Coalition to Stop the Use of Child Soldiers
International Secretariat
2-12 Pentonville Road, 2nd floor, London N1 9HF
Tel: +44 207 713 2761 Fax: +44 207 713 2794
Email: info@child-soldiers.org Web: www.child-soldiers.org

Registered as a limited company (no. 4411965) in England

Reproduced from Bose, R. Jennings, S. Child psychiatry in a multicultural context. PSYCHIATRY, 2005; 4:9 132-137, by kind permission of The Medicine Publishing Company. Permission for printed use is not permitted.

Child psychiatry in a multicultural context

Ruma Bose

Susan Jennings

Almost no society in the world is culturally or ethnically homogeneous. Migration, colonization, globalization and the impact of media provide a multicultural context for our lives and thoughts. The juxtaposition of diverse cultural groups and the interdisciplinary nature of contemporary scientific discourse has brought fresh impetus to psychiatry from cultural psychology and anthropology. Cross-cultural research in child psychiatry has followed two courses: the study of difference in prevalence rates and patterns across cultures, and the consideration of what accounts for difference.

The relationship between culture and child psychiatry is recognized, but recent writing has focused on how to understand the data, the interpretation of which raises important social, conceptual and methodological issues. In accounting for observed differences between ethnic groups, there are several possible explanations to consider before a cultural explanation can be attributed.

Sampling: samples in child psychiatric surveys in developing countries are generally obtained from schools and paediatric, psychiatric and primary care health clinics because of the convenience of access. Generalization of prevalence rates or patterns from these samples is dubious because specialist resources such as schools or psychiatric clinics are not accessed by many children, especially those from disadvantaged families. Furthermore, as the total population of children is probably higher than is officially reported, reliance on official figures alone for calculating population rates is likely to produce unrepresentative results.

Several researchers have drawn attention to the problems inherent in comparing cross-cultural samples that are incomparable in several social variables, which are likely to distort or inflate the cultural difference. However, attempts to eliminate this effect by closely matching the samples in terms of socio-demographic variables results in comparing typical subjects from one culture with an atypical group from another, thereby limiting the possibility of a truly cross-cultural comparison.

Ruma Bose *is Consultant at the Child and Family Consultation Service in Tower Hamlets, London, UK, and Honorary Senior Lecturer at the Queen Mary College, University of London, UK.*

Susan Jennings *is a Specialist Registrar in Child and Adolescent Psychiatry at Great Ormond Street Hospital, London, UK. She qualified from St Thomas' Hospital, London, and trained in psychiatry in Sussex and London.*

Ethnic categories: in a multicultural context the use of broad categories such as 'South Asians' conceals important differences between community profiles. The fourth national survey of the Policy Studies Institute in London revealed wide differences in the socio-economic status of Indians, Pakistanis and Bangladeshis, which is important for future research.[1] As race, culture and ethnicity are both social and biological constructs, a clear understanding of how such terms are used is essential for interpreting the data.

Diagnostic tools: cross-cultural studies in child psychiatry have used a number of diagnostic tools, whether screening instruments or diagnostic criteria, which may account for variable rates. Most of the instruments have not been validated or standardized for use beyond the population on which the initial validation and standardization tests were undertaken, usually in Europe and North America. The limitations of this for comparative research are recognized. For example, using the Child Behaviour Checklist, Bird *et al.* obtained a 49.5% prevalence for child psychiatric disorder in Puerto Rico; this was reduced to 18% when impairment criteria were applied.[2] Even this figure was thought to be too high and was probably accounted for by the tendency of Puerto Rican mothers to over-report symptoms and by the instrument's application in Spanish.

Category fallacy: Kleinman argued that using homogeneous diagnostic categories imposes yet another conceptual error, the 'category fallacy', which seeks what is the same everywhere and tends to ignore what falls outside the tight parameters of a category where the interaction of culture may indeed be the greatest.[3] Littlewood has drawn attention to an instance of category fallacy when semantic equivalents for words describing mood states such as 'depression' were sought in other cultures.[4] The search for lexical equivalents ignored metaphorical and other expressions for mood in many cultures. Kleinman's paper, which proposed that cross-cultural research needs to begin with a culture's own concept of illness or system for articulating distress, stimulated a powerful debate in cross-cultural psychiatry.

