EDITOR'S NOTE

Cultural Currents presents clinical experience derived from the practices of clinicians caring for patients and families whose cultural backgrounds are outside of the mainstream of society. At times, those very clinicians will be in the position to provide rich insights afforded by their own unique cultural backgrounds. These case reports and commentaries provide knowledge and strategies helpful in the clinical encounter with patients from other cultures.

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Attention-Deficit/Hyperactivity Disorder: Presentation and Management in the Haitian American Child

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Abstract: A case study of a young Haitian American is presented that is illustrative of cultural issues that influence care of those with attention-deficit/hyperactivity disorder (ADHD). Medications are the preferred treatment for ADHD and can be combined with psychological intervention. However, many Haitians and Haitian Americans see psychoactive medications as leading to substance abuse or mental illness. Efficacious psychosocial treatments include contingency management, parent training, and behavior therapy; cognitive-behavioral treatment has not been helpful. Complementary and alternative medicine might have appeal; primary care physicians can help families to assess such treatments and not to be enticed by expensive ones of little benefit. A determinant of the treatment a family pursues is their perception of the cause of the ADHD behaviors. While there is no term for ADHD in the Haitian-Creole language, in the Haitian culture the behaviors consistent with the diagnosis might be interpreted as indicating a poorly raised child whose behavior could be modified by parental discipline, an intentionally bad child, or a psychically victimized child suffering from an "unnatural" condition. "Natural" ailments are attributed to natural forces (e.g., wind, temperature), while "unnatural" ones are attributed to bad spirits or punishment by God. Families may "lift their feet" (*Leve pye nou*: to see a Hougan or voodoo priest) to determine the unnatural cause. Haitian Americans often combine therapeutic foods that are considered cold in nature, natural sedatives and purgatives from herbal medicine, religious treatments, and Western medicine. Immigrants often lack support of extended families in an environment not supportive of their interpretation of child behaviors and traditionally accepted parental disciplinary style. Stigma, language, cultural conceptions, concerns about governmental agencies, and physician bias can all be barriers to care for immigrant families. Primary care and behavioral integration are useful in managing families from other cultures. *(Prim Care Companion J Clin Psychiatry 2005;7:190–197)*

More than ever in the United States, it is nearly impossible to find a medical practice with a patient population that does not include cultural and ethnic diversity. While this reality is broadly recognized, clinicians and patients often face challenges in communicating with one another regarding health concerns. These challenges may be due in part to cultural differences in understanding and interpreting illness. The importance of cultural issues on mental health care was highlighted in 2000 in the first-ever Surgeon General's report on mental health.[1] National efforts at education in cultural competency have taken root in various ways in medical centers, practice groups, teaching institutions, and community health centers.

Attention-deficit/hyperactivity disorder (ADHD) is one of the most commonly diagnosed chronic mental conditions of childhood. ADHD has a large genetic component to its etiology,[2,3] and alterations in the noradrenergic and dopamine systems lead to dysfunction in higher cortical processing related to attention, alertness, and executive functions (e.g., planning, working memory, abstract reasoning, mental flexibility).[4]

ADHD has been reported in all continents of the world. Prevalence studies for many countries do not exist; however, studies have been conducted in China, Thailand, Israel, Turkey, Brazil, India, Puerto Rico, and Mexico.[5] Although the signs and symptoms of ADHD are basically the same in these diverse countries,

they each represent a different ethno-socio-cultural context in which the condition is interpreted and responded to by patients, their families, caring professionals, and others.[6] Several recent studies demonstrate that in 40% to 70% of children, ADHD persists into adulthood.[7,8]

