperactivity Disorder (ADHD)*. In 1994, ADHD was divided into three subtypes: a) Hyperactive-Impulsive; b) Inattentive subtype; and c) ADHD combined subtype (Kaiser Permanente, 1995, p.77).

**Developmental course from infancy to middle childhood years:**

Infancy:

Ingersoll (1988) reports that 60%-70% of hyperactive children reveal specific symptoms of ADHD by the age of two years old and maybe earlier. The child is very active in utero (Kaiser Permanente, 1995, p.79). The child is inclined to have irregular and unpredictable habits such as eating, sleeping, and elimination. The child sleeps fewer hours than the average child does. Parent(s) of a child with ADHD report being awakened numerous time throughout the night during the child's first two or more years of his/her life.

The hyperactive child's mood is described as negative because he/she cries and fusses more than coos and gurgles. In addition, the child adapts slowly to change and may respond negatively to anything new (Ibid, 1995, p.8). The child is restless and difficult to hold; thus, it is difficult for the primary caretaker to feed and change the infant's diaper. Parent(s) report the infant demonstrates high level of hyperactivity in the crib by kicking, bouncing, and rocking. The

child climbs out of the crib and is not content in playpen (Ibid, 1995, p. 79). Health problems are common in the child with ADHD; he/she suffers from colds, asthma, and upper respiratory infections, and ear infections with a buildup of fluid in the middle ear.

The Preschool Years:

The hyperactive preschooler has a short attention span and may seem strong willed and unresponsive to discipline. A hyperactive child tends to be clumsy and awkward yet has good gross motor development; thus, he/she never walks, but runs (Kaiser Permanente, 1995, p. 79).

Developmental delays in the preschool hyperactive child are toilet training and speech. Fine motor skills, such as cut and paste activities, are also detained.

Middle childhood Years:

ADHD represents significant challenges for the child to function in school with the teachers and peers, and pediatricians (Kwasman, Tinsley, & Lepper, 1995). "The more structured the setting, the more apt the child is to come into conflict with peers, teachers, and others" (Ingersoll, 1988, p.12). The teacher demands structure and order in the classroom environment. The constrained environment creates a problem for the hyperactive child because of his/her restlessness and short attention span. Consequently, the child may be labeled as "immature" or "seriously emotionally disturbed" because the child might have emotional outbursts to minor events.

A study conducted by Nussbaum, Bigler, & Koch in 1986 mentioned in Nussbaum & Engler (1990) discovered that the high degree of learning disability correlates with a greater chance of emotional problems (p. 11). Children with ADHD have coexisting learning disabilities, i.e. dyslexia and multiple learning problems (p. 10).

The hyperactive child is disorganized, forgetful, and messy. The teacher may label him/her as 'lazy' because the academic performance fluctuates from week to week. In the classroom setting, the child has a tendency to blurt things out in the class, demand immediate attention from the teacher, and an inability to wait one's turn either in the classroom or the playground.

Among the many researchers of ADHD only two have focused on Latinos boys in middle childhood years: Jose Bauermeister, Ph.D. University of Puerto Rico and Orlando Villegas, Ph.D, Clinical Supervisor Hispanic Child and Family Program at Southwest Detroit.

Bauermeister's study (1995) was to discern differences in \*Hispanic children diagnosed with ADHD or ADD-H . The objectives of the study were to analyze whether ADHD and ADD-H constitute separate distinct disorders, and to design a culturally relevant treatment program for Hispanic children who met diagnostic criteria for ADD-H and ADHD. He commented, "researchers agree \*'Hispanic' and 'Latino' will be used interchangeably throughout this research

that social, familial, and the cultural environment of the child influence the expression of the primary symptoms of ADD, such as inattention,

hypractivity, impulsivity, as well as the development of associated psychological/social and academic problmes for children diagnosed with ADHD" (Bauermeister, 1998).

