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Family-Based Intervention for Chinese Families of Children with Attention Deficit Hyperactivity Disorder (ADHD) in Hong Kong, China

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This paper reviews the clinical utility of family-based treatment, comprised of multiple family therapy (MFT) and structural family therapy (SFT), in helping Hong Kong Chinese families of children with attention deficit hyperactivity disorder. The author identifies the psychosocial service needs of these families and examines the contributions of the adapted MFT and SFT in responding to the psychosocial service needs of these families. Critical issues for clinical practice and research are discussed.

Keywords: Family-based intervention, Chinese families, children, attention deficit hyperactivity disorder, Hong Kong

Key Points

1. Family-based treatment (FBT), which integrates multiple family therapy and structural family therapy, has been adapted in helping Chinese families of children with attention deficit hyperactivity disorder (ADHD).
2. Empirical and anecdotal evidence supports the clinical utility of FBT in helping these families.
3. A strengths perspective should be emphasised in assessment and intervention.
4. Engagement of fathers is critical in helping families of children with ADHD.
5. Family therapists are in the best position to offer FBT for families of children with ADHD.

Attention deficit hyperactivity disorder (ADHD), a common neurodevelopmental disorder affecting about 5% of school-age children, is characterised by inattention, hyperactivity, and impulsivity, which is contextually based and developmentally inappropriate (APA, 2013). These symptoms are believed to be closely related to impaired executive functioning of the brain, which affects attention, organisational skills, priority-setting, planning, and implementation of tasks (Thorell, Veleiro, Siu, & Mohammadi, 2013). The prevalence rate of ADHD in children is estimated to be about 6% in Hong Kong (Leung et al., 1996) and 5.8% in mainland China (Shen, Wang, & Yang, 1985). Worldwide, boys are about twice as likely as girls to be affected by the disorder (APA, 2013). Pervasive and chronic in nature, the disorder has serious consequences for the lives of children and their families. If left unidentified and not properly treated, the negative effects of the disorder, such as underachievement, poor self-esteem, peer rejection, and social isolation, can linger into adulthood (Chronis, Jone, & Raggi, 2006).

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In Hong Kong treatment of children with ADHD is in line with international protocol, that is, multimodal treatment (MTA) which comprises stimulant medication and behavioural therapy, with demonstrated treatment efficacy to increase children's attention span and improve their interpersonal relationships (So, Leung, & Hung, 2008). However, children with stimulant medication suffer from short-term side-effects such as nausea, insomnia, and poor appetite. In addition, one-third of children with ADHD are non-responsive to medication (Chan, Hung, Lee, & Wong, 2010), not to mention the limited effects of medication on children's underachievement, relational difficulties, and diminished sense of competence (Chronis et al., 2006).

Despite the compelling empirical evidence for MTA, it does not address multiple stresses faced by parents in caring for children with ADHD. Research evidence on familial factors (e.g., parental ADHD, harsh parenting, and maltreatment in parent–child relationships) and their links to the well-being of children with ADHD (Richards, 2012) has illuminated the importance of family-based treatment (FBT). FBT is defined 'as any modality involving parents as essential participants in treatment' (Diamond & Josephson, 2005, p. 874). FBT views children's development as inseparable from multiple social contexts (e.g., family, school, community) (Bronfenbrenner, 1993). Children with ADHD cannot be helped if their parents are left alone to deal with the struggles and challenges of child-rearing. Active parental engagement and collaboration in helping may enhance the quality of care for these children (Lee et al., 2009).

Among the different FBT approaches (e.g., behavioural management training, problem-solving), multiple family therapy (MFT) has been employed in helping Canadian children with ADHD (Scapillato, 2003) and Hong Kong Chinese children with ADHD (Ma, Lai, & Xia, 2018). Structural family therapy (SFT) has been used to modify maladaptive interactional patterns between adolescents with ADHD and their parents in Western societies (Barkley et al., 2001). However, knowledge is lacking on how MFT and SFT can be integrated to help Chinese families of children with ADHD in Hong Kong.

To fill this knowledge gap, this paper identifies the psychosocial service needs of Hong Kong Chinese families of children with ADHD and critically examines the integration of MFT and SFT in helping this clientele.

