

Adapting an ADHD parent training intervention to different cultural contexts: The experience of implementing the New Forest Parenting Programme in China, Denmark, Hong Kong, Japan, and the UK.

Key words: ADHD; New Forest Parenting Programme; NFPP; culture adaptations

Attention Deficit Hyperactivity Disorder (ADHD) is a highly prevalent disorder affecting around 4% of preschool and school-aged children worldwide (Egger & Arnold, 2006; Polanczyk et al 2007). The presence of ADHD in preschool age children is associated with a clear risk of later educational difficulties (Washbrook et al. 2013) and ADHD leads to family borne costs (e.g. time off work, cost of damage in the home) as well as increased health and education costs (Chorozoglou et al, 2015). The challenges of bringing up a child with ADHD are compounded when parents lack social and educational resources to cope with and manage that child's difficult and challenging behaviour (Larsson et al, 2014).

Parents who have ADHD themselves (Sonuga-Barke et al, 2002) or mental illness will find parenting a child with ADHD more difficult (Chronis et al, 2007).

One of main targets of the New Forest Parenting programme (NFPP) is working with the parent to improve self-regulation in their child. Thus, it was important to discuss with the leaders in each country in which we were going to train, what the influences were behind the development of self-regulation in the children in their culture.

Parenting children with ADHD: Enhancing the development of self-regulation

Self-regulation develops over the first four years of the child's life as he gradually learns to comply with parental commands, ("do" commands and "don't" commands), internalise social rules and develop effortful control to control their impulses, emotions and actions (Kochanska et al,2001; Keller et al, 2004). Bandura (2001) discusses the agentic state, the psychological state a child enters when obeying authority. Theories of social cognition propose that people are both producers and products of social systems; therefore, children have their own agency over the development of self-regulation. This depends on the maturation of brain and biological systems, which influence the innate temperament of the child; this in turn, is shaped by their relationships with parents and other adults in their lives. On the other hand, the child's temperament itself will mediate self-regulation both from a developmental perspective and by influencing the parents' ability to modify their child's behavior. For example, "fearful" children were able to suppress prohibited behaviors in the "Don't" paradigm in a longitudinal study of children 14 months to 33 months, but were not more compliant in the tedious "Do" paradigm. Effortful control was also linked more with committed compliance in the "Don't" category. Girls were better able to self-regulate than boys were (Kochanska et al, 2001).

Children with ADHD take longer to develop self-regulatory skills (Sonuga-Barke et al, 2002; Sonuga-Barke et al, 2010): young children with poorer self-regulatory skills are more likely to have attentional and academic difficulties (McClelland et al. 2007). In addition, children with attention problems respond differently in the development of compliance. Focused attention in infancy is associated with greater compliance at 14 months (Kochanska et al, 1985). Furthermore, the list of ADHD symptoms include elements linked to cognitive (inattention) and behavioral (hyperactivity/impulsivity) self regulation deficits (Barkley 1997; Biederman et al 2012). According to Barkley's theory of ADHD (Barkley 1997) the deficits in

response inhibition are associated with increased emotional reactivity, difficulties dealing with frustration, and increased difficulties in regulating one's emotions (Friedman et al., 2003). Empirical support exists for this model. Crundwell (2005) explored the relationship between ADHD symptoms and emotional regulation and emotionality. They found that ADHD boys, who showed greater emotionality in terms of anger/frustration and less self-control and inhibition, were rated as having more behavioural difficulties. Children with symptoms of hyperactivity and impulsivity were rated as lower in self-control and inhibition and higher in emotionality (Crundwell (2005)).

