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FAMILY PROCESS

ORIGINAL ARTICLE

Generating mutual support in multifamily therapy to promote father involvement and family communication quality of Chinese families of adolescents with Attention Deficit Hyperactivity Disorder: A qualitative study

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Abstract

Previous studies have suggested the negative impacts of attention deficit hyperactivity disorder (ADHD) on parent–adolescent interactions. Yet engaging parents, particularly the fathers, to participate in family-based interventions has been challenging in Chinese contexts given the traditional concerns about keeping the family's "face" and the influence of affiliate stigma. Empirical evidence supports multifamily therapy as an effective modality for parental engagement. This study explores the role of mutual support in promoting parental engagement and family communication quality of Chinese families of adolescents with ADHD. Inclusion criteria of the study were (a) Chinese family of at least one adolescent child having an ADHD diagnosis, (b) the adolescent child was aged between 11 and 15 years, and (c) the family participated in a multifamily therapy program. Families who had not completed a multifamily therapy program were excluded. Fourteen Chinese families of adolescents with ADHD who participated in a pilot multifamily therapy program from June 2017 to September 2018 were recruited for this qualitative study. Photo-elicited parent focus groups and photo-elicited individual interviews with adolescents were conducted. The thematic analysis revealed that a low level of hierarchy in the therapist–client relationship

The work was conducted at the Department of Social Work, The Chinese University of Hong Kong.

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contributed to the building of mutual support among the families in the therapy process. The mutual support was found to play a key role in promoting acceptance, father involvement, and open communication within families of adolescents with ADHD. Discussion was conducted on the importance of the nonexpert stance of the therapist for promoting mutual support among Chinese families in a multifamily therapy process.

KEYWORDS

ADHD, adolescent, Chinese families, father involvement, multifamily therapy, mutual support

INTRODUCTION

Attention deficit hyperactivity disorder (ADHD), a prevalent child neurodevelopmental disorder characterized by inattention, hyperactivity and impulsivity (APA, 2013), affects about 3%–4% of adolescents globally (Costello et al., 2011). ADHD is associated with a range of adverse developmental outcomes, including low academic attainment, interpersonal problems and mood disorders (Humphreys et al., 2013). Families of adolescents with ADHD are usually characterized by poor parent–child relationships, including greater conflict, challenging child behavior and poorer parenting practices (Edwards et al., 2001).

Similar to their typically developing peers, adolescents with ADHD and their parents usually encounter conflicts on themes related to independence. However, their conflicts could be magnified because of the core symptoms and associated features of ADHD (Robin, 2014). Previous research has suggested that the impaired parent–child interactions in families of adolescents with ADHD link to an increased risk of depression, a more severe form of ADHD symptoms and social maladjustment among the young people (Hurtig et al., 2007).

In Chinese contexts, evidence has revealed the adverse impacts of the stigmatizing culture on parent–child interactions in families of adolescents with ADHD (Ho et al., 2011), which could eventually cause them to develop affiliate stigma (Mak & Cheung, 2008). Affiliate stigma refers to the internalization of public stigma experienced by family members of a stigmatized individual (Mak & Cheung, 2008). Affiliate stigma affects not only Chinese mothers of children with ADHD (Chang et al., 2020) but also Chinese fathers whose children with disabilities were found to be disinclined to seek support from outside for fear of stigmatization (Hu, 2022). To avoid loss of face, Chinese parents of children with developmental disorders tend to withdraw from social relations (Chiu et al., 2013). Limited social support may increase the stress level of the parents caring for their hyperactive child (Muñoz-Silva et al., 2017). Chinese parents in one study who were affected by affiliate stigma tended to view and react to their children with ADHD in a less favorable manner (Chang et al., 2020). Furthermore, affiliate stigma was found to exacerbate parental depression and behavioral problems of the adolescents with ADHD (Chang et al., 2021). Impaired parent–adolescent interactions may develop in Chinese families of adolescents with ADHD (Gau & Chang, 2013), which may reduce family flexibility and the capacity to openly communicate or resolve the developmental challenges brought about by ADHD.