Literature Review

Impacts of ADHD on children and families

ADHD unfavourably affects children's learning, sense of competence, psychological well-being and interpersonal relationships. Parent–child relationships when the child has ADHD are characterised by frequent conflicts and hostility (Johnston & Mash, 2001). About 20% of the children in a Hong Kong clinical sample were victims of child abuse (Ma, Lai, & Wan, 2015). They have a greater chance of being bullied at school and may feel increasingly socially rejected by peers (Cardoos & Hinshaw, 2011). Teachers may be unable to render timely help and assistance due to their lack of familiarity with the disorder.

Parents experience high parenting stress in raising children with ADHD (Chan et al., 2010), and among Chinese parents, mothers' stress was higher than fathers'.

Fathers' perception of children's symptoms has been found to be less serious and less pathological than mothers', with paternal competence higher than maternal competence (Ma & Lai, 2016). Two reasons may account for these differences: (a) the gendered division of labour between men and women in Chinese societies, with men expected to assume the role of breadwinner, whilst women take care of children and household chores (Ma & Lai, 2014); and (b) the disparity in how men and women view children's behaviours (Singh, 2003). Ma and Lai's (2016) study supports the contributions of cultural and gender perspectives in conceptualising parental experiences of children with ADHD.

Parental mental disorders (e.g., parental ADHD and maternal depression) have been found to be negatively linked to the well-being of children with ADHD (Mokrova, O'Brien, Calkins, & Keane, 2010). Irrespective of a parent's gender, parental ADHD is significantly related to harsh parenting as well as home disorganisation and chaos, which inevitably provides a less favourable context for children's growth and development. The effect of parental disorders on children's ADHD can be negative and positive. On one hand, the developmental challenges of raising a child with ADHD may worsen parental psychological well-being and may have negative spillover effects on the couple's marital relationship. On the other hand, parents with ADHD may be more sympathetic toward the child's developmental difficulties since they are struggling with their own difficulties.

With the gendered division of labour in Chinese families, that is, the man as breadwinner and the woman as virtuous wife and good mother (賢妻良母) (Ma & Lai, 2016), the mother has to spend a tremendous amount of time and effort on homework supervision. Very little time is left for family activities (Siu & Lo, 2020).

From the perspective of children with ADHD, the parent–child relationship is generally good. The mother–child relationship tends to be closer than the father–child relationship (Ma, Lai, & Lo, 2016). The father–child relationship is shown to have significant effects on older children's cognitive and physical competence whilst the mother–child relationship is significantly correlated with younger children's general self-worth (Ma et al., 2016). Notably, children with ADHD perceived paternal support as lowest when compared to that received from mothers, teachers, and friends (Ma, Lai, & Xia, 2020).

Parents of children with ADHD often experience social isolation and discrimination (Ma & Lai, 2014). Under the dominant social discourse that the failure of a child is the result of bad parenting, parents of children with ADHD often feel blamed by their relatives, friends, teachers, and mental health professionals. Parents may withdraw from social activities to avoid being stigmatised. This social isolation may increase their sense of hopelessness and helplessness, which in turn may have negative effects on child care. Some children with ADHD may be gifted rather than learning-disabled, but parents may overlook these children's athletic, artistic, and musical talents. (Leroux & Levitt-Perlman, 1998). Their distractibility may be mistaken as misbehaviour when in fact it indicates a lack of interest toward subjects or tasks that are repetitive, unstimulating, and unchallenging.

In view of the inadequacies of MTA, the author and her research team launched a cross-disciplinary clinical research on MFT, adapting a culturally resonant MFT model to the service needs of Chinese families of children with ADHD and assessing the treatment efficacy of MFT for these families.

Multiple family therapy

MFT is defined as 'a therapeutic method that brings together several families affected by the same pathology' (Gelin, Cook-Darzens, & Hendric, 2018, p. 2). MFT is a blending of family therapy and group therapy (Asen & Scholz, 2010). It is more cost-effective than single-family therapy and is in line with the underpinning philosophy and therapeutic belief of family therapists: that families and children with ADHD are resourceful and competent.