There are two divergent approaches to cross-cultural research, sometimes referred to as the 'etic', which makes broad comparisons between cultures using standardized measures, and the 'emic', which begins with a culture's own frame of deviance. These terms are derived from the two approaches in the study of sound in language.[5] 'Phonetics' concerns universal sound properties in language, whereas 'phonemics' concerns the culture-specific sound characteristics of a language.

Translation: in cross-cultural research, questionnaires are standardized by rigorous translation and back-translation, but this may not ensure equivalence in meaning, as the same words may have different associations in different cultures. For example, high scores obtained on the Eating Attitudes Test by female college students in northern India revealed, on closer scrutiny, misinterpretation by the students of a large number of questions, possibly on a conceptual basis.[6]

Socio-economic variables: cross-cultural comparisons are often confounded by socio-economic disadvantage, which is commonly associated with minority status. Low socio-economic status and poor physical and mental health in adults are correlated. Social disadvantage (poverty, unemployment, poor inner-city environment, poor housing, inner-city schools with high teacher turnover) increases the risk for psychiatric morbidity in children, both by a direct effect and by compromising parental effectiveness.

The interaction between psychiatric morbidity and material wealth is complex. Hackett and Hackett's study in Kerala, India, demonstrated that although most families in their sample had fewer material amenities than families in the West, the prevalence of child psychiatric disorders was not higher.[7,8] They drew an important conclusion: it is not the absolute degree of deprivation, but deprivation relative to others in the society, that matters. A striking finding of their study was the association between externalizing disorder and social adversity (including poverty). The overall rate for non-organic child psychiatric disorders is not higher in developing countries.

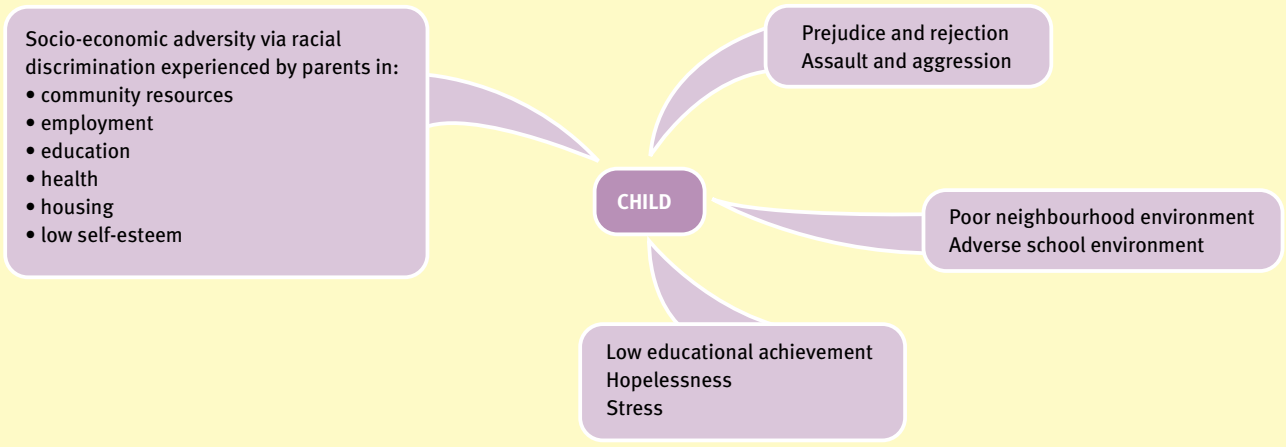
In the UK, although most Asian and Afro-Caribbean families are socially disadvantaged and tend to live in inner-city zones, South Asian children have lower rates of child psychiatric morbidity than the indigenous group while Afro-Caribbean children have slightly higher rates. Standard measures of socio-economic status probably do not accurately reflect the experience of ethnic minority migrants. For first-generation immigrants at least, expectations of material standards in the UK will be influenced by their pre-migration socio-economic status and their long-term aspirations for life in the UK; these are unlikely to be the same for subsequent generations, who will come to have the same expectations and aspirations as the majority.

Discrimination and disadvantage: discrimination in housing, employment and education undermines the allocation of social and economic resources to disadvantaged minority ethnic groups, with significant consequences for healthy parenting capacity (Figure 1). It also has a direct impact on mental health and children's self-esteem. Clinic and hospital attendance is likely to be influenced by differences in accessibility and cultural sensitivity of services for minority ethnic groups.