Family-based intervention has consistently shown effectiveness in dealing with parent–child conflicts, particularly among families of children with externalized problems such as ADHD (Babinski & Sibley, 2022). Parental engagement, which refers to the parents' responsive involvement in the intervention (Karver et al., 2005), has been found essential for treatment

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effectiveness in family-based interventions (Haine-Schlagel & Walsh, 2015). In view of this finding, facilitating the process of parental engagement in a family-based intervention is important for improving parent–adolescent interaction among Chinese families of adolescents with ADHD.

Engaging Chinese parents in a family-based intervention

According to Straudt (2007), the parental engagement process in a family-based intervention consists of two interlocking components: behavioral engagement (attendance and help-seeking) and attitudinal engagement (motivation to participate and a positive expectation about the outcome of the intervention). For Chinese parents of adolescents with ADHD, their treatment engagement to family-based intervention should be understood within the cultural contexts. The cultural concerns on the family keeping face and the influence of affiliate stigma reduce Chinese parents' motivation to seek help (Mak & Cheung, 2008). Chinese people tend to view interpersonal relationships dichotomously as "insiders" and "outsiders" (Gudykunst et al., 1992), and Chinese parents tend to be reluctant to disclose their negative thoughts concerning family members in front of outsiders (Tse et al., 2012), which could reduce their trust in the therapist and hinder their participation in the treatment process. Chinese people value social connections with others who are *zijiren* (自己人), or "insiders" (Bond, 1996). In such a context, a communal sense evolved among a group of people who share similar experience or are regarded as *zijiren* would facilitate the engagement process of Chinese parents in an intervention.

Mutual support for Chinese families of adolescents with ADHD

Mutual support, mutual aid or other terms such as mutual help are used interchangeably in the literature and frequently refer to people helping each other to resolve their problems (Folgheraiter & Pasini, 2009). According to the mutual aid model (Shulman, 1986), when a group of people have developed mutual support, they will experience a dynamic process of a number of phenomena, such as information sharing, experiencing "all-in-the-same-boat" and offering emotional support.

Research evidence has demonstrated the positive effects of mutual support within family-based group intervention (Citron et al., 1999). Successful mutual support was linked to increased emotional stability, personal growth and reduced isolation among parents of a child with ADHD (Klein et al., 2019). A study in a Chinese context suggested that social support from friends has a buffering effect on parental active participation among Chinese parents of children with developmental disorders (Yan et al., 2022). However, there has been a dearth of research exploring the contributions of mutual support in a family-based group intervention, such as multifamily therapy, in facilitating changes in family interaction and parental involvement of Chinese adolescents with ADHD.

Multifamily therapy—Family development vacation (MFT-FDV) for Chinese families of adolescents with ADHD

The *Multifamily Therapy—Family Development Vacation* for Chinese families of adolescents with ADHD was developed from the model proposed by Ma et al. (2018). Ma et al.'s (2018) model was developed for Chinese families of children with ADHD, which was built on a theoretical

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basis integrating family systems theory, developmental theory, and group theory (Ma et al., 2018). MFT's nonstigmatizing group setting and its emphasis on the participants' ability to build mutually supportive relationships are considered to be essential factors contributing to effective engagement with families (Gopalan et al., 2011). The MFT-FDV modified the Ma et al.'s (2018) model by including a wilderness family camp intended to promote the use of the healing potential of the natural outdoors for these families. Descriptions of the organization and the typical program of an MFT-FDV have been reported elsewhere (Lo & Ma, 2022). Hence, only the program design of the MFT intervention that was related to the building of mutual support between families is described here.

Each participating family received a total of 40 h of group intervention over a 3-month period, including two full days of a multifamily program on a university campus (16 h), an overnight multifamily camp in the Hong Kong countryside (16 h), and a full-day multifamily reunion (8 h). In an MFT-FDV, the two full-day family program played an essential role in building mutual trust between the families prior to the family camp. A combination of group-building and family-building activities were conducted to create a mutually supportive milieu in the MFT. The technique of surrogate parenting was employed to promote mutual understanding among the family participants and which helped connect the families.