Because of these problems of self-regulation, parenting a child with ADHD also creates considerable stress in families especially where parents are unsure how to manage their child's overactive and impulsive behavior (Johnson and Mash, 2001). As a result, ADHD is often associated with adverse familial environments and dysfunctional parenting practices (Seipp & Johnston, 2005). Children with ADHD are generally less compliant and more negative than their peers (DuPaul et al., 2001) and parents are more likely to engage in hostile parenting practices, use inconsistent discipline strategies and show less warmth in interactions (Tarver, Daley & Sayal 2014). Negative parent-child relationships may also compromise the development of children's self-regulatory capacities (Bernier et al 2010). This underscores the need to support parents of children with ADHD to develop strategies that can facilitate self-regulations in their children. Grolnick et al (1989) demonstrated that supporting parental autonomy increased children's self-reported autonomous self-regulation, teacher-rated competence and adjustment, and school grades and achievement. Maternal involvement in the child was related to school achievement, teacher-rated competence, and some aspects of behavioural adjustment. Davidov & Grusec (2006) demonstrated separate links between two features of positive parenting: responsiveness to

distress and warmth and different aspects of children's socio-emotional functioning in 6 – 8 year olds. Mothers' and fathers' responsiveness to distress, but not warmth, predicted better negative affect regulation. Mothers' responsiveness to distress also predicted children's empathy and prosocial responding. Maternal warmth, but not responsiveness to distress, was linked to better regulation of positive affect and (in boys only) to greater peer acceptance. Parents of children with ADHD and oppositional behavior were more likely to use more negative and reactive, and fewer positive parenting practices (Johnson, 1996). Oppositionality in the child with ADHD resulted in parents showing less warmth, more criticism and hostility towards the child with ADHD, compared with their non-ADHD siblings (Cartwright et al, 2011)

Furthermore, it is vitally important for the parent to be able to adapt to the child they have. Kochanska & Askan (1995) found that the probability of behaviour problems occurring in children is reduced by 'positive' or 'gentle' reasoning-based strategies that increase the child's compliance. This was also found by Dunn & Kendrick (1982), who suggested that reasoning (e.g. explaining to the child the consequences of their behaviour), enhanced the child's sensitivity to the feelings and needs of others. Parental use of reasoning, the use of humour and incentives enabling the child to feel that they were part of the negotiation, are associated with the development of internal compliance (Grusec & Goodnow 1994; Kuczynski 1984; Robinson 1985). However, parenting approaches and parental reactions to children with ADHD, will also be influenced by cultural factors: Messages that are reinforced by a parent's own experience of being parented when a child, as well as the culture in which they are rearing their child (Byng-Hall, 1985; Trommsdorff, 2012). Their parenting behavior may also be influenced by other important adults who support them e.g. grandparents. For example, both Japanese and Chinese mothers live in cultures where filial harmony is highly

valued and in general, their expectations are that their children will respond with respect toward their elders and exhibit compliance for the general good of the family. They tend to be sensitive to children's behavior, anticipating problems. In comparison, mothers in Western cultural settings may expect less compliance initially, but tend to react more strongly when things do not work out (Trommsdorff, 2012). Given the central role of self-regulation in the development of behavioural problems in children with ADHD, it will be important to help and support parents of children with ADHD to foster self-regulation.

The New Forest Parenting Programme: Helping parents to build their ADHD children's self-regulation

The NFPP was first developed in the UK as a manualized eight-week programme to be delivered at home by a trained therapist. Positive results have been obtained from randomized controlled trials (RCTs) in terms of parental reports of ADHD symptoms, conduct problems and parental well-being (Sonuga-Barke et al, 2001; Thompson et al, 2009). It has recently been adapted for use with a more challenging population in the UK (including children and parents with learning difficulties; parents with depression; parents in poor social circumstances) (McCann et al, 2014; McEwan et al, 2015; Sonuga-Barke et al, submitted). It has also been successfully delivered to groups in clinical practice in the UK (Laver-Bradbury and Harris, 2009); and is used in many community settings in the UK delivered both as both an individual and group programme. A successful trial of a self-help version of NFPP (Laver-Bradbury et al, 2009) has also been conducted (Daley & O'Brien, 2013).

The NFPP set out to educate parents about ADHD, in order to offer them a better understanding of their child and his/her behaviour. Our aims were to help parents develop a more positive relationship and to repair the often negative interactions characteristic of parents and children with ADHD. The idea is that by introducing basic parenting strategies such as using praise, increasing positive communication and establishing appropriate routines and boundaries, the parent gradually learns how to manage the child's behaviour.