The mechanism of change in MFT is at multiple levels: individual, intra-family, interfamily, and group (Asen & Scholz, 2010). The power of MFT lies in the structure of the group. As parents, children with ADHD, and their siblings participate together in group activities, they may experience something unusual for them: relaxing, joyful, and quality family time. The simultaneous participation of five or six families in MFT may generate therapeutic factors (e.g., solidarity, multiple perspectives, hope, mutual help, and mutual support), which are conducive to families' development of personal agency, problem-solving skills, and informal supportive networks that help overcome difficulties in child-rearing. Once these families are connected, their sense of social isolation and stigmatisation may be lifted. They may feel empowered and become hopeful (Asen, Dawson, & McHugh, 2010).

MFT and Families of Children with ADHD: Experiences in a Chinese Context

Our research team launched a clinical research project with three objectives: (a) to respond to the psychosocial service needs of families of children with ADHD; (b) to generate practical knowledge on MFT for Hong Kong mental health professionals, including family therapists; and (c) to assess the treatment efficacy of MFT in helping families of children with ADHD. Four groups (n = 21 families) were included in the first phase of the study, which aimed to develop a culturally adapted and socially relevant model of MFT for Hong Kong Chinese families of children with ADHD. Nine groups (n = 61 participants in the experimental group; n = 53 in the control group) were organised in the second phase of the study to assess the treatment efficacy of the adapted model.

The MFT program

The 42 hours of the MFT program comprised a psychoeducational talk (four hours), a four-day programme (32 hours) held over two consecutive or alternate weekends, and two half-day reunions (six hours) on campus (Ma, Lai & Wan, 2017). We held these groups on weekends to make it more likely that fathers would be able to join.

These families were recruited through multiple channels: leaflet distribution, website announcements, and organisation of talks for community-based mental health professionals and for parents of children with ADHD. Graduates of past MFT groups were invited to share their positive experiences in the psychoeducational talk, and this experiential sharing turned out to be effective in recruiting parents for this round of MFT. Inclusion criteria were as follows: (1) parents with school-age children diagnosed with ADHD by psychiatrists or doctors according to DSM-5 (APA, 2013); (2) parents who could understand Cantonese, the dialect commonly spoken in Hong Kong; and (3) parents and children committed to joining the full MFT program.

Each participating family was interviewed at the pre-treatment phase to assess motivation, degree of commitment, and suitability for MFT.

The design and development of the MFT activities were based on parental feedback gathered from focus-group interviews prior to the implementation of the project (Ma & Lai, 2014) and on continued assessment of the families' service needs. A weekly planning meeting was held to review and discuss whether the MFT activities adhered to the treatment principles: (1) cultivating a secure and supportive safe haven for participating families to interact; (2) fostering intra-familial and interfamilial cooperation, interaction, and dialogue; (3) creating contexts for intergenerational conversation and collaboration; and (4) encouraging mutual support and mutual help among the families.

Adapted MFT activities for children with ADHD

We incorporated mindfulness exercises in the MFT program. Originating in India, mindfulness training is a form of meditation used by Buddhists in ancient China that gradually became a cultural asset in Chinese societies. The therapeutic value of mindfulness training for children with ADHD has been shown anecdotally in the United States (Van der Oord, Bogels, & Peijnenburg, 2012), specifically in emotional regulation and increased attention span. Our program's mindfulness exercises consisted of breathing, stretching, and movements that could be practiced individually or jointly (by a parent and a child) in the confines of a Hong Kong flat (Ma et al., 2017).

The morning session of the group began with ice-breaking games, a tea break, and an intra-familial or inter-family activity (e.g., family story, treasure hunt). Parents and children were expected to prepare their lunch together, except on the first day. In the afternoon, depending on the group dynamics and the families' needs, the participants were divided into two parallel groups, one for children and the other for parents. At the end of the day, families were reunited for an activity to round out the day.

Two group leaders who had training in family therapy and group psychotherapy ran the MFT, assisted by five volunteers, who were our social work students, either undergraduates or in the master's program. One of our clinical team members gave a one-day training session to inform them of the needs of families of children with ADHD and their roles and functions in assisting the group leaders.

The group process: Vignette

The selected vignette illustrates the artful use of a crossover role reversal to enable the participants to gain a new perspective on their day-to-day parent–child conflict and brainstorm alternative solutions for their difficulties.

