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Chapter 17

Exploring the ADHD Diagnosis in Ghana

Between Disrespect and Lack of Institutionalization

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Taking ADHD to Ghana

This chapter explores the diagnosis and treatment of attention deficit<N>hyperactivity disorder (ADHD) in Ghana. The emergence of diagnosis and treatment in the Global South has been researched only partially. African countries remain particularly under-researched, with South Africa being the exception (Meyer and Sagvolden 2006; Snyman and Truter 2010; Seabi and Economou 2012). We know about the diverging prevalence of ADHD in different regions across the globe (Polanczyk et al. 2014). Much less is known about what ADHD means and how diagnosis and treatment are employed across different settings. We explore precisely this, from a biosocial perspective, attending to niche variation in ADHD in relation to contextual institutional differences (Singh 2012).

To our knowledge, this is the first study on the clinical use of the ADHD diagnosis

and treatment in Ghana or any other sub-Saharan African country so far, apart from South Africa (e.g., Meyer and Sagvolden 2006; Snyman and Truter 2010). There are no prevalence statistics or clinical records concerning ADHD in Ghana. We therefore approached clinicians and policymakers and searched the media for references to ADHD. Since the ADHD diagnosis is only sparsely used in Ghana, we were able to survey almost the whole field. At present, there is some recognition of ADHD among children in mental health policy, limited provisions, and some calls for “upscaling” treatment. ADHD among adults and disparities among groups remain almost unknown. Researching Ghana therefore offers the opportunity to obtain an early introduction of the disease category.

We explore how the introduction of diagnosis and treatment is related to the following institutional contexts: mental health provisions, nongovernmental organizations (NGOs), educational facilities, and cultural understandings of intergenerational relations. The question of whether the introduction of the ADHD diagnosis and treatment addresses unmet needs or reflects social transformations is beyond the scope of this chapter. Even if medicalization is not at the center of the analysis, but rather the “glocalization” (Robertson 1995) of ADHD, this chapter points to some “vehicles of migration” (Conrad and Bergey 2014) of this medical diagnosis and its treatment.

Ghana has an estimated population of 25.4 million (World Bank Ghana 2014), 64% of whom live in rural communities. It is ranked as a “lower middle-income” country and has experienced a period of significant economic growth, boosted by oil and gas extraction. The gross domestic product per capita was \$40.7 billion in 2012. Although many people live in poverty, a growing group in Ghana has access to modest financial resources. Not surprisingly, Ghana has a poorly developed mental health and educational sector. Even if psychiatric diagnoses seem to be on the rise, concerns about deviant behavior or--depending on one’s perspective--mental health, are often couched within a spiritualistic explanatory

model in Ghana (Doku et al. 2008; Read 2012; Read and Doku 2013).

Our exploration suggests that corporal punishment, traditional healing, and prayer seem to remain the first treatments for children who are brought to the attention of clinicians who diagnose and treat ADHD. This situation might change given the attempts of Ghanaian health professionals, policymakers, NGOs, pharmaceutical companies, and journalists to “raise awareness” about ADHD. And, even though the importance of school performance is an issue in Ghana almost as much as it is in the West, the difference lies in the fact that school performance more explicitly connotes family status and potential for income generation and upward social mobility, rather than academic accomplishment.

We find that “ADHD” is not a culturally established category, as it is, for example, in many countries in the West. However, there might be a niche in the making: disrespect for parents, teachers, and the elderly seems to be at stake when the ADHD diagnosis and medication are sought in Ghana.

Niches for ADHD Worldwide

Following up on Singh’s (2012) comparison of the United States and the United Kingdom, this chapter asks whether ADHD in Ghana is used for child behavior in specific social situations and in combination with distinct cultural connotations. Our analysis seeks to avoid a strict nature-nurture divide (Singh 2002). This biosocial perspective situates diagnosis and treatment in institutional contexts and provides space for the ambiguities and politico-normative implications of diagnosis and medication. At the same time, the perspective is “biological” in the sense that a biological basis of ADHD is not ruled out; it is possible that one might find universal traits of ADHD, such as problems with self-control, and biology itself may be flexible and in need of translation through culture.

More specifically, we employ the concept of an “ecological niche” (Singh 2012), which “suggests that children’s behavioral development must be seen as a fundamentally situated and relational process in which there is an on-going and mutual process of shaping and of transformation between child actors and their immediate and proximal social and physical spaces” (890). Such an approach will help elucidate how children’s difficulty with self-control on the one hand, and the social environment on the other hand, interact to produce a distinctive phenotype as well as how children and parents understand the disease.