Each MFT was conducted by a leading team composed of one principal therapist (the first author), one co-therapist, and a group of five student volunteers. The MFTs were led by the principal therapist who is a registered social worker and a qualified family therapist in Hong Kong. The co-therapist is an experienced family social worker with a master's degree in family education and counseling, who helped coordinate the student volunteers and provided immediate assistance to the principal therapist during the MFT. The student volunteers were undergraduate or postgraduate students from a university and helped with logistical arrangements and accompanied the families during the MFT. All student volunteers received a half-day training workshop from the first author prior to the MFTs.

The knowledge gap

Even though mutual support has been recognized as an essential active ingredient in an MFT (Gopalan et al., 2011), the extant studies that explore the creation of mutual support in an MFT and the changes facilitated by the dynamic process of mutual support are limited. Systematic review of MFT-related literature (Gelin et al., 2018) has pinpointed the need for more process research to identify helpful components and the change processes of MFT by looking into the families' participatory experience.

The present study

The present study aims to answer two research questions from the perspective of Chinese adolescents with ADHD and their parents.

RQ1: Which factors in an MFT process contribute to the emergence of mutual support among the families?

RQ2: What kinds of changes in treatment engagement and family communication quality were experienced by the Chinese adolescents with ADHD and their parents? How did these changes relate to the mutual support in an MFT process?

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METHODS

Participants

Five pilot MFT-FDVs were conducted from June 2017 to September 2018, with a total of 20 Chinese families of adolescents with ADHD participating. These families were either referred by child and adolescent psychiatric clinics, local schools or social services or recruited from the community through a psychoeducation talk in a university. All participating families joined the MFTs on a voluntary basis. An invitation to join the present study was sent to all families 3 months after completion of the MFTs. Fourteen families (70%) replied and joined the present study, four families (20%) were occupied by their family issues during that period of time (e.g., moving to a new home and sickness), and two families (10%) did not reply.

Among the fourteen families who joined the present study were 10 fathers (mean age = 50.0), 10 mothers (mean age = 45.6) and 14 adolescents with ADHD (9 males and 5 females, mean age = 12.9). Among the parents, five fathers had attained a bachelor's degree (50%), five fathers had graduated from secondary school (50%), eight mothers had graduated from secondary school (80%), and two mothers had graduated from university (20%). Two families were welfare recipients. The average monthly household income of the other twelve families was HKD33,777.8 (USD4,330.4), which was slightly higher than the median household income in Hong Kong at that time (HKD32,300; USD4141) (Census and Statistics Department, 2018).

Ethical approval was granted by the University Ethics Committee of The Chinese University of Hong Kong. Written consent was obtained from all family participants prior to the interviews, and their participation in this research was voluntary.

Measures

Photographic images produced by family participants during the MFT were collected and used in the postgroup interviews with the families. Each family participant was given a disposable analog camera on the first day of the MFT and was told to capture any impressive moments during the therapy. Photos were compiled into a separate photo album for each family participant. The photo albums were distributed to the participants prior to the interviews.

We saw two advantages for using photos in the data collection process of the present study. First, using photos enriched the content shared by the participants in interviews. Focus groups and in-depth interviews rely a great deal on remembering an activity, and such details are vulnerable to memory deterioration as time goes by. Photos offer a visual and participatory approach to the subjective realities of people (Booth & Booth, 2003). They make it possible to extract more psychological content and stimulate more in-depth experiences than can be had from spoken words alone (Harper, 2002). Second, the use of photos in data collection was found to be useful for engaging adolescents to explore family interactions from their perspective (Sibeoni et al., 2017).

Photo-elicited individual interviews with adolescents with ADHD

Fourteen adolescents with ADHD were interviewed. Following a semistructured interview guideline (Lo & Ma, 2022), the adolescents were asked about the content of the photos and the meanings they ascribed to their personal experiences of engaging with family members and other group members in the MFT. As an established rapport with adolescents favors a deeper exploration of personal experiences (Irwin & Johnson, 2005), interviews with the adolescents

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were conducted by the first author or a student volunteer of the MFT. Each interview lasted from 30 to 60 min.