Bauermeister's study designated boys into the following four groups: (1) ADHD; (2) ADD; (3) Learning Disodered (LD); and (4) Adpative group, children with no previous mental health service and within normal ratings of inattention, hyperactivity, and impulsivity.

Bauermeister had the childrens' mothers complete the parent version of the Achenbauch form. The findings from the mothers response resolved that mothers rated boys with ADHD as more hyperactive, impulsive, and display more externalizing behavior than the boys with ADD-H and the two control groups. Both the ADHD and the ADD-H had compatible ratings of inattention (Bauermeister, 1998).

Villegas' study (1998) was to investigate the associated symptoms for Hispanic and \*nonHispanic boys diagnosed with ADHD. The sample size consisted of 120 boys between the ages of 8-14 years old who met the criteria for the disorder. The experimental group consisted of 40 Hispanic boys with ADHD. The two contol groups were the 40 Hispanic boys without ADHD and 40 to nonHispanic boys with ADHD.

*\*nonHispanic and Caucasian will be used interchangably throughout*

The Villegas study had two purposes. The first was to compare the associated symptoms of ADHD within two culturally different groups of boys; the second objective was evaluate the effect of culture and social environments on the exhibition of ADHD associated symptoms. The associated symptoms included were behavior problems such as aggression and delinquent behavior; emotional problems, such as anxiety and depression; social problems such as withdrawal tendencies; family problems, parental distress, parent child dysfunctional interaction, parent's consideration of child as 'difficult', and primary caretaker's total stress; and self-esteem in the home environment, academic performance, social interaction, and general self-esteem (Villegas, Hillman & Doyal, p.2).

Self-esteem was assessed at the home, school, and social interaction situations. The finiding showed that the levels of self-esteem for the three groups showed no significant differences. Latino boys with ADHD and Latino boys without ADHD rated the same for delinquent and aggressive behavior. Caucasian boys with ADHD had a higher score in delinquent and aggressive behavior than the two Latino groups. Villegas indicates the difference is premised on different cultures. He states the close family ties and intense family involvement during infancy, childhood, and adolescence may lesson aggressive behavior found in Anglo-American families (Villegas, et. al, p.7).

Mother's were asked to rate conduct problems in their child. NonHispanic mothers had higher scores than the Latino mothers for the children with ADHD. The Latino boys without ADHD had the lowest score in respect to conduct problems.

In general, the hyperactive child encounters social problems of varying sorts. Delinquent behavior arises in this age group because the child yearns for peer recognition, yet seeks for it in an adverse fashion (Nussbaum & Engler, 1990). In the social setting, he/she may be called "bossy" and "aggressive". The child can not endure the frustration over losing a game; consequently, he/she may have angry outbursts coupled with verbal or physical aggression. The hyperactive child may be seen as self-centered by playmates because he acts and verbalizes things without taking into consideration that of others (Ingersoll, 1988, p.13).

Per Villgas' study, the ethnic group with the highest rating in the area of social problems was the Caucasian sample followed by the Latino boys with ADHD, and lastly Latino boys without ADHD. He explains the differential scores between the two ethnic groups is a result of the long dependent interaction between Latino children, their parents, and extended family members(Villegas, et al., p.8).

Anxiety was also assessed and there were no significant difference amongst the three groups. Non-Hipanic boys presented a higher score in the area of anxiety with depression. Latino children without ADHD had a lower score than Latino and

non-Latino boys with ADHD when assessed for symptoms of withdrawal.

Villegas' study also appraised the teachers' perceptions of the children's possibility of conduct problems. The teachers claimed there no differences existed between the Latino and non-Latino boys with ADHD. An additional study(Greenblatt, 1994)was conducted to determine if there were either ethnic or gender biases in diagnosing ADHD between Hispanic and non-Hispanic boys and girls which consisted of 54 teachers in the Los Angeles area. This study documented there was no difference in diagnosing ADHD, with or without hyperactivity. The results revealed that 33% of the Hispanic children and 28% of the non-Hispanic children were diagnosed with ADHD, without Hyperactivity. The percentage diagnosed with ADHD with Hyperactivity for the Hispanic children was 54.2% and 53.3% for non-Hispanic children.