Differences in interpretation of behaviour: as problem behaviours in child psychiatric disorders are usually exaggerations of normal behaviour, their recognition depends on the expectations and interpretation of those reporting. Recognition of child psychiatric problems varies among teachers and parents, and standards of normative behaviour vary between cultures. Furthermore, in many cultures health institutions are not seen as resources for dealing with difficult behaviour. Mann *et al*. described significantly different ratings by mental health clinicians in four different countries to videotaped recordings of hyperactive–disruptive children.[9] The differences in rating were attributed to cultural differences in perception of what counts as 'normal' and 'hyperactive' behaviour even when uniform rating criteria were applied. In a study by Sonuga-Barke *et al.*, UK teachers were found to have a lower threshold for rating Asian children for hyperactivity.[10] The authors suggest a number of explanations, including variations in the teachers' views about what constitutes acceptable levels of behaviour for different ethnic groups and the limitations of applying universal cut-offs in a multicultural context.

Migration: in a multicultural society the interaction between the effect of migration and mental health could be misread as cultural difference. Migration involves a great deal of social disruption, and the pre-migration experience of those fleeing civil war, for example,

Pathways for the interaction of racial discrimination and psychiatric morbidity in a vulnerable child



1

may have an adverse effect on mental health. The link between psychological health and reason for migration is less relevant for children than for adults, but their experience of migration is likely to be influenced by that of their parents.

Genetic explanations: there are few instances in medicine where there is a correlation between disease and population, such as sickle cell anaemia. Genetic explanations for inter-ethnic differences in mental health have not been convincing. Genetic heterogeneity within socially defined racial groups is enormous, as is genetic similarity between groups.

Rates and patterns in a multicultural context

The prevalence rates for child psychiatric disorders across cultures shows a divergence that may reflect differences due to cultural influences, the influence of risk and protective factors that come into play in different contexts, as well as bias due to methodological issues outlined above. There are broad similarities, however, in symptoms, age and gender differentials across cultures.

This contribution focuses on studies undertaken mainly in the UK with South Asian and Afro-Caribbean children (see Bird[11] and Hackett and Hackett[7] for reviews of cross-cultural epidemiology and research in the developing world). The prevalence rates by ethnicity of the most recent community survey of the mental health of children in the UK are shown in Figure 2. There may be an effect of age as only 5–15-year-olds were surveyed – disorders seen predominantly in the under-5s or in older teenagers are excluded. Moreover, as there were relatively small numbers of children from minority ethnic groups, the authors have cautioned against drawing statistically significant interpretations.

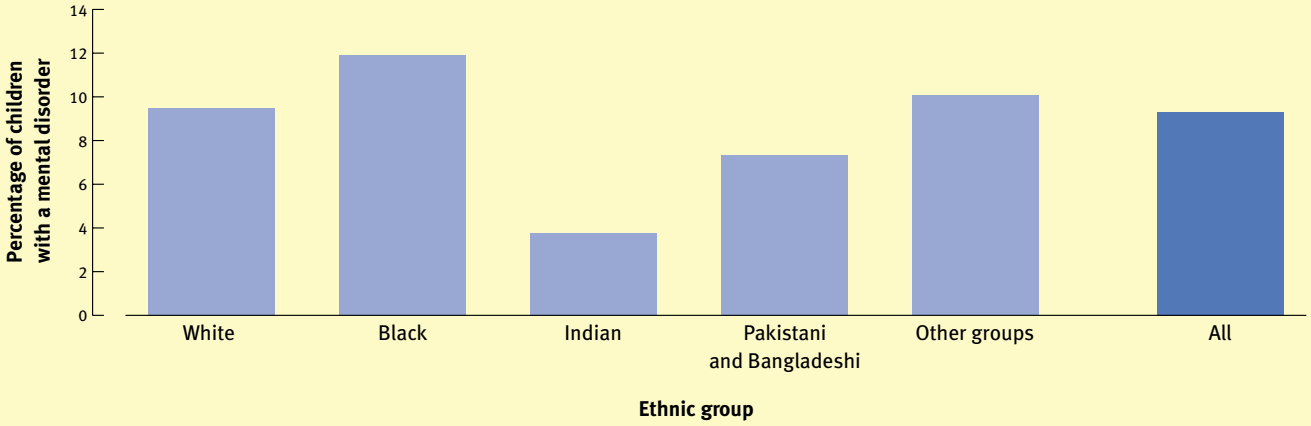
Variation in rates and patterns between ethnic groups