Photo-elicited parent focus groups

Three parent focus group interviews were conducted, each lasting from 60 to 90 min. In total, 10 fathers and 10 mothers were interviewed. Parents were given time to review their own photo albums before the interviews to refresh their memories about the MFTs. Following semistructured interview guidelines (Lo & Ma, 2022), parents were asked about their personal experiences with their own family and with other families in the MFT. The focus group interviews were conducted by interviewers who were experienced in leading MFT and had not been involved in any MFTs in the present study.

Data analysis

Data analysis in this study consisted of two phases. The analyzing process was recursive between two phases. At phase one, the photos produced by the participants were analyzed following the guidelines of polytextual thematic analysis (Gleeson, 2011), which aimed to "identify the repetitive features or themes in the data [i.e., the images] that enable patterns to come into view" (p. 315). The photos were analyzed inductively (Gleeson, 2011) and deductively based on the concepts related to therapeutic landscapes in which a therapeutic space can be conceptualized into physical aspects and social conditions (Gesler, 2003). In this study, the physical therapeutic space in the MFTs included indoors (e.g., activity rooms in the university campus), outdoors (e.g., the campsite) and the natural environment; the social conditions generated in the MFT processes included social interactions (e.g., cross-family interactions, intrafamilial interactions and therapist–client interactions) and MFT activities (e.g., cross-family activities, intrafamilial activities and free time). The physical environment, the social conditions and the participant's perceptions were combined to produce an atmosphere which was conducive to healing (Gesler, 2003). A coding scheme for analyzing the photos was developed (see Lo & Ma, 2022), which was employed for refining the interview guidelines for the interviews. Data analysis in the first phase was conducted by the first author as high familiarity of the MFT therapeutic processes—including the group activities and the relationships between the participants—would be required for interpreting the photos.

In the second phase, data collected from individual interviews with adolescents and the parent focus groups were transcribed verbatim. The data were then analyzed following the step-by-step guidelines for thematic analysis (Braun & Clarke, 2006). The first author read all the interview data and analyzed it inductively and deductively based on the concepts relevant to mutual support, parental engagement and MFT. A preliminary coding scheme containing 42 initial codes was then developed by the first author. As a practitioner-researcher having an intimate involvement in the process and product of the present study, the first author recognized her position as an inherent part of the study that might shape the findings and conclusions. The second author, who is experienced in MFT and family therapy, was not involved in leading the MFTs of the present study and could read the initial analysis in a detached and neutral stance. Subsequently, both authors discussed the classification of the initial codes into emergent themes and subthemes with reference to the thematic findings in the literature. The potential themes were reviewed by the two authors, and all were checked against the raw data set and the coded extracts. Lastly, an analysis was conducted to refine the names of the derived themes until clear definitions were developed for all themes and a consensus between the two authors was reached.

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To put to rest any concerns about confidentiality, codes were substituted for the names of participants, for example, "a2" referred to the adolescent with ADHD of family 2, "f4" referred to the father of family 4 and "m14" referred to the mother of family 14.

RESULTS

In response to the first research question, one theme was identified: low level of hierarchy in the therapist–client relationship. In regard to the second research question, two themes were identified: "increased acceptance in the families" and "increased father involvement and open communication in the families" (Table 1).

Low level of hierarchy in the therapist–client relationship

As explained by the parents, a "nonexpert" positioning of the therapist was essential for encouraging their active participation in the MFT. Such a "nonexpert" positioning of the therapist was characterized as being "friendly" (f12, m6, m10 and m14*),* "unbiased" (m6 and m12*)* and "nonjudgmental" (f10, m9 and m14*)*. The therapist actively, but in a nondirective manner, engaged the parents during the MFT and was helpful in bringing members into the group. Without an authority figure in the group, parents were freed from the psychological burden of "worrying about being judged" (m14). Parents gained psychological autonomy to express and exchange their own viewpoints, thus facilitating member-to-member connections.