In the home environment, often tension frequently exists with a child who has ADHD. Studies demonstrate that tension is prevalent especially between the mother and the child. Befera & Barkley (1985) performed a study to compare the hyperactive and normal boys and girls on mother-child interaction. The mother of a hyperactive child responds to the child's compliance with more commands, directions, and negative remarks than the normal child's mother's response (p.445). The mother's behavior is a result of the hyperactive child's noncompliance. The parent



constantly supervises and hovers over the child to complete homework assignments and household chores.

Bauermeister asked mothers to complete both the Beck Depression Inventory scale and the Family Adgar Scale. The former serves as a gauge to determine how the child's behavior affects the parents feelings towards social life of family, finances, and concerns about the child's future in relations to siblings and spouse. Based on the outcome, the mothers of the boys with ADHD and ADD-H experienced more of an emotional impact from the child's behavior than the adaptive groups.

Villegas' asked the mothers to assess their perception of the mother-child interaction and level of difficulty with the child. Mothers of nonLatino boys described their interaction with the child as dysfunctional and characterized the child as difficult to manage. The Latina mothers of the boys with ADHD and without ADHD did not describe the mother-child interaction as dysfunctional nor was the child depicted as a problem child.

Furthermore, Villegas reported on the mothers total stress level with the child. The group of mothers with the highest score for total level of stress was first the nonLatina followed by Latina mothers of a child with ADHD, and lastly the Latina mother of a child without ADHD. Villegas' rationalization for the different perceptions between the nonLatina and Latina mothers is premised on cultural differences. He reports that Latinos tend to live in large families; therefore, child care is shared amongst the various female relatives, i.e. grandmother,

aunt, etc. Villegas states, "Hispanic mothers usually count on an extensive family support system with whom to share the child rearing responsibilities. The Anglo-American mothers commonly face their rearing duties with a small family circle having less of an opportunity to divert the stress that these duties bring with them" (Villegas, et al., p. 8).

**Medication issue:**

The use of stimulant medication to mollify the hyperactive-impulsive behavior of children with ADHD was first discovered in 1930s by Dr. Russell Barkley, yet the treatment was ignored for many years (Ingersoll, 1988, p.66). From the 1950s to the present, however, psychiatrists and/or pediatricians have tended to recommend stimulants to decrease high activity level.

Kwasman, et al., (1995) surveyed 1000 pediatricians in the US regarding their choice of prescribed medication for children diagnosed with ADHD, as well as how the professionals described to the children and the parent(s) the effects of the medication. The three most common medications were: (1) methylphenidate hydrochloride "Ritalin, 97.6%; (2) slow-release methylphenidate, 79.7%; and (3) pemoline "cylert", 50.8%.

The pediatricians described the purpose for taking the medication as "to help them concentrate better", "to help them pay attention", "to help them with their schoolwork", or "it has a calming effect" (Kwasman, et al., 1995, p. 1213).

These same pediatricians informed the parent(s) the effect of the stimulant medication "to help children concentrate", "to

help with the neurological networking", "to correct chemical imbalances", and "to create a calming effect" (Ibid, 1995 p. 1213).

The common complaints associated with the medication are (1) insomnia, 17.9%; (2) affects mood or affect, 14.5%; (3) headaches, 10%; (4) does not work, 8.9%; (5) wears off, 8.9%; and (6) no complaints, 9.4% (Ibid, 1995, p.1215).

## DESIGN OF EVALUATION STUDY

### Research Question:

The project was a case study which looks at the differences of the age of onset as perceived by the parent completing the developmental/behavioral forms (which is usually the mother), presenting issue, and assessment of Latino and Caucasians boys between the ages of 6-11 years old who seek mental services from an outpatient mental health clinic for ADHD.