This will in turn help the child to learn to self-regulate their own behavior. Additionally, the NFPP offers specific behavioural strategies and skills to increase the competencies and confidence of parents. It also attempts to address ADHD-related neurocognitive deficits, through parents' use of specific games and exercises with their children. These target attention skills, taking turns and learning to wait. The NFPP aims to tailor interventions to the individual child and family. Therapists are instructed how to obtain a detailed assessment of parent-child collaboration in order to achieve an understanding of the dynamics of the parent and family background, the hopes and expectations of the parent for their child and an understanding of the parent's emotional and practical support. NFPP attempts to tune in to the needs of the parents and the child and facilitate development through careful scaffolding of the parents' abilities, their relationship and understanding of their child, and the parents' motivation to be able to do the same in order to help their child.

The specific NFPP treatment targets are:

- Improve parents' understanding of ADHD;
- Increase parents' readiness and capacity for change;

- Restructure parents' attributions about ADHD and remove the barriers to change these may create;
- Enhance the emotional relationship between parent and child;
- Create an effective working relationship between parents and child so the parent can become the child's guide and trainer;
- Strengthen ADHD neurocognitive skills and to teach the child strategies to work around their difficulties (including scaffolding principles);
- For parents to understand the cyclical relationship between the child's behaviour and others' responses - help them to encourage the child to choose positive behavioural choices over unwanted ones;
- Generalising the parent's use of NFPP methods outside their comfort zone and facilitating the parent to show others NFPP methods for their child (extending);
- Sustaining the use of NFPP methods after the formal programme has ended, and transferring responsibility for management of ADHD behaviour and thinking differences to the older child.

These targets are typically addressed in the above order, however the exact timeline and landscape of change that occurs in the individual parent, child and family when treating ADHD is as yet unknown. For this reason, the timing of different aspects of the NFPP in the context of a complex developmental condition such as ADHD has to remain flexible to a degree and many of these changes happen in parallel (McEwan et al, 2015).

The New Forest Parenting Programme: Can it be adapted for use in non-UK cultural settings?

ADHD in young children is a problem across the world (Polanczyk et al 2007) and so it is therefore important to research culture adequate interventions in different settings.

Since the publication of evidence in support of its efficacy in UK and the USA, the UK team, which developed the programme, have been invited to extend its use to a range of other countries, where English is not the native language. This work is the focus of this paper.

When considering whether a parenting programme developed in one country is useful to parents in other countries it is vital to take an account of a range of different factors.

First, there are the cultural expectations and values of parents and therapists. The starting point for cultural adaptations has always, therefore, involved a collaborative process of working with therapists and academics native to the countries where the NFPP is going to be applied. This allows the developers to get a sense of adaptations that may be needed for cultural appropriateness, and better understand ways to measure whether the same positive effects seen in the UK delivery would be seen in other countries, having made adaptations. When working within different cultural contexts, consideration was also given to the method of delivery most commonly accepted within the countries with whom we worked. Intensive training and discussions about the above always preceded the commencement of the process of adaptation of the intervention materials, via a process of forward and back translation.

Therapists were trained by the intervention developers, with the initial therapists in each country supervised and tapes of their work reviewed fortnightly. This allowed for understanding of any concerns or queries that arose before embarking on implementation and evaluation trials, with training of other therapists

If interventions are to be adapted for use in other cultures, it is important to ensure that the intervention targets are culturally appropriate and acceptable. They also need to be clear and understandable, adhere to the translated version of the programmes and be conceptually equivalent, with high programme fidelity, to allow for comparisons between the original NFPP and the new NFPP adapted for cultural context, to be studied.

There is the issue of parental background. Parents often have a range of educational backgrounds and language abilities. Consideration needs to be given to parents' level of education and language comprehension; but also variation in therapists' skills, abilities and different theoretical orientation when delivering training to professional groups.

In addition, there are specific issues both in terms of the healthcare structure and organization. For example, in some countries, assessment is the norm, but little in the way of treatment is offered. In other countries, the dominant treatment is medication, which is covered under healthcare insurance, whilst non-pharmacological approaches may not be. There is also the issue of social stigma associated with a disorder such as ADHD in different cultures, which may create greater barriers in some cultures than others.