Singh’s (2012) study describes different ecological niches that children inhabit and posits some mechanisms that may underlie the development of variations at the phenotypic level among children with the same diagnoses. For example, in the United States, a modal “performance niche” means that oftentimes children and families see ADHD as a disorder of academic performance and associate stimulant drug treatments with improvement in the classroom (Singh 2012: 895). Similarly, in the United Kingdom, a modal “conduct niche” means that “a child’s difficulty with behavioral self-control finds its expression in, is shaped by, and gives shape to, a normative behavioural channel” (Singh 2012: 895). Niche variation is further illuminated in a small number of studies (Stolzer 2005; McIntyre and Hennessy 2012; Bröer and Heerings 2013).

The current study is the first one to apply the niche model to a non-Western country. It explores when, where, and how ADHD diagnosis and treatment are employed among clinicians and NGOs, in policy, and in the media. We identify the institutional context and practices of diagnosis and treatment. Future research needs to address children to see which phenotypes might develop in Ghana.

Methods

Based in Cape Coast, Ghana, Kraak conducted the field research between November

2011 and March 2012, while Spronk was working on a different project concerning the emerging middle classes (Spronk unpublished manuscript). The fieldwork was coordinated with Bröer through repeated online sessions.

The research design was exploratory and aimed at a broad survey of the field of ADHD diagnosis and treatment among clinicians and policymakers and in media reports in Ghana. Patients and relatives were not included in the present study, though they were referred to in the interviews. The findings from 2011-12 were checked and updated with desk research and through the ongoing contacts and fieldwork of Spronk in 2014.

At the start of the project, we had no idea about the scope of the ADHD diagnosis. We therefore started interviewing clinicians as a way to delineate the possibility of an ADHD niche. From there, we identified the specific context and practices in which a diagnosis comes about, the meanings attached to it, and the problems addressed in its application.

The contextual analysis included the institutions of mental health (including NGOs and hospitals) and partly those of education (particularly schools). Here, we assessed policy documents and interviewed policymakers and stakeholders. We gathered research literature, newspapers, and web sources, searching for explicit references to ADHD in Ghana. Most mental health treatment in Ghana is provided by inpatient and outpatient facilities in psychiatric hospitals (WHO 2007). We found that most clinicians involved in child mental health are also working in Accra, the capital of Ghana. We therefore focused on clinicians in Accra.

We approached all major mental health clinics, private clinics, and university departments to find clinicians using the ADHD diagnosis and asked for respondents to identify colleagues using the diagnosis. After several rounds, we were confident that we had spoken to almost all professionals using the ADHD diagnosis and treatment. We found hardly any professionals working on ADHD outside Accra. It is not uncommon that services are

clustered in Accra, partly because people search for anonymity to avoid stigma (Dapaah 2012). One psychiatrist interviewed had worked in Kumasi, the second largest city of Ghana. He assessed children with special educational needs. We identified 10 relevant clinicians: 4 psychiatrists, 4 clinical psychologists, and 2 pediatricians, of whom we could interview 8 (see tab. 17.1). Interviews were held face to face (and one by phone) and lasted between 30 minutes and 1 hour. None of the respondents was able to provide more than an estimate of the number of cases. In addition to the clinicians, we interviewed two government officials.

Table 17-1. Overview of clinicians in our study

Profession	Organization	Public or private	Estimates of number of patients per year
Psychiatrist	Accra Psychiatric Hospital	Public	60
Clinical Psychologist	Korle-Bu Teaching Hospital, Department of Psychiatry	Public	12
Clinical Psychologist	Korle-Bu Teaching Hospital, Department of Psychiatry	Public	4-5
Clinical Psychologist	Ankaful Psychiatric Hospital	Public	
Pediatrician	Korle-Bu Teaching Hospital, Department of Child Health	Public	300-400
Psychiatrist	Smarthealth clinic and government clinic in Kumasi	Private	100
Developmental Pediatrician	Child & Associates	Private	8
Psychiatrist	Peace Be Clinic	Private	8

We first called respondents to introduce ourselves; they received information about the study and were then finally interviewed. The interviews were held with a structured topic list, which we developed on the basis of initial conversations. The items included mental health policy, debates about ADHD and mental health, collaboration, the uptake of the diagnosis,

clinical definitions, patient characteristics, and the professional background of the respondent. All interviews were recorded and transcribed verbatim with the respondents' consent.

We performed qualitative thematic content analysis (Mayring 2000; Hsieh and Shannon 2005) on the interviews and documents. Inductively, we established the local interpretation of ADHD-related concerns. Initially, interpretations were drawn up individually and then compared and discussed among team members. Deductively, we gathered information about the other items. Preliminary interpretations were repeatedly compared among members of our team.

Institutional Context

Below, we report the findings of our study, moving from the wider institutional context (education and health) to ADHD diagnosis and treatment more specifically.