### Focus of Evaluation:

The data was gathered from Santa Teresa Kaiser Permanente Child and Adolescent Screening Contact Form as well as the Child and Adolescent Assessment form. The author examined the client's (1) age; (2) ethnicity; (3) presenting problem, as identified by the therapist; (4) psychological symptoms as warranted by the ADHD; (5) medical symptoms; (6) learning disability; (7) comorbidity; and (8) treatment given.

### Design:

The project entailed a retrospective chart review of completed Achenbach forms, Child Behavior Checklist and Teacher Report Form, including the SCLAM and SKAMP forms, from January to August 1998. All the forms were a visual report of the child's behavior. To acquire a random sample of charts, the researcher will look at referrals from the 7 licensed clinical psychologists, 8 LCSWs, and 1 LM FCC employed at the Child and Adolescent Psychiatry Department.

Procedures:

The charts were obtained from Kaiser Permanente's CIPS computer program that details the client's diagnosis. The writer obtained the file on the individual and extracted relevant information that led to the diagnosis. The client's parent identifies the child's ethnic/racial background in the space reserved for self identification on the Achenbauch psychological questionnaire. The client will be designated either in the Caucasian or Latino variable, per the parent's response. The purpose of the research project was to answer the questions:

- 1.) *How are Latino boys diagnosed? How are non-Latinos boys?*
- 2.) *Are Latino boys diagnosed with ADHD at a higher or lower than Anglo-American boys?*
- 3.) *Are there different associated symptoms between Latino and Caucasian boys from 6-8 years old diagnosed with ADHD?*
- 4.) *Are there different associated symptoms between Latino and Caucasian boys from 9-11 years old diagnosed with ADHD?*
- 5.) *What co-morbid disorders do Latino and Caucasian boys have in common? Differences?*
- 6.) *What percentage of Caucasian and Latino boys referred to an outpatient mental health clinic have learning disabilities?*

Risks to Subjects:

Confidentiality and anonymity of clients was observed in that names, medical number, or other identifying data were not revealed in the study. Approval to review medical charts was

granted when the client's parent(s)/legal guardian signed the release form to receive psychological services. The data gathered was kept in a locked file cabinet.

**Presenting Problems  
for children aged  
6-8 years old**

<b>CAUCASIAN</b>	<b>LATINO</b>
Child directs anger towards sister and mother.	Parent child problem.
Difficulty staying focused on a task; easily distracted.	Behavior problems.
Hyperactive; easily distracted; difficulty focusing	Recommended by school to get tested for ADD.
Disruptive in class; does not follow instructions or class rules.	Trouble focusing.
Impulsive; runs off into danger.	
Extreme anxiety at school; afraid to be alone at recess.	
Difficulty making friends at school; daily stomachaches and forced vomiting.	
Behavior problems; disobedient.	
Prefers to lead and set rules; rebellious and bossy; threatens death to others.	

The chart outlines the presenting problems for a child per his age and ethnic background. The presenting problem was expressed by one of the parents, which commonly was the mother. As an age group, the children primarily appear to have difficulty focusing and maintaining attention to tasks. If viewed from the ethnicity component, two Latino parents described behavior problems as the primary reason to seek mental health services. The respondents for this age and ethnic group is too small to validate any correlation with the findings of Dr. Villegas' study which purports that Latina mothers view their children as having less conduct problems than Caucasian boys.



***Presenting Problems  
for children aged  
9-11 Years old***

<b>CAUCASIAN</b>	<b>LATINO</b>
Trouble concentrating at school.	Difficulty concentrating and following directions given by teacher; does not stay still; peer problems; feels he always must be accepted.
Inability to stay focused on a task; lack of motivation to do well on schoolwork; self expression of fear; hopelessness; despair.	Difficulty paying attention in school; does not remember tasks to an activity; low academic performance.
Out of control behavior; very mean and disrespectful to mother; thinks of dying.	Needs assistance with peer relations and social skills.
Impulsive; out of control; talks about hurting self; lack of friends; bad mouth; does not turn in homework.	Behavior problems at school.
Short attention span; does not listen; short temper; dreams; argues; is bossy.	Behavior problems at school and at home; loses temper; swears; talks out of turn at
Inability to concentrate or finish homework; has hopeless and worthless feelings.	Easily distracted; low self esteem; becomes hysterical if asked to take responsibility for own actions.