The trend for lower rates of psychiatric disorder among Asians is attributed to protective factors in the Asian family system. Lower rates are also reported in most studies for Asian children. Hackett and Hackett revealed significant differences in Gujarati and British parental attitudes.[12] The Gujarati parents were less tolerant of aggression and encouraged more sharing. If parental tolerance of aggression in children is lower, aggressive behaviour is likely to be dealt with early, thereby lowering the rates for conduct problems. In a cross-cultural study in cultures where obedience and compliance in children is highly valued, disorders tended to be associated with over-controlled behaviour, such as fears and somatic concerns.[13] In the USA, where there is greater emphasis on self-expression, disorders tended to be in the direction of under-control, such as arguing and disobedience at home.

Several studies in the UK have reported high rates of deliberate self-harm among young Asian women that are not found in the Indian subcontinent. The UK rates may reflect the women's experience of growing up in a bicultural world as well as their adoption of a cultural strategy for expressing distress in the new milieu.

The mental health of Afro-Caribbean children has been studied by several researchers in the UK. The findings have consistently indicated a higher ratio of conduct disorder to emotional problems for both boys and girls. However, the conduct problems are not associated with disturbances in peer relationships, which have a worse significance. One explanation is the tendency of teachers to describe disruptive behaviour more readily in Afro-Caribbean children. Rutter *et al.*'s study showed a significant difference between parent and teacher ratings of disruptive behaviour among Afro-Caribbean children, with teachers rating significantly higher.[14]After allowing for the effect of possible confounding variables, bias on the part of teachers was thought to be a factor. Truancy is rarer in Afro-Caribbean children and most stay on in school after the age of 16. The prevalence of delinquent behaviour in young males is significantly higher, and has been attributed largely to high levels of social adversity. An over-representation of autism and related disorders reported in Afro-Caribbean children is also noted among the immigrant population of other countries.[15] As Afro-Caribbean children with autistic disorders are more likely to be severely mentally handicapped, it may reflect a higher proportion of autism secondary to brain damage (e.g. from prenatal exposure to a virus) and a lower proportion due to genetic loading.

UK prevalence rates by ethnicity of children's mental disorder



(Reproduced with permission from the UK Department of Health Survey, 2000)

2

The high rate of schizophrenia among Afro-Caribbeans and West Africans in the UK has been the subject of considerable debate. Rates of schizophrenia in the West Indies are no higher than elsewhere, but rates in the UK are disproportionately higher for Afro-Caribbeans. This is not associated with an increased familial loading, obstetric complications or drug use. Normally, the prevalence rates for disease in the second generation of migrants begin to approximate that of the indigenous group, but rates of schizophrenia are even higher. Several hypotheses have been put forward, although none are satisfactory: one theory is that acute psychotic reaction among the young is caused by the stress of high levels of social adversity and discrimination.

Cross-sectional survey of in-patient 13–17-year-olds in psychiatric units in London in 2001 revealed over-representation of Black adolescents with psychosis.[16] The adolescents of African origins were particularly highly represented but were less likely to suffer from schizophrenia. Further studies are necessary to ascertain whether high levels of stressors may contribute to both higher incidence and greater need for admission.

Culture-specific disorders

There is little evidence of culture-specific disorders in children, although there are some reported differences in symptomatology. Pseudo-psychosis characterized by hallucinations has been described in young South Asian women in the UK. Anorexia nervosa, which is now widely recognized as a culture-specific disorder of the affluent developed world, has been reported in many parts of the world undergoing westernization.

Local authority care by ethnicity

Figure 3 gives a comparative profile if the indices of children's well-being are extended to social care. Research in this area has only recently begun to attract interest.