Education

Ghana has more than 12,000 primary schools, more than 5,500 junior secondary schools, more than 500 senior secondary schools, more than 20 training colleges, around 20 technical institutions, several diploma-awarding institutions, and 5 universities. Most Ghanaians have, in theory, relatively easy access to good education. In the past decade, Ghana's spending on education has increased (Ghana Statistical Service 2013). School is mandatory from the age of 6 years until at least 15 or 16 years. It comprises primary and secondary education.

According to official statistics, 85% of school-age children attended school in 2001, and by 2010, gross enrollment was reported to have reached 90% (Ministry of Education, Science, and Sports 2007). In 2011, primary school enrollment was estimated at 107% due to the re-enrollment of over-aged children (World Bank 2014). Primary school education in

public schools is tuition-free, but the financial contribution for books and school materials remains an obstacle to school attendance. Social conditions in children's families are key contributing factors to dropout, retention, and completion (Ananga 2011). Financial means are a necessity for pursuing education in order to attain higher levels of formal employment. There are therefore large differences in the rates of completion of higher education among social classes.

As one of the interviewed professionals in this study stated, education is paramount in Ghana. This has been the case for a long period of time. One of the first Ghanaian professors in psychology, Samuel Danquah <Googled for first name>, stated in 1987: "High parental expectations are illustrated by the popular Ghanaian household saying, 'Seek first the kingdom of education and everything shall be added unto you.'" Social capital is measured by educational achievement (Sackey 2005) and has become an icon of social accomplishment. The pursuit of social mobility through education can be found in lower and higher strata of society, and most Ghanaian families invest a large part of their household budget in the education of (some of) their children. Both girls and boys are equally represented, and school performance is slightly higher among girls (Ghana Statistical Service 2013). From childhood on, engaging in this pursuit is an inescapable route, or expectation, of growing up. The fear of not being able to generate an income, or of falling down to less successful levels of society, hence of failing social expectations, is mentioned as a driving force behind people's ambitions in one of our studies (Spronk unpublished manuscript). Not being successful is considered a disgrace and a personal failure of perseverance. Therefore, parents are very concerned about successful school results.

Mental Health in Ghana

<this lead-in sentence doesn't seem necessary to me>As in most sub-Saharan

countries, resources and facilities for mental health in Ghana are scarce (Asare 2010). The treatment gap is estimated to be 98% in sub-Saharan Africa and 98.8% in Ghana (WHO 2007). The Ghana Health Service estimated 6,316 inpatient cases and 26,559 outpatient cases in 2005. An estimated 2.8 million adults have a mental disorder according to World Health Organization (WHO) prevalence rates (WHO 2007). Inpatient facilities are offered by three psychiatric hospitals, some regional hospitals, and district hospitals, which are mainly based in the south of the country. Access to these institutions is free. The most common reasons for admission to a psychiatric hospital are schizophrenia, substance abuse, depression, and mania (Read 2012). The most common outpatient diagnoses are epilepsy, acute psychosis, substance abuse, and neurosis (Read 2012). Ghana has between 4 and 15 psychiatrists (WHO 2007; Asare 2010) and 4 psychologists working in the mental health field. Over the past decade, a few private institutions have been set up that offer outpatient services in Accra, often by professionals who also work in public service. We also believe that the numbers have increased since the turn of the century, with more and more students finishing their graduate education in psychology. No data are available on their numbers. Besides pressing financial limitations, the limited mental health sector has also been shaped by years of a lack of political commitment and the continuous emigration of highly skilled professionals (Connell et al. 2007).

The WHO has identified Ghana as one of the countries to receive intensified support by the Mental Health Gap Action Programme (mhGAP) to improve treatment for mental, neurological, and substance use disorders (http://www.who.int/mental_health/mhgap/en/). This is the result of the much broader initiative of the WHO Mental Health Programme, which seeks to improve access in low-income countries by scaling up mental health services and treatment, promoting human rights, stopping social exclusion, and developing mental health laws. Ghana is also participating in the Mental Health and Poverty Project (MHaPP), a

Research Programme Consortium funded by the U.K. Department for International Development (DfID) for the benefit of developing countries. The purpose of the consortium is to provide new knowledge regarding “comprehensive multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health” (Mental Health and Poverty Project 2008; Kleintjes, Lund, and Flisher 2010; Faydi et al. 2011).

Mental health services for children are offered by some institutions such as the Accra Psychiatric Hospital and the Korle Bu Teaching Hospital, but children’s facilities are not strictly separated from adult facilities. The implementation of the Mental Health Bill, passed in 2012 (Doku, Wusu-Takyi, and Awakame 2012), aims to separate children’s facilities from adults’, since there had previously been no national plan to support the implementation of provisions for children and adolescents. In rural parts of the country, there are several projects to set up community-based mental health services that also include children. In Accra, some privately based psychiatrists, clinical psychologists, and pediatricians offer outpatient psychiatric and psychological services for adults, families, and children--however, none specialize in ADHD. Respondents in this study report that families from all socioeconomic backgrounds patronize these facilities, and there is a clear trend among middle- and upper-class families to visit private clinics. There are no nationwide data available on the number of children who are treated for psychiatric problems.