The common presenting problems for the children in this age group dealt with continual academic problems, persistent difficulty concentrating and/or completing a task, and a lack of peer relationships. Studies have proven that children who have ADHD have a greater probability of being termed 'bossy'. Children who have ADHD have a low self esteem and expresses hopeless and self-worth feelings. Both the Caucasian and Latinos boys for this age group expressed to a parent a lack of self-worth. Conduct problems are an associated psychological factor for a child who has ADHD. The children in this study display negative conduct behavior, i.e. 'swears', 'argues', and 'out of control behavior'.

**Comorbid Disorders of ADHD  
Ages 6 to 8 years old**

ETHNICITY	DEPRESSION	ANXIETY	CONDUCT DISORDER	DEFIANT DISORDER
CAUCASIAN	3	5	2	5
LATINO	0	1	1	3

The chart describes the comorbid disorders associated with ADHD. Usually, the mothers complete the behavior checklist which accompanies the ADHD evaluation packet. The checklist details the symptoms for each disorder mentioned above per the DSM IV criteria. The sample of Latino and Caucasian boys do not appear to have the same degree of comorbidity symptoms with ADHD. The Caucasian boys appear to have greater comorbidity.

**Comorbid Disorders of ADHD  
Ages 9 to 11 years old**

ETHNICITY	DEPRESSION	ANXIETY	CONDUCT DISORDER	DEFIANT DISORDER
CAUCASIAN	4	4	1	2
LATINO	1	2	2	1

From the total number of boys diagnosed with ADHD, the nonHispanic boys have a greater occurrence of comorbidity associations. A parent, usually the mother, completes a behavior checklist based on the symptoms from the DSM IV.

**Learning Disabilities  
Ages 6 to 8 years old**

ETHNICITY	BEHAVIORALLY DISORDERED	LEARNING DISABILITY	SPEECH/LANGUAGE IMPAIRMENT
CAUCASIAN	0	0	2
LATINO	0	0	1

The study looked at three types of learning disabilities: behaviorally disordered, learning disability, or speech/language



impairment. The table presents the number of boys from the sample population a type of learning disability. There were two Caucasian boys and one Hispanic boy diagnosed with the speech/language learning disorder type.

**Learning Disabilities  
Ages 9 to 11 years old**

<b>ETHNICITY</b>	<b>BEHAVIORALLY DISORDERED</b>	<b>LEARNING DISABILITY</b>	<b>SPEECH/LANGUAGE IMPAIRMENT</b>
<i>CAUCASIAN</i>	0	2	1
<i>LATINO</i>	0	2	1

This table describes the number of boys in the study by type of learning disorder. From the sample population, two Caucasian boys have been diagnosed with a learning disability, and one has a speech/language impairment. Since the children have been in the school setting for at least four years, the probability of having been tested for a learning disability are greater than for the children aged 6-8 years old.

**DISCUSSION**

From January-August 1998, the multidisciplinary team at the Child and Adolescent Psychiatry Department distributed 182 Achenbauch forms to parents seeking mental health services for their children. From this pool of clients, 24 boys were diagnosed with ADHD and met the requirements for this study. The ADHD pool was comprised of 10 Latino boys and 14 Caucasian boys.

As evidenced by literature and in this sample, both Caucasian and Latino boys experience identical psychological, social, and academic problems associated with ADHD.