> The therapist was like a "friend" of mine. That encouraged more information to flow within the group. I would not have talked so freely if I was facing a therapist playing an expert role.
>
> (f12)

> When we asked questions on parenting issues, for example, instead of giving advice, the therapist asked another question to stimulate us to interact among ourselves and exchange our own ideas.
>
> (m12)

TABLE 1 Data analysis of the qualitative data.

Theorizing phase (% of family participants endorsed the theme)	Conceptual categories	Subtheme
Low level of hierarchy in the therapist–client relationship (50.0%)	Decentralization of the MFT therapist and the leading team	Nonexpert positioning of the leading therapist
		Subordinate positioning of the leading team
Increased acceptance in the families (47.1%)	Feeling accepted by the group members and the leading team	A nonblaming group environment
Increased father involvement and open communication in the families (76.5%)	Alternative relational experiences in the families	Active involvement of the fathers
		Mutual learning between the parents

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> The therapist would talk to me individually during the free time. This helped narrow the distance between me and her and connected me to the group.
>
> (m10)

Unlike their parents, the adolescents with ADHD revealed that a subordinate positioning of the leading team was helpful in engaging them and connecting them with one another. The leading team served as "buddies" and companions to the adolescents with ADHD (a2, a3, a4, a6, a8, a9 and a14). Throughout the group, the adolescents took the leading role in this companion relationship. This served as an important basis for the adolescents to gain psychological security in reacting to other interpersonal contexts in the MFT.

> These "big brothers" and "big sisters" were like backroom staff. Their support in the back brought connections in the group.
>
> (a9, Photo 1)

Increased acceptance in the families

Immersed in an accepting group ambience cultivated by the leading team, the participating parents became more open to talk. Through the information sharing in the MFT, the parents learned how their children differed from non-ADHD children (m9, m11, m13 and f6), about the parenting difficulties of other group members (m9, m13 and f10) and what relational difficulties were faced by other couples in the group (m1 and f1).

> As our children shared similar problems, I would therefore trust what he [another parent in the group] said, and he would also trust what I said here. I would not be

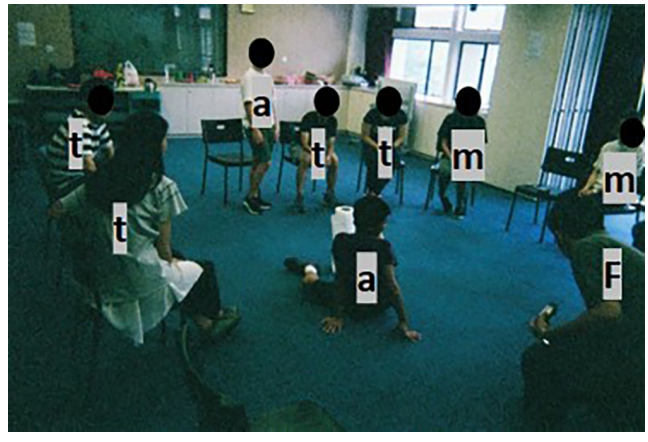


PHOTO 1 *A subordinate positioning of the leading team* ("a" refers to an adolescent with ADHD, "m" refers to mother, "f" refers to father and "t" refers to leading team). This photo was taken by a9 on the morning of Day 2. The families were waiting for the session to start. One adolescent found a roll of paper and another found a ball in the room. The two adolescents created a new game (throwing the ball into the small hole of the paper roll). Members of the leading team joined the game and played with the adolescents. The mothers and fathers sat in a circle. While the parents talked among themselves, they were able to observe the play between the adolescents. The leading team sometimes passed the ball to the parents and invited them to participate in the game.