Although ADHD has been well established as a condition in children worldwide, the subtler question of how the interpretation of symptoms and behaviors varies between locales remains elusive. Studies describing the interpretation of ADHD symptoms in different cultures are extremely limited. African American parents have been shown to be more unsure of the potential causes and treatments of ADHD and less likely to connect the school system to ADHD issues than white parents.[9] In another school-based study, white children with ADHD were twice as likely as African American children to receive evaluation, diagnosis, and treatment, and the threshold of parental recognition and seeking of services contributed to this discrepancy.[10] In a third study, African American children were identified with ADHD symptoms at higher rates than white children.[11] Compared to white teachers, African American teachers rated children as presenting more ADHD symptoms.[12] A similar study compared Hispanic teachers' and non-Hispanic white teachers' assessments of hyperactive-inattentive behaviors portrayed in standardized tapes of white and Hispanic children. Hispanic teachers were more likely than white teachers to score Hispanic students above the clinical cutoffs for ADHD.[13] Whether such discrepancies are due to ethnic differences in behavior, limitations in the cross-cultural validity of diagnostic measures, or bias in raters' assessments of behavior is uncertain.

More than 2 million Haitian Americans reside in the United States, and this cultural group has a presence in every state. The following case study of a young Haitian American illustrates the cultural issues that can influence the care of a person with ADHD and the difficulties that can result from culturally based disagreement or inadequate communication between medical professionals, educators, social service personnel, and families.

CASE PRESENTATION: MR. A

Mr. A is a 25-year-old man with a history of ADHD. He was an overactive child from early infancy, and his parents initially attributed his exuberant behavior to the natural tendencies of his sex. Mr. A's parents tried their best to keep his behavior under control by corralling him in his crib, verbally disciplining him, and occasionally spanking him.

From when Mr. A was 3 years of age, his parents became increasingly aware of his hyperactivity, impulsivity, and inability to follow directions. Throughout his preschool years, he was repeatedly suspended from school and was forced to move from one school to the next. In his community, he developed a reputation for being *mal élevé*—a French term for "badly reared," which in turn reflected negatively on his parents within their extended family and community. At age 5, Mr. A was diagnosed by a specialist as having ADHD. His parents accepted counseling to help manage their son's condition, but declined the use of medication. Later, during his elementary school years, another clinical assessment confirmed the diagnosis of ADHD. This time, Mr. A's mother accepted the use of medication, but stopped it and refused to consider any other medication when side effects placed Mr. A into a "zombie-like" state that included sluggishness, difficulty sleeping, and loss of appetite.

When Mr. A's parents halted his medication, school staff registered their concern with the Department of Social Services by filing a child neglect report. Mr. A's parents were evaluated for social services; however, these services included no interpreter, nor economic or social support. His parents were placed on the defensive all the time and began to feel threatened, stating that "the focus was no longer on [Mr. A's] condition, but on our parental abilities." As a result, to attend to Mr. A and coordinate his care, his mother stopped working outside the home.

Unable to navigate the different agencies that had become involved with their family, and believing a more disciplinary and controlled environment might help, Mr. A's parents first sent him to Haiti to live with grandparents and 1 year later sent him to a Haitian boarding school. Neither environment had an effect on his behavior. Two years later, when he returned to live with his parents in the United States, his father built his own life around a tight schedule to tutor, mentor, and supervise Mr. A's school activities. Mr. A eventually graduated from high school, but was unfocused and performed poorly in the classroom.

After graduation, Mr. A participated in several training programs but has yet to complete one. He continues to be hyperactive and unfocused. At work, he is known as a "good guy" who regularly jumps to defend coworkers, a behavior that often costs him his own employment. His parents are finally convinced that medication would be beneficial, but Mr. A refuses to take medications and denies his disorder.

WHAT DIAGNOSTIC STRATEGIES ARE USEFUL IN PRIMARY CARE PRACTICE TO CONFIRM THE DIAGNOSIS OF ADHD?

Table 1 lists the DSM-IV criteria for the 3 subtypes of ADHD. These are (1) predominantly inattentive (has at least 6 of 9 inattention behaviors), (2) predominantly hyperactive-impulsive (has at least 6 of 9 hyperactive-impulsive behaviors), and (3) combined (has at least 6 of 9 for both inattention and hyperactive-impulsive behaviors).