The experiences of adapting NFPP to different cultural settings.

We have illustrated that the parenting strategies used in the NFPP in western cultures indicate positive change in ADHD symptoms and oppositional disorder symptoms, which are a proxy marker for underlying self-regulation. We embarked on this project not knowing if the NFPP would be as effective in other cultures. We outline the concepts of reviewing a programme prior to this introduction. We thought it should translate, as the

concepts, themselves were universal, but work would clearly need to be done to adapt and incorporate particular culture issues.

The NFPP programme was first implemented outside the UK when it was successfully adapted for the USA and included in a large Random Control Trial (RCT) in New York (Abikoff et al, 2015). Since then it has been used in many countries around the world – in cultures that range very widely in terms of family structures, parental attitudes and behavior and cultural norms relating to children’s conduct. In this section, we present the experiences of researchers’ use of the NFPP in some of these different cultural settings. We include a consideration of the appropriateness of its implementation within different cultures and ways it has been adapted to make it relevant for the challenges of parents facing the challenge of ADHD- in young children across cultures. It is important to note that the UK population is itself, of course, ethnically diverse and so there is a degree of cultural adaptation both within and between nations.

Specifically we aim to:

- 1) Discuss the approach taken and challenges associated with adapting NFPP for use in other cultural settings.
- 2) Provide narrative descriptions of how and why NFPP has been adapted for use in non-English speaking cultures, (Denmark, Japan, and China (Hong Kong and Shanghai)). The focus will be on the specific adaptations (clinical and cultural) clinicians and researchers have identified as necessary for program delivery in their specific cultural context, as well as some of the challenges and barriers that needed to be overcome to successfully implement NFPP.

To meet these aims, some of the adaptations that were made for parents and clinicians during the delivery of NFPP in different cultures are outlined below.

To provide a basis for considering the cultural dimension of the NFPP and how it can be adapted to work in different settings, we consider programme structure, targets for change and process methods addressing the following themes:

(1) What behavioral, cognitive and schematic adaptations need to take place in order to produce change in ADHD symptoms in different cultural settings?

(2) What ADHD-related behavioral, psychosocial and developmental theories underpin these adaptations?

(3) What factual and conceptual understandings need to be explained to parents in different settings and how does the NFPP's written and spoken content achieve this?

(4) What instructional and therapeutic techniques are needed to facilitate, operationalise and maintain these changes in the individual parent, child and family in different settings?

(5) What are the implications of such considerations for therapist training?

Adaptations with regard to training and supervision

NFPP therapists come from a variety of different social and professional training backgrounds. From our experience, professionals can be from different backgrounds, but it is advisable that they have extensive experience of working with parents and families and have enough child development knowledge to be able to assimilate the programme. Some professionals will be familiar with behavioral and social models, others with biological and genetic approaches and some will have a focus on attachment theory. However, the NFPP

program adopts a hybrid model of the role of the child, parent and wider family as influencing outcomes. This integrates; 1) the biological model-underpinning ADHD; 2) the psychodynamic model-highlighting the impact that ADHD has on the parent child relationship; 3) the notion of cognitive attributions of why their child behaves in the way they do; 4) behavioural theories that encourages self-regulation based on an implicit understanding of ADHD; and 5) family systems theory that hold that consistency is key to helping the child.

Adaption of NFPP with Danish therapists required additional assistance in understanding behavioral management and social learning theory; so that adaptations were made to the treatment manual to ensure that together with further explanation and practice during the experiential and supervisory sessions during training, therapists could fully adopt the principles of the intervention.

Adaption to supervision is especially important when the developers of the NFPP program are unable to understand the language in which the treatment is delivered. Methods needed to ensure programme fidelity are also paramount. This has been especially the case in Denmark, Hong Kong and Japan. The program has undergone translation and then back translation to ensure adherence to the principles and processes. Therapist training has always been provided in English; for supervisor training, supervisors in each county are encouraged to try to apply NFPP skills with English speaking parents first and access supervision about their application of NFPP skills with English speaking families to gain accreditation. Then supervision and extensive discussion occurred with regard to the cultural challenges associated with required adaptations. To date site visit supervision has

occurred in Denmark, Hong Kong and Japan and this is strongly encouraged. Table 1 describes other NFPP supervision challenges and how they have been overcome.