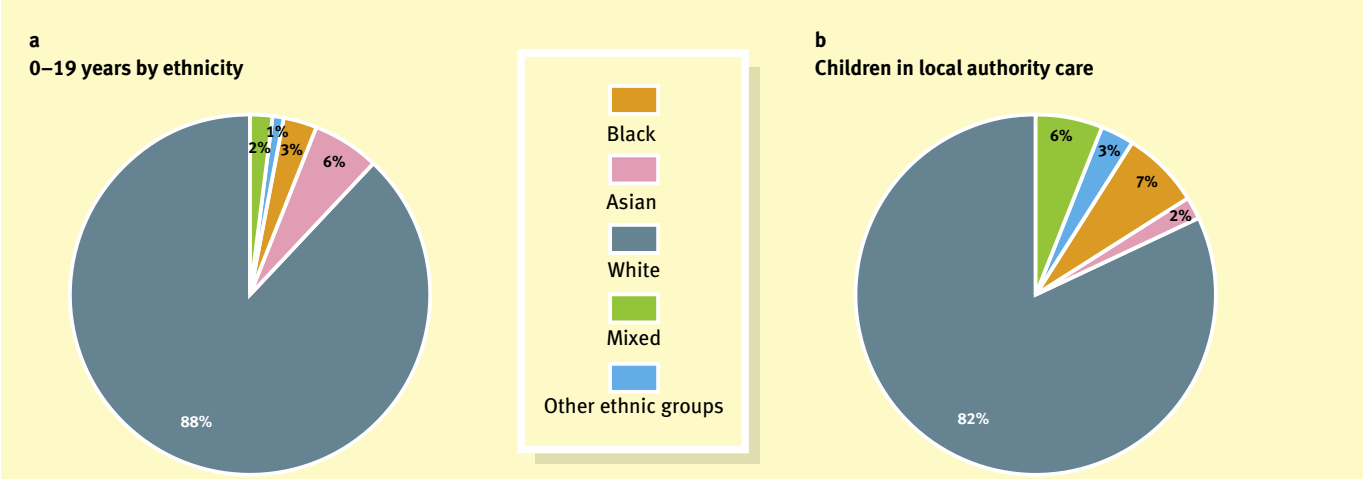
Assessment and treatment issues

The practice of child psychiatry in a multicultural society requires an understanding of why cultures are different. Although cultural explanations are often readily evoked in explaining difference, the explanations are generally stereotypical and ethnocentric, the term 'culture' often being used to describe differences from the normative practices of the West. While previous research has mainly described how cultures differ, the study of cultures has been advanced by cultural psychology, which has introduced a dialectical understanding of the interplay between child-rearing and the cultural frame that directs the socialization of children. Each culture is understood in its own terms with reference to its own values, beliefs and goals. A few examples are presented briefly below.

Differences in child-rearing practices

Cultural studies reveal differences in beliefs and practices, such as those regarding the fragility of children, perception of an infant's crying, beliefs about the extent of a child's need to be held or spoken to, and the need to develop certain developmental skills over others. Care-giving environments develop to some extent in accordance with the competencies and roles that are expected of adults in that culture.

For example, in many parts of the world where the unit of economic production is the family, such as in Asia, Africa and among the indigenous populations of the Americas, children are encouraged to sleep with their mothers, grandparents or older siblings even when ample space is available. Such co-sleeping in childhood promotes closeness and togetherness in cultures where interdependency and solidarity is the goal for the family or where children are thought to be fragile, particularly in the context of high infant mortality rates. On the other hand, in European and American contexts, where autonomy and entrepreneurial exploration are greatly valued, infants are encouraged to sleep alone from an early age, which promotes individualism.[17] Neither practice is 'better', but each is contingent on what is the required competency for that society.



0–19 years of age by ethnicity in England.
Results of the Labour Force Survey, 2000. (Adapted from ONS)

Children in local authority care in England by ethnicity,
March 2001. (With permission from the Department of Health)

3

Similarly, in a study undertaken in Paris among African families from cultures that value highly the construction of social bonds,[18] mothers showed less responsiveness to their child's initiative concerning objects (such as toys and household items) than did the French mothers. The African mothers were more responsive to their children's initiative towards vocalization, postural changes and glances towards others and crying. The French mothers also tended to name objects and describe their properties in their speech which reflected the value accorded to objects in the socialization of children in a technological society.

The significance of any parental behaviour must be understood in relation to the norms of the society. For example, the use of physical chastisement for disciplining children may not have the same significance for children in different cultures. Deater-Deckard and Dodge have shown that the correlation between the parental use of physical chastisement short of abuse and aggressive behaviour in children did not hold true for African-Americans where it is not significant.[19] This is contrary to the finding of a positive correlation between physical discipline and child aggression described in European-American children. It may be that in cultures where physical chastisement is outlawed its occurrence indicates loss of control in the parent or deviant parenting behaviour. This illustrates that, for clinicians, what is important is an understanding of how risk and protective factors come into play for children in different cultures and contexts.