Table 1. DSM-IV Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder[a]

Six or more symptoms from the specified category (or categories) listed below must have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

314.01 Attention-deficit/hyperactivity disorder, combined type: categories A1 and A2
314.00 Attention-deficit/hyperactivity disorder, predominately inattentive type: category A1
314.01 Attention-deficit/hyperactivity disorder, predominately hyperactive-impulsive type: category A2
314.9 Attention-deficit/hyperactivity disorder not otherwise specified: prominent symptoms of inattention or hyperactivity-impulsivity that do not meet criteria for attention-deficit/hyperactivity disorder

A1: Inattention
- Often
  - Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
  - Has difficulty sustaining attention in tasks or play activities
  - Does not seem to listen when spoken to directly
  - Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
  - Has difficulty organizing tasks and activities
  - Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
  - Loses things necessary for tasks or activities (eg, toys, school assignments, pencils, books, or tools)
  - Is easily distracted by extraneous stimuli
  - Is forgetful in daily activities

A2: Hyperactivity-Impulsivity
- Hyperactivity
  - Often
    - Fidgets with hands or feet or squirms in seat
    - Leaves seat in classroom or in other situations in which remaining seated is expected
    - Runs about or climbs excessively in situations in which is inappropriate (in adolescents or adults, may be linked to subjective feelings of restlessness)
    - Has difficulty playing or engaging in leisure activities quietly
    - Is "on the go" or often acts as if "driven by a motor"
    - Talks excessively
- Impulsivity
  - Often
    - Blurts out answers before questions have been completed
    - Has difficulty awaiting turn
    - Interrupts or intrudes on others (eg, butts into conversations or games)

Additional required criteria
- B. Some hyperactive-impulsive or inattentive symptoms that cause impairment were present before 7 years of age
- C. Impairment in 2 or more settings (eg, at school, work, or home)
- D. Clinically significant impairment in social, academic, or occupational functioning
- E. Symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder (eg, mood disorder, anxiety disorder, dissociative disorder, or a personality disorder)

[a]Modified with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition.[48]

Due to their ability to function with ADHD during adolescence, children with the inattentive subtype of ADHD tend to be the easiest group to manage and are the least likely to have recurring problems; however, they often are the hardest to diagnose. Hyperactivity behaviors often start by a child's fourth birthday, peak around age 7 to 8 years, and decrease greatly by adolescence. Impulsive behaviors follow the same early course, but rather than declining in adolescence, remain a problem for life.[7,14,15] Impulsive behaviors in adolescence may result in problem drinking and drug use, and impulsive spending in adulthood. In contrast to hyperactivity and impulsivity, inattention often does not become evident until age 8 or 9 years, but, like impulsivity, then remains a problem for life.

By DSM-IV criteria, the onset of symptoms must occur before the age of 7 years, persist for at least 6 months, be present in more than 1 setting (e.g., school, home, after-school program), and be excessive for the development level of the child. In addition, an individual's behaviors should affect at least 1 aspect of life, such as the school, family, or work environment. As with Mr. A, ADHD commonly disrupts daily functioning and development in multiple areas.

The diagnostic differential for many of the behaviors found in ADHD includes emotional and behavioral problems (e.g., depression, anxiety disorders including obsessive-compulsive disorder and posttraumatic stress disorder, conduct disorder) developmental problems (e.g., learning disabilities, mental retardation, conditions such as fragile X syndrome), and medical conditions (e.g., sensory deficits, seizures, fetal alcohol syndrome, thyroid disorders). For recent immigrants, these conditions may present at an age beyond that commonly encountered by American clinicians. Environmental concerns and experi-

ences can also lead to behaviors mimicking ADHD and can be particularly difficult to define in recent immigrants.[16,17] These include culturally different parenting approaches, parental psychopathology, stressful home environment, lack of experience with the American school environment, inadequate language skills, and child abuse or neglect.[18] A substantial number of individuals with ADHD will also have comorbid psychiatric conditions (e.g., depression, oppositional defiant disorder, learning disabilities).