Six families (six mothers and five fathers) were present for the group activity of role reversal in the morning session of day four. All the children with ADHD were boys, whose ages ranged from eight to 10 years. Each family was asked to take turns and enact a typical family situation at home, in which the family members decided to reverse their roles. Tommy (11/M) was the first child to enact a family meal. Tommy was playing the role of 'his mother' while his mother, Mrs C, acted as 'her son.' Tommy, 'the mother,' ordered 'her son' (the mother) to take his legs off the table while eating. Suddenly, Tommy 'the mother' slapped her son. The group leader invited Mrs C to sit on Tommy's chair and asked if similar conflicts had occurred at home during mealtime and why she was so annoyed by the misbehaviour of her child. While Mrs C was sharing her discontent towards Tommy, all the other

children in the group started to move around. The group was in chaos; the children simply fled to avoid facing this unpleasant situation.

The group leader called for a brief parent brainstorming session to elicit help from parents of other families and allow time and space for children to calm down. Peter's (11/M) mother, Mrs W, asked her son to jointly enact a family situation. Mrs W started to act out as 'her son.' 'You go to hell!' Mrs W shouted at her son and pointed at his forehead. Peter fought back and pretended to slap on his mother's face. Mrs W then pushed her son away, but Peter pulled her back and started to bite her. This activity uncovered the violence happening in Peter's home. Other mothers and fathers in the group joined in to stop this violence. 'How could you do this to your mother?' 'Do you love your mother?' Parents of other families wanted to support Mrs W but in a way that placed challenging questions on Peter. The group leader was aware of the power imbalance between the parent and the child and stood behind the son to support him. She asked, 'Are there any alternative solutions to resolve your conflict with your mum?' 'No, I can't think of any,' said Peter hopelessly. The group leader turned to the group and invited other families to generate better ways for the son to express his discontent towards his mother. The parents suggested alternatives such as writing a letter or venting the anger towards a toy teddy. However, Peter refused to accept any advice given.

The group leader sensed Peter's powerlessness in the group and suggested other children sit next to Peter to support him. 'Did you try running?,' one of the mothers from another family asked. 'Yes, he used to run ceaselessly at home when he felt annoyed but he couldn't do so anymore after we received complaints from the security office,' said Mrs W. 'That guy kept saying foul language to me!,' said Peter. 'But you can control yourself in that situation!' The group leader asked, 'What made you better control yourself in the group but are less able to do so in front of your mother?' Tommy, a child of another family suddenly uttered, 'He hit his mother deliberately so as to provoke her.' Tommy's remark gave another perspective for the mother to understand the meaning behind Peter's emotional outburst – it was definitely not a symptom manifestation but a result of the mother–child interaction.

Results of the Study

The treatment efficacy of the adapted MFT model was assessed using a two-group pre- and post-comparison study design (Judd, Smith, & Kidder, 1991). Since the details of the study have been previously described elsewhere (Ma et al., 2018; Lai, Ma, & Xia, 2018), here we summarise the research outcomes: (a) parents in the experimental group (EG) who had gone through MFT reported a significant change in perception of children's symptoms from pre-treatment to post-treatment, that is, the parental view of the ADHD symptoms was less pathological and less serious, whereas parents in the control group (CG) who had merely attended psychoeducational talks did not experience a similar change (Ma et al., 2018); (b) MFT had a different impact on fathers and mothers, with fathers in both the EG and the CG reporting a significantly better father–son relationship at post-treatment than pre-treatment; in contrast, while the EG mothers' parental efficacy significantly increased from pre-treatment to post-treatment, no significant change was found in parental efficacy for the CG mothers (Lai et al., 2018); (c) the father's active involvement in treatment enhanced the father–child relationship irrespective of the type of treatment

provided (Lai et al., 2018); and (d) children with ADHD in both the EG and the CG reported no significant change in perceived competence, hope, and parent–child relationship from pre-treatment to post-treatment (Ma, Lai, Wan & Xia, 2019).

In a qualitative inquiry (Wan et al., 2018), which explored the subjective experiences of parents and children in MFT, fathers perceived observing parent–child interactions and parenting practices of other families as invaluable to their learning. Mothers in the same study said that feeling that others were in the same boat, that is, knowing that the problem was not unique to their own family, gave them the courage to share their parental stresses and challenges with other parents.

