# CONDUCT DISORDER VS. ATTENTION-DEFICIT HYPERACTIVITY DISORDER: DIAGNOSTIC IMPLICATIONS FOR AFRICAN-AMERICAN ADOLESCENT MALES

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The purpose of this article is to heighten awareness among school counselors and educators around diagnostic issues involving African-American adolescent males. Additionally, this article seeks to challenge counselors and other helping professionals who work with African-American adolescent male populations and who are in positions to diagnose or impact diagnoses to carefully examine any faulty predispositions, prejudices, or stereotypes they may harbor that will adversely impact diagnoses.

It seems that the buzz diagnosis for adolescents experiencing difficulties focusing and attending in class, as well as staying on task, and following instructions, is Attention-Deficit Hyperactivity Disorder (ADHD). Attention-Deficit Hyperactivity Disorder formerly Attention-Deficit Disorder (ADD), has its semantic derivation in the 1970s. ADHD is defined symptomatologically. It is a behavioral disorder characterized by two separate subtypes. Those two subtypes are *inattention* and *hyperactivity-impulsivity*. ADHD with inattention describes in part a child who fails to pay close attention to details, has difficulty sustaining attention, does not seem to listen when spoken to, or who has difficulty organizing tasks and activities (DSM-IV, 1994). ADHD with hyperactivity-impulsivity describes in part a child who appears fidgety, leaves seat in classroom regularly without permission, runs about excessively, or blurts out answers before questions have been completed (DSM-IV, 1994). It is estimated that 3 to 5% of all children have some form of a primary ADHD with or without hyperactivity (Barren, 1994). The pharmacological drug of choice in treating this behavioral disorder is ritalin. As numbers of students receiving an ADHD diagnosis continue to grow, so has prescriptions for ritalin (Howell, 1997). Interestingly enough, teachers become very instrumental in identifying student behaviors that may be indicative of an attention and/or hyperactivity disorder. With the aforementioned in mind, the role of teachers and school counselors in identifying behaviors that contribute to a diagnosis of Attention-Deficit Disorder becomes very important.

Another disorder that seems to be finding its way into our schools is Conduct Disorder (CD). By contrast to its attention-counterpart which is characterized by inattentive and hyperactivity/impulsivity,

Conduct Disorder is characterized as a "repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" (DSM IV, 1994). The implications for treatment of the aforementioned respective disorders become significant when one considers the etiological factors offered for the disorders. ADHD is attributed to central nervous system dysfunction (Barren, 1994), whereas Conduct Disorder is attributed largely to social maladjustment.

In many school systems, teachers, administrators, and counselors serve as informal diagnostic teams in assessing students' behavioral issues. This is particularly true to systems that have alternative educational settings for students who have been diagnosed with behavior problems or conduct disorder. There is a marked disparity in the diagnoses of White males and African-American males with regard to ADHD and Conduct Disorder. In a society where negative stereotypes unfortunately still persist of African-American males, it is no wonder that Black males who exhibit Attention-Deficit Disorder characterized by lack of impulse control are often given an immediate and informal diagnosis of Conduct Disorder.

Conduct Disorder and Attention-Deficit Hyperactivity Disorder are widely diagnosed. It appears that a particularly large number of African-American males particularly are diagnosed as CD as opposed to ADHD. Educators and counselors play an increasingly important role in the diagnostic process. A lack of a clear understanding of our personal perceptions and prejudices coupled with a lack of knowledge of the DSM-IV criteria for diagnosis can result in misdiagnosis of African-American adolescent males.

The purpose of this paper is to make counselors and educators aware of their need to examine and explore personal prejudices and to increase their knowledge of the criteria for diagnosing both Attention-Deficit Hyperactivity Disorder and Conduct Disorder.

There is a mistrust of counseling and service delivery systems by oppressed populations (Atkinson, Morton, & Sue, 1998). This mistrust is based on some facts of past prejudices and mistreatment from institutions which were supposedly there to serve oppressed people. With this backdrop, professional educators and counselors find themselves faced with the responsibility of increasing their knowledge and awareness of how oppression has impacted the perceptions of oppressed population. Three areas that educators and counselors might examine would include: (a) Providing for role models by hiring African-American educators, (b) examining the impact of homogeneous grouping on African-American students, and (c) increasing multicultural curriculum.

It is the contention of this article that faulty diagnosis of African-American adolescents males may be the result of faculty perceptions and stereotypes of African-American adolescent males. If the aforestated contention is true, the implications are that schools and persons in positions of diagnosing these students must examine themselves and their perceptions of African-American males in such a way as to eliminate and minimize any personal prejudices or biases that may adversely

impact their assessment. Add to that the fact that while students who are diagnosed as ADHD go on to receive medication, generally ritalin, dexedrine, or the newer adderall, students with a Conduct Disorder diagnosis generally go on to be labeled socially maladjusted and are subsequently placed in alternative educational settings that more closely resemble incarceration instead of education.

Of the many factors that can contribute to an educational environment conducive to the misdiagnosing of African-American adolescents males, this article identifies three that are significant. They are: (a) schools that do not have a significant number of African-Americans on staff in teaching positions, (b) schools that favor homogeneous or ability grouping over heterogeneous grouping, and (c) schools that do not support a curriculum that promotes multicultural awareness and sensitivity.