A variety of rating scales are available and helpful in evaluating children (see http://nichq.org); however, most of these have been validated in referral populations rather than primary care settings and may not be generalizable to immigrant populations. These scales include ones for use by clinicians, parents, and teachers. Also, collecting information from other settings (e.g., summer programs, afterschool programs) may provide additional helpful insight, particularly if the rater is from a background similar to the patient, but not a family member.

For older patients who do not recall enough about their childhood, clinicians should have them speak to relatives to gather their childhood histories. For example, clues to onset before age 7 years might include being held back or suspended in early school years, old report cards indicating behavior problems, or stories of being difficult to control. Scales for adults (e.g., the Wender Utah Rating Scale,[19] also available in French[20]; the Copeland Symptom Checklist for Attention Deficit Disorders[21]; the Conners Adult ADHD Rating Scale[22]) can be useful, but yield large numbers of false positives and cannot be relied on for diagnosis without supportive evidence from clinical assessment.[23]

TREATMENT

Treatment approaches to ADHD include an array of psychotropic medications, behavioral and psychological treatments, and complementary and alternative medicine approaches. Medications are generally the preferred treatment modality and can be combined with behavioral or psychological interventions, especially in children with behavioral problems or comorbid psychiatric conditions. Stimulant medications and psychosocial treatment have been the major foci of clinical research; however, the duration of most randomized trials has been 3 months or less, and thus the literature on long-term treatment is sparse. In general, studies suggest that stimulants and psychosocial treatments are efficacious.[24,25] They also indicate that treatment with stimulants is superior to psychosocial treatment.[26]

Short-term trials of stimulants support their efficacy, with response rates in the 70%-to-90% range.[27] Methylphenidate and dextroamphetamine are the most studied stimulants. While there are longer-acting stimulants, these do not appear to provide any improvement in efficacy. Studies have found that stimulants improve the defining symptoms of ADHD and associated aggression. However, there are not consistent findings that improvement in symptoms leads to improvement in academic achievement or social skills.[28,29]

Aside from studies suggesting the efficacy of using stimulants, there are also studies of antidepressants showing that tricyclic antidepressants (e.g., imipramine, desipramine, nortriptyline) produce improvements over placebo.[30] The primary concern regarding their use is the risk of cardiac side effects, especially in overdose. Atomoxetine also has proven efficacy for ADHD[31,32]; it is the only medication approved by the U.S. Food and Drug Administration for use in adult ADHD, is not a controlled medication, and might be particularly useful when possible comorbid substance abuse is a concern.[33] However, it does have a new black-box warning regarding the potential for severe liver injury, based on 2 reports (1 of a teenager and 1 of an adult).

Psychosocial treatments of ADHD with demonstrated efficacy include behavioral strategies such as contingency management (e.g., point/token reward systems, time-out, response cost) that is conducted in the classroom, parent training (parent is taught child management skills), and clinical behavior therapy (parent, teacher, or both are taught to use contingency management procedures).[34] In contrast, cognitive-behavioral treatment (e.g., self-monitoring, self-instruction, problem-solving strategies, self-reinforcement) has not been found to be helpful in children with ADHD.[35,36]

Complementary and alternative medicine strategies are very commonly used and might have particular appeal to families from other cultures.[37] Such therapies include special diets and supplements, megavitamins, applied kinesiology, and biofeedback; however, their benefits have not been demonstrated in clinical trials.[38] Diet, including reducing sugar, affects behavior in less than 1% of children.[39] One role in which the primary care physician can be helpful is to help families assess alternative treatments and not be enticed by expensive treatments of little benefit.