Of the total number of children referred to an outpatient mental health clinic, the percentage diagnosed with a learning disability for each ethnic and age group was about equal. Comparing the two age groups, the older boys, aged 9-11 years old, presented to have more learning disabilities than the younger boys. A possible explanation for the outcome between the two age groups is that the younger boys have not been in school as long as the older boys; therefore, they have not been tested for a learning disability. The Child and Adolescent department does not test for learning disabilities.

There exists evidence to suggest that ADHD is a universal condition and carries a strong biological and hereditary predisposition (Bauermeister, 1995). However, there still is an inadequate amount of data about the prevalence of ADHD among various racial and ethnic groups (Williams, L., Lerner, M., Wigal, T. & Swanson, J. 1995). The information about ADHD is derived from research conducted predominantly on Caucasian children (Bauermeister, 1995). Therefore, non-Caucasian boys are diagnosed for ADHD per the standards of the dominant culture.

Researchers are concerned the cultural, ethnic, and economic factors of the child and his family system are not adequately assessed in the current ADHD evaluation process. As a result, children may be either under or over diagnosed (Williams, et. al,

1995). For that reason, Williams suggests the use of the Scales of Independence Behavior (SIB) and the System of Multicultural Pluralistic Assessment (SOMPA) be implemented in the assessment phase. The two measures collect information pertinent to the child's cultural, ethnic, and economic factors (ibid,1995). An additional measurement to use in the assessment phase is the School Behavior Inventory (El Inventario de Comportamiento Escuela) designed by Bauermeister, normed on Puerto Rican children(Bauermeister, 1995).

ADHD is a mental health disorder which does not discriminate based on ethnic background as demonstrated by the literature and this study. Measures which assess a family's social, cultural, and economic situation should be incorporated in the assessment process so as to provide a broad understanding of the child.

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**Appendix A:**  
**DATA COLLECTION SHEET**

## **DATA COLLECTION SHEET**

For a case study review of Caucasian and Latino boys  
diagnosed with Attention Deficit Hyperactivity Activity Disorder

### **Clinical Data, parent(s) is source of information**

#### **Demographic Data:**

##### **Age:**

- 6-8
- 9-11

##### **Ethnicity:**

- Caucasian
- Latino  
(includes Mexican/American, Central & South American, Carribean)

### **Presenting Problem**

#### **Psychological Symptoms:**

**Inattention.** At least six of the following criteria must apply:

- Fails to pay close attention to details or makes careless errors in schoolwork, work, or other activities
- Has trouble keeping attention on tasks or play
- Does not appear to listen when being told something
- Neither follows through on instructions nor completes chores, schoolwork, or jobs (not because of oppositional behavior or failure to understand)
- Has trouble organizing activities and tasks
- Dislikes or avoids tasks that involve sustained mental effort (homework or schoolwork)
- Loses material needed for activities (assignments, books, pencils, tools, toys)
- Is easily distracted by external stimuli
- Is forgetful

**Hyperactivity-Impulsivity.** At least six of the following apply:

##### **Hyperactivity**

- Squirms in seat or fidgets
- Inappropriately runs or climbs (in adolescents or adults, this may be only a subjective feeling of restlessness)

- Has trouble quietly playing or engaging in leisure activity
- Appears driven or “on the go”
- Talks excessively

#### **Impulsivity**

- Answers questions before they have been completely asked
- Has trouble awaiting turn
- Interrupts or intrudes on others

#### **Learning Disability**

- Behaviorally disordered
- Learning disabled
- Speech/Language impairment

#### **Comorbid disorders**

- Depression
- Anxiety
- Communication Disorder
- Oppositional Defiant Disorder
- Conduct Disorder



**Appendix B:**  
**LETTER OF CONSENT**

# The Permanente Medical Group, Inc.

260 INTERNATIONAL CIRCLE  
SAN JOSE, CALIFORNIA 95119-3000  
(408) 972-3000

ANTIOCH  
DAVIS  
FAIRFIELD  
FREMONT  
FRESNO  
GILROY  
HAYWARD  
MARTINEZ  
MILPITAS  
MOUNTAIN VIEW  
NAPA  
NOVATO  
OAKLAND  
PARK SHADELANDS  
PETALUMA  
PLEASANTON