ADHD Facilities for Children in Ghana

Considering the above, it is not surprising that there is no central body, government organization, or government policy focusing on ADHD. Nor is there any specialized center for the diagnosis and treatment of ADHD. Still, in 2010, the government included ADHD in the latest edition of the Standard Treatment Guidelines (<http://ghndp.org/images/downloads/stg2010.pdf>).

This document provides a description of ADHD as a disorder and its symptoms, together with treatment options for children only. Besides behavioral therapy, methylphenidate is recommended as the only pharmacological treatment option. It is also recommended that “children suspected to have ADHD should be referred to a child psychiatrist or pediatrician for full assessment and treatment” (160). This shows that there are efforts to formalize the diagnosis and treatment of ADHD by psychiatrists participating in the mental health workgroup of the Ghana Health Service.

Clinicians, Caseloads, and Treatment

The introduction of diagnosis and treatment of ADHD in Ghana was partly the result of the gradually growing number of clinicians who started diagnosing and treating children with ADHD symptoms, mainly in Accra and the rest of the coastal region. We found 10 clinicians who stated that they worked with children with ADHD symptoms. Nine of these clinicians were interviewed (see “Methods” for more details). The clinicians ranged in age from roughly 25 to 65 years and had begun their careers in the 1980s up to the present. With one exception, all of these professionals had spent at least part of their career in an educational institution in the West for graduate, doctorate, or postdoctorate education. Knowledge of ADHD was acquired during their studies either in the West or in Ghana.

All interviewed clinicians stated that they diagnosed children with ADHD at some point during their career, and more recently, in the institution where they were currently working. Clinicians typified ADHD-related behavior, for example, as “bouncing off the walls” (clinical psychologist, Ankafu Psychiatric Hospital). Respondents said they based their diagnoses on the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (APA) and on the *International Classification of Diseases* of the WHO. They described symptoms in interviews in the following ways:

<BL>

- doesn't sit still
- fidgets a lot
- talks excessively
- gets up when they shouldn't
- restless/constantly in motion
- overactive/lots of energy
- throws things (at other children)
- destroys things/destructive
- doesn't follow instructions/not cooperative
- fights easily, quarrels, hits other children
- screams
- disruptive behavior/social disruption
- no friends/difficulty maintaining social relationships
- doesn't pay attention/inattention
- failure to progress academically
- impulsive
- distractible
- unable to complete tasks

</BL>

All but one clinician established the diagnosis with unstructured observations and verbal reports. Clinicians mentioned diverse causes of ADHD: genetic factors, (neurochemical) disturbances in the brain, lower threshold for stimuli, trauma and perinatal factors, and mental retardation as both a cause and an effect. Mental retardation was said to mask ADHD. All respondents signaled extensive comorbidity. When describing children with ADHD, some

clinicians pragmatically defined levels of severity of ADHD: “The children that do not severely have ADHD, they will slowly catch up (at school)” (clinical psychologist, Korle-Bu Teaching Hospital).

Quite a few clinicians implied that ADHD is underdiagnosed because schools and parents do not recognize the problematic behavior, or parents do not know where to get help. The reported number of children with ADHD whom clinicians see varies from between as few as two to up to several hundred per year. Most of the ADHD cases seem to be treated through the Accra Psychiatric Hospital and the Department of Child Health at Korle-Bu Teaching Hospital in Accra.

Following an ADHD diagnosis, psychiatrists and pediatricians offer the following pharmacological treatments: haloperidol, chlorpromazine, carbamazepine, imipramine, atomoxin, and methylphenidate. These differ from the Standard Treatment Guidelines, which only recommend methylphenidate. Scarcity of the medication is a problem; one government official stated: “I cannot assure you that once a product is listed [in the Essential Medication List] it is available in every facility. It should be, but it isn’t” (policy official, Ministry of Health). One clinician has arrangements with pharmaceutical companies to import methylphenidate and sell it only under his prescription. We suspect that he, being a younger professional, is in conflict with senior colleagues who reject methylphenidate:

<EXT>I don’t like it [methylphenidate]. Because it is an amphetamine, it is addictive...you should control drugs. You should be careful. (Psychiatrist, private clinic)</EXT>

Medications that are provided by public services (Accra Psychiatric Hospital, Korle-Bu Teaching Hospital) are government-financed and cost little for patients. Ghana has a National Insurance Scheme that makes access to health care more available to larger groups in society. Haloperidol, chlorpromazine, carbamazepine, and imipramine are (partly) reimbursed under

this scheme, but atomoxin and methylphenidate are not. The costs of atomoxin are estimated to be \$200 a month, whereas methylphenidate is estimated to be \$80 a month (compared to a per capita income of \$1,770 per year; see World Bank GINI 2015). Although clinicians reported treatment compliance, the duration of treatment seems to depend on the costs of medication.