The reader is referred to Mhemooda Malek's critical review of the range of issues to be considered when developing mental health services for minority ethnic children.[20]

Conclusion

The practice of child psychiatry in a multicultural society raises important issues for cross-cultural methodology and for therapists working with diversity. Given that cultures are not static but dynamic, responsive and changing, the end-point of the debate is less likely to be how cultures differ than how we study culture and how we work with diversity. Examining our own means for understanding culture reveals how culture permeates all our thinking – including our thinking about culture. ◆

REFERENCES

1 Modood T, Berthoud R, Lakey J *et al. Ethnic Minorities in Britain: Diversity and Disadvantage.* London: Policy Studies Institute, 1997.
2 Bird H R, Canino G, Rubio-Stipec M *et al.* Estimates of the prevalence of childhood maladjustment in a community survey in Puerto Rico. The use of combined measures. *Arch Gen Psychiatry* 1988; **45:** 1120–6.
3 Kleinman A M. Depression, somatization and the 'new cross-cultural psychiatry'. *Soc Sci Med* 1977; **11:** 3–10.
4 Littlewood R. From categories to contexts: a decade of the 'new cross-cultural psychiatry'. *Br J Psychiatry* 1990; **156:** 308–27.
5 Pike K L. *Language in relation to a unified structure of human behaviour.* The Hague: Mouton, 1967.
6 King M B, Bhugra D. Eating disorders: lessons from a cross-cultural study. *Psychol Med* 1989; **19:** 955–8.
7 Hackett R, Hackett L. Child psychiatry across cultures. *Int Rev Psychiatry* 1999; **11:** 225–35.
8 Hackett R, Hackett L, Bhakta B, Gowers S. The prevalence and associations of psychiatric disorder in children in Kerala, South India. *J Child Psychol Psychiatry* 1999; **40:** 801–7.
9 Mann E M, Ikeda Y, Mueller C W *et al.* Cross-cultural differences in rating hyperactive-disruptive behaviors in children. *Am J Psychiatry* 1992; **149:** 1539–42.
10 Sonuga-Barke E J S, Minocha K, Taylor E A, Sandberg S. Inter-ethnic bias in teachers' ratings of childhood hyperactivity. *Br J Dev Psychol* 1993; **11:** 187–200.
11 Bird H R. Epidemiology of childhood disorders in a cross-cultural context. *J Child Psychol Psychiatry* 1996; **37:** 35–49.
12 Hackett L, Hackett R. Parental ideas of normal and deviant behaviour. A comparison of two ethnic groups. *Br J Psychiatry* 1993; **162:** 353–7.
13 Weisz J R, Sigman M, Weiss B, Mosk J. Parent reports of behavioral

and emotional problems among children in Kenya, Thailand, and the United States. *Child Dev* 1993; **64:** 98–109.

14 Rutter M, Yule W, Berger M, Yule B, Morton J, Bagley C. Children of West Indian immigrants. I. Rates of behavioural deviance and of psychiatric disorder. *J Child Psychol Psychiatry* 1974; **15:** 241–62.

15 Goodman R, Richards H. Child and adolescent psychiatric presentations of second-generation Afro-Caribbeans in Britain. *Br J Psychiatry* 1997; **167:** 362–9.

16 Tolmac J, Hodes M. Ethnic variation among adolescent psychiatric in-patients with psychotic disorders. *Br J Psychiatry* 2004; **184:** 428–31.

17 Shweder R A, Goodnow J, Hatano G, LeVine R A, Markus H, Miller P. The cultural psychology of developments: one mind, many mentalities. In: Damon D, Lerner R M, eds. *Handbook of child psychology. Vol 1. Theoretical Models of Human Development.* New York: Wiley, 1998.

18 Rabain-Jamain J. Language and socialization of the child in African families living in France. In: Greenfield P M, Cocking R R, eds. *Cross-cultural roots of minority child development.* Hillsdale, NJ: Erlbaum, 1994.

19 Deater-Deckard K, Dodge K A. Externalising behaviour problems and discipline revisited: nonlinear effects and variation by culture, context and gender. *Psychol Inq* 1997; **8:** 161–75.

20 Malek M. Meeting the needs of minority ethnic groups in the UK. In *Mental health services for minority ethnic children and adolescents.* Malek M, Joughin C, eds. London: Jessica Kingsley Publishers, 2004.