RANCHO CORDOVA  
REDWOOD CITY  
RICHMOND  
ROSEVILLE  
SACRAMENTO  
SAN FRANCISCO  
SAN JOSE  
SAN RAFAEL  
SANTA CLARA  
SANTA ROSA  
S. SACRAMENTO  
S. SAN FRANCISCO  
STOCKTON  
VALLEJO  
WALNUT CREEK

ANN VON GEHR, M.D.  
Physician-in-Chief

ELLEN CHAN ROSENBERG  
Medical Group Administrator

## DEPARTMENT OF PSYCHIATRY

Child and Adolescent Services  
175 Bernal Road, Suite 140  
San Jose, CA 95119  
(408)972-3099  
(408)972-6494 (FAX)

December 4, 1998

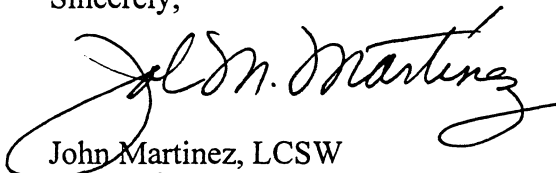
To Whom It May Concern:

This letter is to inform you that M. Johanna Mayorga, an MSW intern from San Jose State University, has received approval from her supervisor, John Martinez, LCSW, and the Department Chief, Pilar Bernal, MD, at Child and Adolescent Psychiatry for her Special Project 298.

Ms Mayorga will conduct a retrospective chart review of approximately 30 to 50 Latino and Caucasian boys between the ages of six to 13 years old referred to an outpatient mental health clinic for Attention Deficit Hyperactivity Disorder. The data collected will reflect age, ethnicity, presenting problem, co-morbidity, psychological symptoms, and treatment prescribed by the therapist. The information will aid to determine if Latino boys are diagnosed with Attention Deficit Hyperactivity Disorder at an older age than Caucasian boys.

Thank you for your attention.

Sincerely,



John Martinez, LCSW  
Supervisor  
Child & Adolescent Services



KAISER PERMANENTE

**Appendix C:**

**FIELD AGENCY'S APPROVAL OF RESEARCH PROSPECTUS**

San José State University  
College of Social Work

Field Agency's Approval of Research Project Prospectus

Instructions: This form must be completed by all students participating in university related research projects, including S.W. 298 projects. The form should be completed and submitted to the student's S.W. 298 instructor or faculty sponsor. All students are expected to advise their agencies of the content of their research projects as well as plans related to their proposed methodology, data collection, and data analysis activities. Completion of this form does not remove the obligations of students to complete other college, university, or agency research review and approval procedures/policies.

If significant changes are made in the project a new form must be completed and submitted. All S.W. 298 students must complete and submit this form prior to commencing their actual research work with data collection or clients; and in any event before the end of their first semester of study.

The field instructor's or other agency representative's signature certifies that the student has discussed and shared their plans with the agency, and that the agency is not in opposition to the project. The S.W. 298 instructor and/or other college officials should be contacted if there are any concerns, questions, or objections.

Name of Student M. Johanna Majoiga Name of Agency Kaiser Permanente - Santa Teresa, Dept. of Child & Adolescent Psychiatry

Field Instructor's Name John Martinez, LCSW F.I.'s Telephone # 972-3099

SJSU Instructor's Name Dr. Kyle Titus Semester(s) Fall '98

Proposed Topic:

This is a review of clinical records to determine if Latino boys are diagnosed with Attention Deficit Hyperactivity Disorder at an older age than Caucasians.  
Brief Description of Project - Timelines, Sample/Subjects, and Methodology:

The study will be conducted between January - March 1999. Confidentiality will be maintained because names, medical number or other identifying data will not be revealed in the write-up. The methodology will be a retrospective chart review of approximately 30-50 clients. Subjects will be Latino and Caucasian boys between the ages of 6-13 years old.