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> afraid of being stigmatized in this group. We would therefore share openly—both the good and bad sides of our family.
>
> (f10)

> My husband and I do have friends outside this group, but we could never discuss our relational difficulties together with our friends. This group let us talk to each other. (m1)

Such a nonstigmatizing and supportive group ambience induced the parents to be trustful and open toward the other parents in the MFT, and the parents started to observe their adolescent children from a different angle (e.g., observing their strengths and understanding their needs). This widened understanding about their children helped to enhance the parents' acceptance of their adolescent children (m3, m4, m7, m8, m9, m11 and f4) and promoted the parents' self-acceptance (m3, m11 and f4).

> This group bolstered sharing between us. I know my son still makes lots of mistakes, but this group really gave me trust, which supported me in giving more room to my son.
>
> (m3, Photo 2)

> I had been pushing my daughter to join different treatments to fix her "problems." I felt dejected and questioned myself. After sharing with other parents, I started to realize that some problems were actually not big problems.
>
> (m11)



PHOTO 2 *A parent's increased acceptance of her own child with ADHD* ("a" refers to adolescent with ADHD). This photo was taken by m3 on the afternoon of Day 2. The activity involved joint meal preparation. "Surrogate families" were formed between the participating adolescents and parents (e.g., an adolescent was paired with parents from another family). Adolescents were the main chefs, and their surrogate parents acted as their assistants. The arrangement of surrogate parenting served two purposes. First, it created spaces for adolescents to experience trial and error with minimal assistance from their surrogate parents. Second, it allowed the parents to observe their own child from a distance. According to m3, she had never let her son cook before for fear that he would get hurt due to his lack of self-control; therefore, this was the first time that he had ever cooked. Her son was calm, patient and careful during the meal preparation. The mother was surprised to see that her son could manage all the utensils well.

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Increased father involvement and open communication in the families

The participating mothers acknowledged the importance of father involvement during the development of their children. However, many of them expressed difficulties in engaging the fathers to participate in such family-based group interventions. Concerns of the fathers that hindered their participation included "disagreements with the mother on parenting" (f6, f10, f12 and f13), "perceived uselessness of the group" (f1, f2 and f5) and "worry of re-stigmatizing the child." (f1)

> I have never participated in parenting our son. My wife always told me not to question her.
>
> (f13)

Parental narratives showed that the leading team played an important role in triggering a "ripple effect" in the MFT process, which encouraged more active involvement of the fathers. One mother mentioned that a positive engagement between the therapist and the fathers during the pregroup interview was particularly effective in increasing the fathers' motivation (m13).
However, hearing the fathers' voices and making their role more visible to the family in a pregroup interview only motivated them to leap forward. Data showed that the social interactions among the fathers were helpful in sustaining their continual participation in the MFT (f1, f12, m5 and m12).

> When there was one father actively involved, it encouraged active involvement of another father.
>
> (m12, photo 3)

> During the break time, John (f13) and I would take a cigarette break together just to chit-chat about trivial family matters. This let me have a chance to readapt myself into the social activities. I seldom have social interaction with others. (f1)



PHOTO 3 *Active involvement of the fathers* ("a" refers to adolescent with ADHD, "f" refers to father and "t" refers to leading team). This photo was taken by m12 on the morning of Day 4. After a sleepover in a campsite the night before, the families were having their breakfast. This morning session allowed plenty of free time for the family participants to enjoy themselves in the natural environment. During the free time, there were a lot of exchanges among the fathers. According to m12, her husband seldom participated in social activities. The presence of fathers from other families encouraged her husband's full attendance in the MFT and his active participation in the process.

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Some mothers shared that as the fathers were continually participating in the group, they became more attentive to the parenting difficulties of the mothers. This heightened attention due to the mutual learning of the parents brought about an increase in intrafamilial understanding and a reduction in mother-blaming.

> After he observed and listened to the others, he started to understand that the problem did not originate from me. He realized that it's a matter of how we communicate. I received less pressure from him.
>
> (m12)

Because of the participation of other families, some fathers shared that the MFT was helpful in the way that cross-family interactions in the MFT provided many observations about their children and their family interactions. Based on these observations, the fathers found it easier to talk to their partners in the group than on normal days (f1, f4, f6 and f9).