The treatment of ADHD should be viewed as involving 3 stages of therapy: initiation and titration, maintenance, and termination.[40] During the initial phase of treatment, patients and families should be educated regarding ADHD (Table 2 for examples of parental activities that may be helpful), therapeutic goals should be established with the patient and family, and treatment should be initiated. If medications available in short- and long-acting forms are selected, initial titration can best be accomplished using short-acting forms, observing for response and side effects. This can be followed by switching to longer-acting forms if desired. Starting and adjusting

Table 2. Parent Activities That Can Help Modify the Behavior of a Child Who Has Attention-Deficit/Hyperactivity Disorder (ADHD)[a]

Maintaining a daily schedule
Keeping distractions to a minimum
Providing specific and logical places for the child to keep his or her schoolwork, toys, and clothes
Setting small reachable goals
Rewarding positive behavior
Using charts and checklists to help the child stay "on task"
Limiting choices
Finding activities in which the child can be successful (eg, hobbies, sports)
Using calm discipline (eg, time out, distraction, removing the child from the situation)
(Additional tips for parents are in the National Initiative for Children's Healthcare Quality ADHD Toolkit [www.nichq.org].)

[a]Based on *Understanding ADHD: Information for Parents About Attention-Deficit/Hyperactivity Disorder*.[49]

Table 3. Five Barriers to Care for Haitian Immigrants With Attention-Deficit/Hyperactivity Disorder (ADHD)

1. Stigma of ADHD in the community
Poor behavior in children in Haitian communities is sometimes seen as a sign of poor discipline by parents or as a sign that a child is cursed by an unnatural spirit
2. Language and semantics
Not being able to speak English is a hindrance when conversing with a physician. Even when a physician explains an illness or treatment from a careful and basic view, some words in English have a different connotation in the Creole language
3. Cultural conceptions of biomedicine
In Haiti, patients generally see doctors for severe illness or emergency care and do not consider medical care as a resource in managing ADHD behaviors. Immigrants may attribute their illness to natural forces (eg, wind change, temperature) or possibly a punishment or malediction from God[a]
4. Negative interactions with government agencies (eg, Department of Social Services, school system, or immigrations services)
The physical punishment that is often used to discipline children is sometimes considered child abuse by North American standards. Fear of having their children taken away from them because of their methods of discipline can cause parents to withdraw or not follow through on health care appointments if such abuses are evident[a]
5. Physician and teacher bias
A child who appears restless and does not sit still may appear to be abnormal if the culture of the evaluator equates normalcy with sitting still. It is essential that a provider acknowledge his or her own cultural bias or beliefs when evaluating and treating a child with ADHD

[a]Based on *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*.[1]

medications on a weekend provides opportunity for parents to observe effects and side effects directly.

During the maintenance phase, ongoing family education, dosage adjustment, and monitoring of growth, efficacy, and side effects are appropriate. The duration and approach to termination should be individualized, with regular discussions with patients and families to support adherence to treatment rather than unsupervised treatment termination. Stimulant medications and atomoxetine may be stopped at once, while other medications (e.g., tricyclic antidepressants) may need to be tapered. Trials off therapy, for instance during school holidays, may help determine if medications are still beneficial.

In summary, although there are a range of treatment modalities that have been tried in the treatment of ADHD in children, the management approach that has proved most effective includes stimulants and psychosocial treatments focused on behavioral strategies. Of note, in one large study funded by the National Institute of Mental Health, there was no difference in response to treatment between ethnic groups (Latino, African American, and white).[41]

ADHD AND ITS CARE FROM A HAITIAN PERSPECTIVE

While there is no corresponding term for ADHD in the Haitian-Creole language, in the Haitian culture the behaviors consistent with the diagnosis of ADHD might be interpreted as indicating the following:

- A "poorly raised child," whose behavior could easily be modified through parental discipline. This can be stigmatizing within the Haitian community and places parents on the defensive. Mr. A's parents suffered from the reputation of having a *mal élevé* child.
- An "intentionally bad child" who embarrasses his or her parents. Children with ADHD are often compared to "good kids" who are held up to them as examples to follow. This can be a severe insult to both the child's and parents' self-esteem and their sense of self-efficacy.
- A "psychically victimized child," or one suffering from an "unnatural" condition, a curse from a superior force. A religiously influenced family might believe a child is being punished for sins and direct attempts to intervene accordingly.