ADHD Advocacy

Based on the analysis of Ghanaian newspapers, television programs produced in Ghana, and news websites, there is limited public attention to ADHD. We found 14 newspaper and Internet-based articles for the period of 2008 to 2014 and 1 television item--lasting 10 minutes in a lifestyle program--in 2014. We did not find references to ADHD before 2008.

Half of the contributions introduce ADHD and are intended to “raise awareness.” The others are more focused and concern the following factors: dietary advice, coping with an ADHD-diagnosed “husband” or “employee,” ADHD and traffic accidents, and ADHD-related activities. ADHD is generally discussed in terms of a specific setting and limited focus, such as a failing spouse or employee. Since ADHD is mentioned so little, we cannot relate it to broader patterns, such as gender disparity. It was not possible to trace most of the authors of these articles, but one author was the globally operating mental health advocate Cory Couillard, who explicitly asked his readers to answer the question “do you have ADHD?” (<http://vibeghana.com/2013/04/17/do-you-have-adhd/>). NGOs and a pharmaceutical company also promote ADHD diagnosis and treatment. CareplusGhana is a U.K.-based patient organization that uses Jansen Cilag’s promotional video-footage (<http://www.careplusghana.com/home/>). Special Attention Project Ghana is an advocacy group for learning disabilities that also explicitly targets ADHD. The Ghanaian African Social

Development Aid Foundation in 2010 collaborated with the Dutch National Committee for International Cooperation and Sustainable Development (NCDO) in a seminar on ADHD in Ghana

(http://www.foundationasda.org/index.php?option=com_content&view=article&id=11&Itemid=13). As this site shows, the collaboration is initiated by Ghanaian expatriates in the Netherlands. A U.K.-based volunteer organization advertises special education projects and explicitly mentions ADHD care. These intermittent engagements show that since the turn of the century, ADHD has received more consideration, albeit sparsely.

Disease Etiology and Health-seeking Behavior in Ghana

In Ghana, an estimated 70% to 80% of people with mental health problems consult an herbalist, a traditional healer (Ae-Ngibise et al. 2010), or so-called Christian prayer camps (WHO 2007). There were an estimated 45,000 traditional healers in Ghana and a handful of practicing psychiatrists before the turn of the century (WHO 2007). The three existing psychiatric hospitals are understaffed and overcrowded, and patient living conditions are qualified as inhumane by mental health advocates (<http://www.basicneeds.org/where-we-work/ghana/>). Biomedical explanations of ill health stand next to or are combined with “traditional,” “indigenous,” or “ethno” medicine in Ghana (Twumasi 1979; Tsey 1997). In Ghana, mental illnesses are generally believed to be the result of social pressure, life events and spiritual forces, curses, and charms (Lamensdorff, Ofori-Atta, and Linden 1995; Ofori-Atta, Read, and Lund 2010). Ae-Ngibise et al. (2010) describe how “juju, supernatural powers and evil spirits” are central in local etiology in their explanation of mental suffering (561).

Mental illnesses are feared in most communities in Ghana, and people suffering from mental illness are severely stigmatized (Kleintjes, Lund, and Flisher 2010). People have reported direct experiences of stigmatization, as well as the fear of stigma (Scambler 2009).

Moreover, courtesy stigma (Goffman 2009), the extension of stigma to those close to the stigmatized person, is also a real threat (Quinn 2007; Sonuga-Barke et al. 2010). The stigmatization of mental illness can have a significant influence on one's willingness to disclose and seek help; on the quality of health care received; and on access to family, community, school, or work support for recovery. In a qualitative study involving persons who care for people with mental health problems, about half of the caregivers interviewed in Accra and Kumasi believed that mental illness could be explained by secular causes. In contrast, in the northern region, most caregivers explained mental illness in terms of spiritual or supernatural factors (Quinn 2007). Previously, Lamensdorff, Ofori-Atta, and Linden (1995) found that among schoolteachers, higher incomes and living in urban areas correlated with the view that mental health was caused by "internal" problems.