> My wife kept telling me something was wrong with our son. I didn't believe her before. If I didn't join this group, I wouldn't be able to observe things that our son is capable of and things that he needs help with. Based on these observations, I could talk to my wife. (f1)

> As my wife and I attended the group together, we could discuss between ourselves based on the things that happened here. We observed that other parents also faced challenges with their adolescent child. I told my wife to be relaxed. Don't only focus on the development of our daughter! We should attend to the development of the three of us. (f9)

The existence of mutual support in the MFT process was perceived by some participants to be helpful in inducing open communication in families. "Open communication" referred to a wider range of discussion topics (f3 and f4), allowing rooms for negotiation (a6) and talking calmly (m1, m6, m9 and a9). As mentioned by the parents, exchanges with other parents were helpful in promoting open communication between couples, and mutual learning between the parents (f1, f2, f3, f6, f10, f12, m1, m3, m5, m6, m10 and m12).

> As there were more members in the group, we could receive more advice here. But there were always only two of us at home. We would easily fly into a quick temper mode. (f6)

> The group allowed us to take the others' experiences for reference, and then reflect on myself. (f1)

Many participating adolescents had a conflictual relationship with their parents on typical days, but in the MFT they described noticing a "different face" of their parents. Some attributed this alternative to the mutual support of other families (a1, a6, a10 and a12).

> This group helped me to be less confrontational toward my mother, because I learned about her worries about me from other parents. I felt that she became more tolerant. (a6)

> When my father came out of that room [after parent sharing time], I felt that his mood had changed. He didn't scold me after he had talked to other parents. (a1)

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> Even if we [parents and adolescents] had conflicts in the group, there was always somebody who helped by mediating. First, this helped stop the conflicts from getting worse. Second, the group members would talk to us—this helped both of us get into one another's shoes.
>
> (a12)

Experiencing parents from a different perspective encouraged the adolescents to react differently as well. A father, who had received strong rejection from his son, mentioned that during the therapy, his son gave him a helping hand in preparing food (f10). Another father mentioned that his son, who was very passive at home, became more actively involved in doing housework after the group sessions (f4). Some fathers realized that the changes in their parenting practice had induced changes in their adolescents (f1, f2, f4 and f10).

> My son was afraid of failure, and he always gave excuses to escape from doing a task. During the family camp, my wife and I stood away from my son and allowed some space for him. I was impressed to see that he kept trying to set up the tent even after he had failed several times. (f2)

To conclude, the mutual support among families increased both the father involvement and the quality of family communication in the MFT process, which created opportunities for the adolescents with ADHD and their parents to interact with one another in a different way. Using a term that appeared in an adolescent's narrative (a6), these alternative relational experiences were helpful in "soothing the family relationships" of Chinese adolescents with ADHD.

> Imagine that you were suffering cramps in your arm. If someone hit your arm, you would feel pain. But if your arm was hit after you finished doing stretching exercises, this kind of hit would turn into a massage. You would feel more comfortable than before. This group was just like encouraging us to do stretching exercises, which helped "soothe our relationship." (a6)

DISCUSSION

The present study has explored the role that mutual support can play in multifamily therapy in facilitating changes in family interactions of Chinese families of adolescents with ADHD. The findings of this study suggest that the low hierarchy of the therapist–client relationship contributed to the building of mutual support in an MFT. Furthermore, this mutual support was seen as helping promote mutual acceptance, father involvement and open communication within these families.

In line with previous studies (e.g., Lemmens et al., 2009), the reduction in the prominence of the therapist's central role in an MFT was identified as a distinctive characteristic that promoted mutual support in the treatment process. The present study found that the decentralized positioning of the leading team played a key role in promoting interactions between group members, bridging individual members to the other group members and engaging the fathers and the adolescents with ADHD, which led to the creation of mutual support in an MFT. While Chinese people often expect therapists to take on an expert role in helping them to find solutions to their problems (Yang & Pearson, 2002), our findings suggest the importance of therapists taking a nonexpert role in leading an MFT for families of adolescents with ADHD in a Chinese context. Since Chinese people tend not to see individual problems as family-related (Lee & Mock, 2005), they are slow to agree with the direct advice given by the therapists in a few MFT sessions. Because of the traditional hierarchical structure in families,

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directly pointing out the unhelpful family interaction patterns prevalent in the family may trigger strong resistance from Chinese parents, especially the fathers who are the heads of their family, as they may consider this criticism as disrespecting their authority over their children. In such a context, suggestions from "insiders," rather than advice from an expert—an "outsider" of the family—may be more helpful in producing an alternative understanding of their difficulties among Chinese people.