Among Haitians, the interpretation of ADHD-related behaviors varies widely from family to family depending on religious affiliations, level of education, and experience with school and primary care systems. Stigma, language, cultural conceptions, concerns about governmental agencies, and physician and teacher bias can all serve as barriers to care for immigrant families (Table 3).

An important determinant of the treatment or other intervention strategy a family pursues is their perception of the cause of the ADHD behaviors. Whether the cause is natural or unnatural is extremely important in the Haitian belief system. "Natural" ailments are often attributed to natural forces (heat/cold, gas, wind, temperature), while "unnatural" ailments are attributed to bad spirits or pun-

ishment inflicted by God. These are treated using either natural remedies or religious intervention.[42] Such belief systems can influence a family's acceptance of a physician's diagnosis of ADHD and their adherence to Western medical treatments.

In the United States, as in many other countries, the diagnosis of ADHD is mainly a medical one and involves pediatric and family medicine providers, social workers, and psychologists. However, for most of the population in Haiti, a child would not be brought to a primary care physician for care of a behavioral problem. Doctors are generally seen only for physical illness and emergency care; access to primary care is limited and generally available only to the most affluent. ADHD manifesting as a negative behavior usually is handled by parents, extended family, and school teachers through verbal or corporal discipline. Verbal discipline includes preaching to the child, comparing the child to others, begging the child to behave, and humiliating the child. Corporal discipline and punishment can be inflicted by any member of the family, neighbors, and schoolteachers, all of whom are given full authority to educate and "correct" the child.

Immigration adds a complex dimension to raising children. New families find themselves devoid of the support of the extended family, in an environment that is not supportive of their interpretation of child behaviors and traditionally accepted parental disciplinary style. Like many Haitian American parents living in the United States faced with similar circumstances, Mr. A's parents chose to send him back to Haiti with the hope that a more authoritative parenting style, the enforcement of discipline in school (schoolteachers are very respected), and removal of the interference of the American social worker would offer a better environment for rearing their child. Mr. A went to live with his grandmother first and then off to a boarding school, a setting seen by many Haitian parents as the ultimate answer to a child with behavioral problems.

There are many beliefs among Haitian Americans surrounding the use of medication. Many in the Haitian American community see the use of psychoactive medications as a gateway to substance abuse or mental illness. Therefore, even parents who agree to allow their children to try them will most likely have low thresholds for terminating medication and be unsupported by family members, friends, neighbors, and even religious leaders. Mr. A's parents received much unsolicited advice, and some friends wanted them to "lift their feet" (*Leve pye nou*: to see a Hougan or voodoo priest) who might be able to determine the unnatural but real cause of their son's problem.

Being transnational and having access to both native Haitian medicine and Western medicine, Haitian Americans routinely combine therapeutic foods that are considered cold in nature, natural sedatives and purgatives from traditional herbal medicine, religious treatments, and Western medicine to treat illness. Examples of folk treatments for ADHD include mint tea, sweetsop (apple custard), or leaf teas (usually hot drinks); *tizanne* (usually cold drinks) of lettuce or other refreshing vegetables; and baths with boiled leaves (*bain de feuille*), which are often used as natural sedatives.

While it may be difficult to establish trust with Haitian families initially, such trust in the doctor-patient relationship is essential in obtaining their participation in the development of a treatment plan to which they will adhere. Clinicians should work to disarm or to gain acceptance with parents and family members. It may be helpful to learn a few words of Creole or tidbits of Haitian history, to be respectful of combining benign natural remedies with conventional Western medicine, and to find ways to show respect for the family's heritage. Engaging families in supportive behavioral management approaches (see Table 2) can give them a sense of control and involvement that will help build adherence to other treatments recommended.