In our study, clinicians reported that parents often seek the help of traditional healers, herbalists, and faith healers before, during, or after ADHD treatment. Furthermore, corporal punishment is a common form of "treatment" at home and in school. Clinicians told us stories about children with ADHD in which spiritualistic beliefs were described:

<EXT>I even got someone from the UK. It was a girl, the father sent her away [back to Ghana], because the mother thought she was a witch and wanted to kill her. Now she is in university. Amazing, isn't it? (Pediatrician, Korle-Bu training hospital)</EXT>

As far as we can infer from clinicians' reports and the sparse literature on mental health in Ghana, we have found that parents of unruly children might be pushed to see a clinician because the behavior of children can discredit the whole family. At the same time, seeking psychiatric help may also be associated with the fear of stigma. Therefore, clinicians repeatedly see parents who are seeking clinicians' advice outside their own community (this was also reported for other help-seeking behavior, such as seeking treatment for HIV/AIDS;

see Dapaah 2012). Parents often complained of unruly children, which is indicative of the emergence of a particular niche.

Intergenerational Relations

Intergenerational relations in Ghana are based on explicit and pervasive notions of reciprocity (Twum-Danso 2009: 426). Whereas children depend on their parents to provide care for them as they grow up, parents are dependent on children later in life. Parents spare no efforts to support and educate their children--especially during adolescence--in order to raise their status and increase their ability to improve the welfare and resource base of the family. In return, parents expect their children to serve them: "The reciprocities between parents and their children are life-long ones and are backed not by legal requirements necessarily, but by moral and religious obligation. Society does not spare those parents and children who fail in their reciprocal obligations. The recalcitrant child or parent may be ridiculed or gossiped about by concerned others" (Awedoba cited in Twum-Danso 2009: 427). It is crucial for children to practice respect, to show their parents that they are grateful, as well as to assume responsibilities such as household chores, succeed in school, and secure an income. Paying respect and behaving respectfully are culturally treasured values in the gerontocratic culture in Ghana (Van der Geest 2004). Twum-Danso (2009: 420) outlines how "in Ghanaian culture children are trained from a very early age that they must respect and obey all elders, be humble towards adults, and take their advice."

Disrespect is a violation of social values, and disrespectful children are seen as failures on the part of their parents, which might lead to the stigmatization of the entire family. Not only are disrespectful children punished, they also risk incurring a curse. According to a child in Twum-Danso's study, "if you respect you will get a long life [because you are accepted], if you do not respect you will get a short life because someone will curse you" (Twum-Danso

2009: 420). Respect and obedience are considered duties of children, and failing to conform to these social values discredits children and may bring shame on their parents.

Clinical Practice

From our study, we can conclude that most children are referred to clinicians by their parents, often on the basis of school staff's advice. According to the clinicians with whom we spoke, parents' and teachers' primary concerns are classroom interactions and performance at school. ADHD seems to figure primarily in relations between "educators" and children, but reports of parents also include unruly behavior in public and at home. Although this seems similar to ADHD, as reported in schools in Western countries, a closer examination reveals differences. In the first quote, disruptive behavior in itself is deemed problematic, and school performance is considered secondary. A clinician outlines the reasons for referral:

<EXT>The reason why they come is, one, teachers advise parents to take them because of their disruptive behavior and, two, pre-school performance is declining.
(Psychiatrist, public clinic)</EXT>

Below, we will demonstrate that disruptive behavior at school is problematic because it signals disrespect toward elders; threatens family aspirations, status, and earning capacity; and reflects badly on parents as good educators and nurturers.

Pay Attention to Your Teacher

The words "disruptive" and "social disruption" are used by informants repeatedly in relation to many aspects of classroom behavior that are associated with ADHD. As one clinician described a child:

<EXT>He was distractible and disruptive in the classroom...He was throwing things at children, he would engage in contact with children when he was not supposed to,

and he was not paying attention to what the teacher was ordering him to do.

(Developmental psychiatrist, private clinic)</EXT>

Other clinicians stated:

<EXT>He had disruptive behavior, he could not sit down in the classroom, he was talking to others, he constantly had to be punished. (Pediatrician, public clinic)

<LS>

They are very restless, fidgeting, destructive and disrupting, paying little attention, they are not able to sit down, and the performance at school is poor. (Psychiatrist, public clinic)</EXT>

Being disruptive means that the behavior is disturbing others, usually the child's classmates, and implies noncompliance with the teacher's orders and not paying attention to the teacher. Academic decline is mentioned, but not as a core concern. "Performance" is a problem in addition to or as a consequence of "disruption." In two of the three citations, performance is not even mentioned. Instead, respondents expand on disruptive behavior.

Children suspected of having ADHD are repeatedly called "stubborn," which can be interpreted as not obeying the teacher's rules or instructions. In the statements below, ADHD is again related to not paying attention to the teacher because of stubbornness.