From the perspective of children with ADHD, the MFT was full of fun, enjoyment, and freedom. What they treasured most was the time with their parents in the group and the positive changes in their parents' attitude and parenting practices. The children said their parents had become more empathetic and accepting toward them, both in the group and at home (Ma et al., 2019).

Nevertheless, for a few of the neediest families, this MFT programme had insufficient time and space for in-depth resolution of critical issues (e.g., maltreatment in parent-child relationship) that surfaced in the group and warranted immediate follow-up. To address this, our team did offer additional family therapy for these families.

Structural Family Therapy

The author trained in SFT and is professionally competent to employ it in helping families of children with ADHD. Pioneered by Salvador Minuchin (1974), SFT values family members' ability to identify ways of dealing with their family challenges and difficulties after a therapist sets up a safe and secure therapeutic platform. The treatment goal is to assist the family in discovering and challenging family structures or patterns that have blocked their efforts at resolving difficulties. The therapist helps the family navigate the journey of healing through four steps: (1) opening up the presenting complaint; (2) highlighting problem-maintaining interactions; (3) exploring the past via a structural focus; and (4) exploring alternative ways of relating (Minuchin, Nichols, & Lee, 2007, p. 9).

Chinese families of children with ADHD usually view developmental challenges through an individual-oriented lens: a child with ADHD is the problem-bearer in the family; hence, they need to be changed. Mindful of this tendency, the therapist uses care, curiosity, and humility to invite the family to jointly explore the relationship patterns that may have contributed to and exacerbated their difficulties. In one family, a child with ADHD may have been triangulated into the couple's marital discord and may have become the scapegoat of the family. In another family, a child's symptoms may be a manifestation of multiple stresses experienced by the family such as unemployment, poor mental health, financial difficulties, and social discrimination.

If the therapist cannot initially see why the current relationship patterns are so rigid and difficult to change, the therapist can explore the past. For instance, when a therapist observes a repetitive relationship pattern between a fearful son (with ADHD) and a self-righteous father, they may explore the following: Did the father physically abuse his son in the past? If so, did the mother try to protect her son? Did the mother's rescue attempt(s) affect the spousal relationship? With a deeper understanding of the connection between the family's history and their present dynamics, the

therapist may introduce new options and possibilities for family members to relate to one another.

Case Illustration

The Ng[1] family came to receive family therapy from the university centre upon the advice of the author because of maltreatment in the parent–child relationship, as identified during the parents' sharing in the MFT. The family consisted of three members: Mr Ng, aged 40; Mrs Ng, aged 38; and Paul, aged nine, their son with ADHD. Mr Ng had had an unhappy childhood in Hong Kong. He spent several years in residential care after his mother's death and his father's abuse. After completing primary school, he worked in low-paid jobs as an unskilled worker. His wife, a migrant to Hong Kong, grew up in a rural area of Guangdong Province. She received her secondary school education in mainland China and had been working as an assistant in a nursery ever since she came to Hong Kong. In the eyes of his parents, Paul was impulsive, aggressive, and uncontrollable. He hit and kicked his father when his father swore at him, but Mr Ng seldom retaliated in return.

Throughout family treatment, Paul sat close to his mother but kept far away from his father. Mrs Ng took the lead in narrating their family difficulties while Mr Ng and Paul kept silent most of the time. Paul, however, actively took part in treatment. He uttered furiously in the first session: 'I like to change my surname … He (his father) is bad. I wish to have another man to replace him.' In response to Paul's painful moaning, Mr Ng sighed and gazed at the floor and Mrs Ng wept. Further exploration of the family's history revealed that Paul was angry with his father for treating his mother badly. Also, the family had serious financial problems – Mr Ng regularly gambled away his salary and was heavily in debt. Mrs Ng had to support the family as well as pay back her husband's debt.

The family had resilience. Mrs Ng was a Christian, and the tremendous support provided by the church helped her to cope with adversity. Under Mrs Ng's influence, Mr Ng had become a Christian a year before treatment. Christianity had powerfully transformed Mr Ng's life: he stopped pathological gambling and enthusiastically participated in church activities. However, the couple's marital distress and the parental maltreatment remained unresolved.