Our findings were that the mutual support in an MFT was helpful in promoting the quality of family communication, particularly between Chinese couples. A previous study in Hong Kong (Ma & Lai, 2016) reported a significant difference in paternal and maternal perceptions of their children's ADHD symptoms, and highlighted that such discrepancies between the fathers and mothers might diminish their parenting partnership and create conflicts between the couple. Our study demonstrates that the mutual support helped the couples feel they were being heard and understood by their partners through mutual observation and learning in the MFT process. This led to a reduction of any discrepancies regarding parenting and a decrease in the blaming, thus deepening the emotional connections between the couples. This research supports Knudson-Martin's (2013) argument that creating emotional attunement (one aspect of mutual support) between the couple in a treatment process could help reduce their power disparities and thus improve their relationship.

Previous studies have highlighted the importance of actively involving fathers in the treatment process of children with ADHD (Fabiano, 2007). Our study suggests two possible roles that mutual support can play to facilitate effective engagement of Chinese fathers in a family-based intervention. First, the mutual support in the treatment process may be helpful in creating a welcoming and nonstigmatizing entry point—a "neutral doorway," as suggested by Weeks (2004)—for the fathers. Reducing the psychological barrier of the fathers is the key to promoting engagement with them (Pfitzner et al., 2017). Our findings also support the notion that social exchange with peers in the family-based intervention helped induce emotional relief for the fathers, which encouraged them to open themselves to listen to the advice. Second, the mutual support in the treatment process encouraged active contributions of all family participants in the MFT, which may be linked to a success in father engagement. Rather than viewing the fathers as lacking parenting skills, which has been found ineffective for father engagement (Addis & Mahalik, 2003), our study recognized the fathers' expertise in their own lives and perceived them as active contributors to the treatment. This finding aligned with Pfitzner et al. (2017) that a strength-based approach is useful for engaging men in psychosocial interventions.

Given that the service culture in Hong Kong values efficiency above effectiveness (Munro, 2004), adopting a decentralized role in a family group on ADHD may not be easy for family therapists in Hong Kong. Family therapists in Hong Kong might easily fall into a directive role in providing quick solutions to the families, such as managing ADHD behaviors and resolving parent–child conflicts. Further investigation is warranted to explore hindering or facilitating factors at the intrapersonal level (e.g., Would particular personalities favor or hinder the adaptation to decentralization of the therapist?), at the interpersonal level (e.g., Does the composition of group members influence the way the therapist reacts?) and at the organizational level (e.g., Are there any agency cultures or practices that may favor or hinder the application of MFT?).

LIMITATIONS AND RECOMMENDATIONS

The results of the study should be interpreted cautiously due to the potential threat of social desirability bias affecting the quality of the data. Objectivity in the data analysis may have been influenced by a researcher playing the dual roles of a group leader and an investigator.

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Due to limited resources, this study lacks member-checking. This may have led to potential investigator bias and the lessening of the trustworthiness of the results.

It is recommended that future studies further explore the potential interplay effect between the physical group environment (i.e., the natural outdoors) and the social group environment (i.e., group composition and intervention content) that may contribute to or hinder the building of mutual support in the MFT process.

CONCLUSIONS

Mutual support played an important role in a multifamily therapy in facilitating changes in family interactions of Hong Kong Chinese families including adolescents with ADHD, leading to the promotion of father engagement in the treatment process, increasing mutual acceptance of the status quo in the families and improving the quality of family communication.

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