<EXT>He would not hear instantly when the teacher was talking to him, or he would pay some attention at what the teacher was ordering him to do, but after a short time he would be not doing it again. Stubborn. (Psychiatrist, Accra Psychiatric Hospital)

<LS>

Causing a lot of trouble and being stubborn. [Stubborn] means when children are "not hearing," they don't do this or that. They are not obeying instructions even after they have been repeatedly told things in the face of punishment. (Psychiatrist, private clinic)</EXT>

In the descriptions of ADHD-related problems, the respondents emphasize the importance of obeying instructions and responding to punishment. Attention deficit is primarily a problem of not paying attention to elders, when children are “not hearing.”

Children are labeled “disruptive” or “troublesome” when they violate norms about how to respect not only the teacher but also the older generations, as a pediatrician tells us when describing typical ADHD behavior:

<EXT>They can’t sit down, they are all over the place, they talk excessively and interrupt others, that is what worries the relatives. Interrupting is rude here in Ghana, especially when it comes to the elderly. Children are typically not allowed to talk in front of elderly people. It is changing, but it is still here. Children here are not allowed to express their thoughts. Parents want their children then to be in check. So when a child cannot be controlled, it is like sticking up a sore thumb. They would be spanking the child, calling it troublesome. (Pediatrician, public clinic)</EXT>

Here, ADHD-like behavior explicitly violates the belief that children have to keep quiet and “stand at attention” when in the presence of grownups. Moreover, disrespect might threaten the moral status of family members. ADHD-like behavior is associated with “badness” and can be disgraceful to parents. Being “bad” thus implies disrespect:

<EXT>[Parents] think that they have a bad boy, meaning that they will be abused, targeted and bullied, beaten by other children or their parents. These are the children who are called stubborn, obstinate. (Psychiatrist, public clinic)</EXT>

Respect for the older generation is central to the gerontocratic culture of Ghanaian society. Elders should be greatly respected for their age and associated wisdom, and younger people are expected to listen and follow up on elders’ advice. Not adhering to elders thus undermines generational reciprocity, which rests on the notion that respect expresses the generational contract.

Disrespect and Punishment

When a child is considered stubborn or troublesome, what often follows is corporal punishment, at school and at home. Informants stated this when asked how teachers react to these behaviors:

<EXT>They cane them. Or they incarcerate them. Or they give them activities to do so they don't have to keep still. (Psychiatrist, private clinic)</EXT>

Corporal punishment, or caning, is lawful in schools. It has a long history and is contested at the same time. On the one hand, certain severe forms of punishment are seen as outdated and unjust, while on the other hand, “a good beating with a well selected stick or belt still awaits the disobedient child” (Twum-Danso 2009: 421). In reaction to reports on abuse and injuring children through corporal punishment in the 1970s, the Ghana Education Service (GES) decided that caning should consist of a maximum of six strokes and be administered by a head teacher or person authorized by the head teacher. More recently, this partial ban has come under attack. For example, in 2007, Central Regional Minister Isaac Edumadze and the chairman of the School Management Committee in Antwiagyekrom, Kwashie Boakye, reiterated that the partial banning of corporal punishment has contributed to a lack of discipline in schools and advocated for its full reintroduction (*Ghanaian Chronicle*, April 3, 2004 <not in References--please add.>). Similarly, in 2007, the chiefs and queen mothers of Mfantseman District called for the reintroduction of corporal punishment in schools (*Accra Daily Mail* 2007).¹ They viewed the ban on teachers' use of the cane in schools as responsible for a breakdown of discipline and identified public video shows, child labor, listening to music late at night, and broken homes as factors that inhibited good academic performance. In 2011, an opinion poll found that 94% of parents, 92% of students, and 64% of teachers favored the use of corporal punishment (Ghana News Agency 2011).

The debate about punishment bears upon ADHD and help-seeking behavior significantly. As one pediatrician stated:

<EXT>Discipline varies across schools or people...Quite a number of the new generation never have been caned. So we have two groups with different arguments: The ones that use harsh discipline for what they see as the disruptive behavior. They think they should beat children, that they should be disciplined for that [bad] behavior. But when they go through a barrier, when they see that even beating is not working, then they see there is something wrong and come for help. (Pediatrician, public clinic)</EXT>

The emphasis on obedience and discipline legitimizes harsh punishment and (re)affirms the authoritative position of adults. At the same time, this practice seems to preclude psychiatric explanations and treatment.

School Failure

Although respect seems to be a major concern, clinicians also relate “academic decline” or “falling grades” to ADHD.