Signature of Student Maria Pilar Bernac Date 12/01/98

Signature of Field Inst./ Agency Rep. J.M. Martinez Date 12/3/98

Signature of 298 Instructor/ College Rep. Kyle Titus Date 12/1/98

MARIA PILAR BERNAC  
CHIEF, CHILD + ADOLESCENT SERVICES

## Request to Use Human Subjects in Research Cover Sheet

Date Submitted: 12/07/98 Project Period: From 1/99 To 4/99  
Funded By: N/A  
Name: Johanna Mayorga Department: Social Work  
Phone Number: Work 972-3472 During W-F Home 929-4337 During anytime  
Address: 36 N. Jackson Ave. #215 San Jose, CA 95116  
Faculty  Student  Staff  Non-SJSU (contact)   
Title of Proposed Project This is a review of clinical records to determine if Latino boys are diagnosed with Attention Deficit Hyperactivity at an older age than Caucasian boys  
Abstract: The project is a retrospective chart review of approximately 30-50 Latino and Caucasian boys between the ages of 6-13 years old referred to an outpatient mental health clinic for Attention Deficit Hyperactivity Disorder. The data collected will reflect age, ethnicity, presenting problem, learning disability, co-morbidity, psychosocial symptoms, and treatment prescribed by therapist.

Number of Subjects: 30-50 approximately Age of Subjects: 6-13 years old  
Type of Subjects: Latino and Caucasian boys  
Proposed Research Method: Retrospective chart review  
What Kinds of Data Will Be Collected: Age of onset; presenting problem, psychological symptoms  
Is a copy or description of each data collection instrument attached: YES  NO  (see after)  
Are procedures to protect confidentiality delineated: YES  NO   
Are agreements from participating institutions (on their letterhead) included: YES  NO   
Is a consent form attached: N/A YES  NO   
Is it on SJSU letterhead? N/A YES  NO   
Possible Risks: N/A

### Category of Risk:

#### A. Research involving only minimal risk to human subjects:

Probably and magnitude of harm or discomfort are no greater than encountered in daily life.

#### B. Research involving reasonable risk to human subjects:

Risks to the subject are reasonable in relation to anticipated benefits to the subjects and the importance of the knowledge that may reasonably be expected to result.

Please submit two copies of the completed protocol and supporting materials to: San Jose University, Human Subjects-Institutional Review Board, Walquist Library N., Room 125, San Jose CA 95192-0025. For questions call the HS-IRB at (408) 924-2479.

## Extension of Time Request Format

Name \_\_\_\_\_ Dept. \_\_\_\_\_

Phone: work \_\_\_\_\_ home \_\_\_\_\_

Address \_\_\_\_\_

Title of project \_\_\_\_\_

Reason for request \_\_\_\_\_

Changes or significant events that have occurred during the approval period \_\_\_\_\_

Include a copy of the original protocol.

## Verification of Translation Accuracy

Title of Proposed Project: \_\_\_\_\_

I, the undersigned, verify that all translated materials related to the above named study reflect the intent and spirit of English text.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_

## Responsible Faculty Member Form

Must be submitted with all student research protocols

Title of Proposed Project: This is a review of clinical records to determine if Latino boys are diagnosed with Attention Deficit Hyperactivity Disorder at an older age than Caucasian boys.

Student Investigator(s): M. Johanna Mayorga

Responsible Faculty Member(s): Kyle Titus, PhD

I (we), the undersigned, have reviewed the above named study and believe the research conforms to federal, state, and SJSU policy for the protection of human subjects in research. Further, I (we) will monitor the course and conduct of the proposed research.

[Signature] \_\_\_\_\_ 12.1.98 \_\_\_\_\_ School of Social Work \_\_\_\_\_  
Signature Date Department