To the degree that schools do not actively seek to hire an appropriate number of African-Americans, Black male adolescents' self-concept and achievement are adversely impacted resulting in the African-American adolescent male becoming detached from the educational process and those charged with educating them (Blake & Darling, 1994). This detachment, which often becomes a way of interaction for these students, is often perceived by teachers as willful disobedience and defiance ironically both of which are characteristic of Conduct Disorder. Considering these points, schools that favor homogeneous grouping, a system whereby students are grouped according to their ability levels, generally come across as promoting and perpetuating the status quo which further alienates African-American adolescent males.

There has been much research in the area of educational practices such as tracking or ability grouping that clearly suggests that grouping students in such a way tends to adversely impact the racial identity development of minority students (Davidson, 1997). This tracking proves more often than not to be more destructive than constructive as African-American adolescents become frustrated at the notion of being separated and grouped on the basis of special characteristics. This for them resembles too closely segregation and as a result resentment builds in such a way as to pervade the general disposition of the African-American adolescent. The combination of feelings of frustration and resentment often manifests itself in the form of behavioral episodes characterized by the African-American adolescent male defying authority in a passively aggressive fashion or an overtly aggressive fashion. In either case, the more often than not resonating informal diagnosis is that of Conduct Disorder. It appears that for African-American adolescent males at least the unwritten rule is that any misconduct must be seen as Conduct Disorder. Of course, we can see that there are a number of issues that could and should be addressed before making such a diagnosis as Conduct Disorder, and this diagnosis is to be made by a qualified professional such as a psychiatrist, psychologist, or licensed mental health professional. The often founded resentment and frustration of the African-American adolescent male may very well be addressed effectively within the context of individual counseling or

some other direct counseling intervention.

Lastly, schools that do not support a curriculum that promotes cross-cultural awareness and sensitivity send the message that there is but one culture that matters and that is the dominant one. Of course, this message is met with further resistance on the part of African-American adolescents males. There are still many school districts that have not integrated multiculturalism into their curricula. Multicultural awareness and sensitivity are crucial to the development of an environment conducive to the understanding of the unique problems that plague minority and other special populations. The significant contributions of African-Americans are often discounted until the month of February when some teachers do a few lessons on a couple of African-American figures that contributed in some significant way to the advancement of humankind. Clearly, African-Americans have contributed immensely in virtually every aspect of human exploration. There is not a single reason that teachers in every discipline cannot include the accomplishments and achievements of African-Americans into their lessons on a consistent year-long basis. The message that is being sent to African-American adolescents by relegating the study of African-American contributions to one month is that your culture contributed so little until we can discuss everything in one month. From talking with African-American adolescents, it can be unequivocally stated that they are unaware of the magnitude of African-American contributions to science, medicine, general technology, mathematics, etc. The cumulative effect is a developing sense of worthlessness and eventual hopelessness that very well has the potential of leading and/or contributing to depression. Having counseled with adolescents for a number of years who have been depressed, one thing is clear. That is the striking resemblance between Conduct Disorder and African-American adolescents' reaction to depression. The influence of culture on the experience and communication of symptomatology consistent with depression is well documented in the DSM-IV (Smart, 1997).

Diagnosing adolescent disorders is a process that involves understanding the developmental characteristics of adolescence as well as an understanding of one's own issues that may contribute to faulty diagnosis. One thing should be clear on the issue of diagnosing disorders using the DSM-IV. Many clinical diagnosticians will diagnose the same client exhibiting the same apparent symptomatology in vastly different ways. This can be understood and explained when one considers the concept of subjectivity. It is in this subjectivity that one's own issues work to influence one's diagnosis. Stereotype, racism, prejudice, and sexism are just a few of the variables that have the potential of impacting clinical diagnoses formal or informal (Smart, 1997). For the aforementioned reasons, it is paramount that persons in positions of diagnosing or influencing diagnosticians go through the often telling but always necessary process of self-examination as a means of identifying and subsequently eliminating those pieces that have the potential of adversely impacting diagnoses.

Also, the issue of dual diagnosis or

comorbidity must be addressed. There are times when adolescents may exhibit symptomatology that is consistent with two separate diagnoses. In such cases of dual diagnoses, the clinician must ask the question, "Which disorder do I treat first?" or "Do I treat them both at the same time?" Both are legitimate questions that require careful attention. According to Dr. Joseph Biederman, chief of the Joint Program in Pediatrics and Psychopharmacology at Massachusetts General Hospital, depression, anxiety, conduct, and oppositional disorders are the most common disorders that cooccur with ADHD (Biederman, Jensen, & Wilens, 1995). In his article included in the June 1995 edition of Child & Adolescent Psychiatry, Biederman points out that conduct disorder cooccurred in approximately 20% of children with ADHD. Interestingly enough, the article pointed out that of the four most common disorders cooccurrent with ADHD cited earlier, the disorder that cooccurred with ADHD in children in the smaller percentage of cases was conduct disorder.

What are the implications for African-American adolescent males who exhibit ADHD symptomatology but who are victimized by faulty and suspect diagnoses predicated on faculty perceptions and stereotypes of them? Furthermore, what are the implications for African-American adolescent males who may exhibit symptomatology consistent with both ADHD and Conduct Disorder? Will their ADHD not be addressed as diagnosticians or persons in positions of influencing diagnosis see them solely in terms of Conduct Disorder? A question that each and every person in a position to diagnose or impact diagnoses must ask where African-American adolescent males exhibit some impulsivity in action, hyperactivity, inattentiveness, and general out-of-control behaviors is to what degree is my diagnosis impacted by how I think, feel, and react to African-American adolescent males.

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