Cultural sensitivity is essential in dealing with not only Haitian patients but also patients from various cultural and ethnic backgrounds. One definition of cultural competency is "a set of congruent attitudes, behaviors, and policies that come together in a system, agency, or amongst professionals and enables them to work effectively in cross-cultural situations."[43] Haitians, like most immigrant patients, need sympathetic advice and help from their physicians, as they often feel governmental agencies such as the local department of social services place a great deal of pressure on them to either medicate their children or move their children to other school systems.

In direct contrast, it is also important not to "overemphasize" a patient's culture when considering a diagnosis and treatment. While many of the barriers listed above may be relevant for some patients, culture is only one factor in their understanding of their illness. Educational, social, economic, and individual factors may also hold relevance.

Because the interface of psychiatric disorders—in this case ADHD—and culture is complex, it is a useful context for examining the integration of psychiatric and primary care. While there are a number of models of such primary care and behavioral integration, one, called "primary mental health care,"[44–47] is particularly useful in managing families from other cultures. The goal of this approach is to resolve problems within the primary care service context: "primary mental health" is designed to support the ongoing behavioral health interventions of the primary care provider. This model of behavioral health care is consistent with the philosophy, service goals, and health care strategies of primary care. This approach in-

volves making psychiatric consultative services available to primary care providers and allows for behavioral health and primary care comanagement of patients who require more concentrated services, but nevertheless can be managed in primary care. Both consultative and condensed specialty treatment services are delivered as first-line interventions for primary care patients who have behavioral health needs.

CONCLUSION

In summary, there are several options for assisting Mr. A and his family and other Haitian children and adults with ADHD:

1. Gain insight into the patient's and family's perception of the problem, its cause, and impact on behavior and function. This often is the starting point for patient education and coming to a shared understanding of the diagnosis and potential interventions.
2. Develop treatment plans using the family's experiences with helpful and unhelpful strategies as the starting ground. For example, it may be useful to ask the family, "Who (or what agencies) have you found helpful in working with Mr. A? Why?" If the family is unable to name anyone, it may be necessary to broaden the question to "What do you feel you need most in order for Mr. A's functioning to improve?" With this feedback from the patient and parents, it may be possible to revise strategies that have been unhelpful or alienating in the past. Setting appropriate short- and long-term goals for Mr. A is essential to monitor his progress with treatment and behavior.
3. Support a team-oriented, collaborative approach that incorporates expertise from family and community members, mental health professionals, educators, and other disciplines if necessary, yet anchors the patient's care in a primary care context. In Mr. A's case, there were clearly gaps in communication between the family, school, medical professionals, and social service system, as each worked independently to solve the same problem. Department of Social Services involvement and the attitude of its workers can send a message to the parents that they may be investigated or punished rather than helped. A team-oriented approach might mitigate some of the resultant stress and negative perceptions. The primary care physician often needs to serve as the family's advocate in coordinating and mobilizing others involved.
4. Identify a cultural consultant and/or case manager. This ideally is someone known and respected by the family. Mr. A and his parents might have benefited from close contact with a skilled case manager, who ideally could have served as a "cultural broker," facilitating access to proper management for Mr. A's condition.
5. Offer and encourage biomedical and psychosocial treatments that have been demonstrated to be effective, and invest time in directly discussing concerns and barriers that families have in accepting these treatments. Explicitly state a willingness to be flexible in supporting traditional cultural treatments as part of the care plan. If Mr. A and his family had felt that their concerns and beliefs were more deeply understood, they might have been more trusting and more willing to try different treatments.
6. Follow through. Maintaining long-term contact and interest in the family and their problems and providing consistent and dependable follow-up are critical to families' developing trust and accepting interventions. It may be necessary to persist for some time in the face of lack of adherence to recommendations before the patient and family gain the confidence required to try new interventions if they have had previous negative experiences with "caring professionals."

Drug names: atomoxetine (Strattera), desipramine (Norpramin and others), dextroamphetamine (Dexedrine, Dextrostat, and others), imipramine (Tofranil and others), methylphenidate (Metadate, Ritalin, and others), nortriptyline (Pamelor, Aventyl, and others).

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