Paul was fiercely loyal and emotionally attached to his mother. Mrs Ng's frustration, disappointment, and anger toward her spouse had become Paul's rage, which was inappropriately expressed as physical violence toward his father. The therapist shared her problem formulation with the couple, a crucial step to engage them in improving their marital relationship. By so doing, Paul could be de-triangulated from the parents' marital conflict and start to learn a civilised and respectful way of relating to his father. Couple and family sessions were scheduled alternately to allow sufficient time and space for the couple to repair their marital relationship. Because of his past misdeeds, Mr Ng was playing the role of an 'underdog' in relating to his wife, whose suffering had paradoxically given her immense power in the relationship. The therapist utilised a repertoire of therapeutic skills – joining, focusing, enactment, and unbalancing (Minuchin, Reiter, & Borda, 2014) – to help redress the couple's power disparity. The family accomplished their treatment goals after 10 sessions over six months.

Discussion

Clinical applicability of FBT for children with ADHD in Southeast Asia is progressing slowly. With the exception of our MFT study (Ma et al., 2018), empirical evidence on FBT for this clientele is lacking. Our study (Ma et al., 2018) showed that MFT can be effective in changing parental perceptions of children's ADHD symptoms in Hong Kong, which is quite important. Doctors usually prescribe and adjust the dosage of stimulant medication according to parents' observations. When parents view the child's symptoms less seriously and less pathologically, over-medication can be avoided, which in turn may improve the child's functioning with peers, in the classroom, and in the family. Stimulants do increase the attention span of children with ADHD (So et al., 2008), and combining medication with MFT appears to work for children with ADHD.

Despite the contributions of this study (Ma et al., 2018) to develop knowledge pertinent to the practice of FBT for this clientele, a few limitations warrant attention: (1) families of children with ADHD were not randomly assigned to the control and experimental groups, which weakens the generalisability of the study; (2) the data in this study were self-reported, which could admit perceptual bias from children and parents; and (3) the duration of the study was relatively short, that is, it is unknown whether the positive impact of the MFT can be sustained over the long run.

Integrating MFT and SFT is ethically necessary since betterment of families of children with ADHD is our primary concern. In our clinical project, SFT was provided as a follow-up service to assist the neediest families (e.g., the Ng family) in resolving their difficulties. Integrating SFT and MFT in helping participating families such as the Ng family is feasible: duration of work is shorter because of the trustful therapeutic relationships between families in MFT and the group leaders. The positive effects of SFT on the Ng family provide anecdotal evidence to support the cumulative benefit of combining both approaches in helping this clientele.

Chinese families tend to be seen as reserved and inhibited, hesitant about disclosing their difficulties to helping professionals such as couple and family therapists (Yang, 2001). Our clinical experience has shown otherwise. Through MFT, families of children with ADHD are connected with one another and have fun together, experiences which are typically lacking for these families because their time and energy is consumed by homework (Ma & Lai, 2014). Family-based treatment for children with ADHD has been recommended in Western countries such as Australia and New Zealand (Richards, 2012). Through FBT, fathers of children with ADHD are actively involved in child-rearing, which offers timely support to the mothers and enhance the quality of care for the children.

A strengths-based perspective (Lo & Ma, 2019) should be an integral part of family assessment and treatment, emphasising outcomes of competence, adjustment, and well-being for children with ADHD, rather than symptom reduction. In the group, the children appeared to be distracted and inattentive, but when they were asked to prepare artwork or a script, for example, for a puppet show or a surprise party, they were as creative and artistic as typically developing children. Most parents did not recognise these talents in their children with ADHD, probably due to the bias inherent in the pathological lens. The continued feedback from children and parents of other families, as well as the group leaders' onsite reflection, gave the parents a greater appreciation of their children's strengths and talents.

Trained in systemic intervention and able to utilise FBT knowledge and skills, couple and family therapists are better equipped than other mental health professionals to help children with ADHD. The author, as a result of her training, has employed SFT in helping these families. Other family therapy approaches (e.g., narrative school) may also be promising ways of helping.

Note

[1] Families' personal information were altered and pseudonyms were used in the case and group illustrations in order to protect privacy of the families.

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