<EXT>We have stubborn children whose academic performance is declining, who would be described as brilliant but not doing well at school. And they would not sit still, be talking in class, making a mess, getting into quarrels, fights, losing books. (Psychiatrist, private clinic)</EXT>

School performance is an issue of respect for teachers and parents, as we have seen. Failure easily leads to dropping out of or expulsion from school. As far as clinicians report on the issue, there might be two dimensions to school dropouts. First, they are the result of a general social failure, testifying to a child’s intemperateness and possibly contributing to the marginalization of the child and even the family. Second, dropping out of school might be

more closely tied to academic performance and upward social mobility or at least income generation. This is expressed, for example, in the following statement from a clinician:

<EXT>When children fail to perform, parents cannot cope with that. “It cannot be that my child cannot perform.” They think that if their child is given this label, that then they are potentially useless. They don’t want to hear that. They don’t know then what will come of them. (Pediatrician, private clinic)</EXT>

The clinician refers to how parents may translate lack of performance into being “useless.” Being “useless” is considered to be the inability to contribute financially to income and socially to status. It undermines the intergenerational contract. Among the upcoming middle class, the desire for mobility might even be more pronounced. Some clinicians suggested that low-income groups do not care about dropping out of school:

<EXT>The low-income structures, they don’t care. The children are expelled from school, they drop out of school and then they stay at home and that is it. With the middle and upper class, education is paramount. (Psychiatrist, private clinic)</EXT>

From the perspective of the clinicians, disruptive and stubborn behavior might lead to a child dropping out of school when disciplining and caning fail. But the relationship between punishment and dropping out is more intricate; on the one hand, dropping out can be a reaction to punishment itself (e.g., Dunne and Ananga 2013); on the other hand, dropping out and failure are more than academic underperformance. They are also related to lack of obedience, lack of humility, and inability to endure discipline itself.

Respondents in our study indicate that some parents adopt strong negative attitudes to their unruly or mentally ill children, up to the point that children are abandoned in front of hospitals or psychiatric wards. According to some respondents in our study, a child who is not performing and being useless is a source of severe stigma for parents. In any case, the threat of a child dropping out is a major motivation for parents to seek help, first from traditional

healers or priests and second from clinicians.

Respect Niche

In this chapter, we analyzed ADHD in Ghana from an ecological perspective, which assesses the proximal and distant social context relevant to the phenotypical development of problematic behavior. Extending the line of research of Singh (2012), we identified relevant niches for ADHD within and across several countries in the Global West and South.

In Ghana, a handful of clinicians, mostly trained abroad, use the *DSM*-based ADHD diagnosis and treat this condition with haloperidol, chlorpromazine, carbamazepine, imipramine, atomoxin, or methylphenidate, depending on availability. More recently, advocacy groups--closely related to those in Western countries--and one pharmaceutical company have tried to raise “awareness.” However, except for the inclusion of ADHD in governmental guidelines in 2010, there is hardly any standardized diagnosis or treatment. This lack of institutionalization coupled with scarce resources means that ADHD has yet to become a common diagnostic category. Still, clinicians do use the diagnosis for children who are referred to them by parents and teachers. Psychiatrists, clinical psychologists, and pediatricians are usually a last resort, after healers and priests have been consulted in vain.

From an ecological perspective, the lack of institutionalization means that other culturally available frames and mental health definitions and solutions come first. This shapes the understanding and identification of ADHD. Our exploratory research among clinicians suggests that in Ghana, ADHD is a problem of respect due to elders. Informed by cultural values where reciprocity and respect are key notions, unruly behavior at school is primarily an issue of disobeying teachers and not responding to disciplinary punishment.

This chapter points to a respect niche where “stubborn” children are diagnosed and treated with ADHD medication. Stubbornness and disobedience are generally described in

Ghana as not listening and paying attention, speaking loudly in the presence of elders, being boisterous, and, in particular, not being humble. Stubbornness and disobedience are considered unacceptable behaviors because they are believed to result from a lack of respect.

Similar to observations in the West, schools are fertile grounds for medical diagnoses, and children's academic performance is a widely shared concern. But performance is itself a sign of respect and obedience. Underperformance, moreover, threatens family status and social aspirations. School failure and dropping out are not only tied to academic performance but also to the ability to abide by disciplinary measures. Problems of "attention" in relation to respect do not refer to tasks and learning (as studies in the United Kingdom and United States suggest), but to obedience and standing still at attention.

We find that the training of clinicians (often abroad), the import of pharmaceuticals, and the work of NGOs serve as vehicles for the migration of ADHD diagnosis and treatment to Ghana. Because of the lack of institutionalization and the stigma attached to a mental health diagnosis, it is unclear whether, in the long run, ADHD will serve as a way of dealing with problems of respect-related inattention and overactivity in Ghana. Nonetheless, these findings suggest that the global spread of ADHD to Ghana is not--as of yet--marked by hegemonic medicalization. In a trial-and-error way, clinicians and patients seem to piece together a local variant of ADHD around the central norm of respect.

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<ENDFILE>

<ECH>Notes

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¹ The title of queen mother can relate to the rank of a paramount queen, a queen, or a sub-queen among certain ethnic groups. This woman is not necessarily the respective chief's mother. Her role in the system is to keep an eye on the social conditions.