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Specific examples of culture specific implementations:

We now explore some of the challenges that have been identified during the process of adaptations for use in Denmark, Hong Kong, Japan and Mainland China.

NFPP in Denmark

NFPP was chosen as an ADHD treatment suitable for Denmark, due to its existing evidence base, but importantly also due to the relatively short treatment duration of 8 sessions, which contributes to the economic feasibility of the programme. Economic feasibility is a serious concern when implementing a new treatment into public clinical services, and is assumed to enhance the sustainability of the intervention, once the research study ends. In advance of the implementation of the intervention, it was decided to conduct a randomized trial with one main objective, i.e. to examine whether the NFPP could be implemented effectively as a treatment for preschool children with ADHD in routine specialised Danish Child and Adolescent Mental Health Services. (Lange et al., 2016). When we set out, the NFPP had not been tested in a European country outside the UK, and it was the first time the NFPP had been tested on children referred through established clinical pathways to tertiary child psychiatry services. It has been shown that there is a risk that interventions will lose impact and potency when implemented in everyday clinical settings (Barwick et al., 2005). Hence, it is emphasised that the transition of efficacious treatments has to be carefully planned and adapted to the clinical setting in which the treatment is being

implemented (Santucci et al. 2015). For these purposes, the NFPP programme was adjusted to fit the clinical and cultural context of Danish child and adolescent psychiatry services.

The original NFPP (Sonuga-Barke et al., 2001) was developed as a home based intervention. However, the catchment of Danish specialised CAMH services cover large geographical areas, which make home-visits time consuming, expensive and difficult to carry out. Second, specialised Danish CAMH services rarely, if ever, offer assessment and treatment in the home. To optimize the acceptability and deliverability of the NFPP in Danish CAMH services, changes to the delivery of the original program were made and the majority of the eight sessions were offered in the clinic in designated child and family friendly treatment rooms. Only two sessions, where the child is present, were offered in the home. The content of the NFPP manual remains otherwise unchanged. The NFPP manual, course materials, handouts, and a treatment DVD were translated from English into Danish by a professional translation agency. The original developers approved all corrections or changes to the original wording. A-ML trained as a NFPP therapist and a supervisor prior to the implementation of the trial in Danish CAMHS. A group of four therapists (1 nurse, 1 educator, and 2 psychologists) with considerable CAMHS experience (range 12-25 years) were recruited from the participating trial centres, who were then supervised by A-ML. A-ML, in turn, was supervised by the original developers of NFPP and co-authors of this paper, i.e. MT and CLB, through regular Skype-calls.

A number of interesting cultural differences became clear during the implementation of NFPP in Denmark. Firstly, the Danish therapists had very little training in behavioural methods, as behavioural therapy is not routinely taught during professional training in Denmark. Secondly, it is the impression that praise is simply not practiced by parents or

professionals as regularly as in Anglo-American cultures. For example, it is uncommon for adults to praise a child by exclaiming: 'Good boy'. NFPP highlights the importance of praise and **this issue** illustrates that an understanding of cultural parenting practices is important in the cultural implementation of interventions.

NFPP in Hong Kong

There have been many debates about how we should understand Chinese parenting.

Parents in Hong Kong are also widely exposed to the Western perceptions of parenting and with the Western perceptions of Chinese parenting. Depicting strict discipline and often neglecting the happiness of the children, the stereotype of the tiger mom represents an attempt to use American cultural beliefs of parenting as a baseline from which to make sense of Chinese parenting (Chua, 2011). However, there is in fact a wide range of beliefs, strategies and styles in Chinese parenting (Chen, Chen, & Zheng, 2012). Chinese parents may at times adopt strict discipline to train children to act in a socially acceptable manner. Chinese parents may assume the children will understand the connotation of trust and expectations behind the harsh language (Chan, Bowes, & Wyver, 2009).

This is important in terms of the possible characteristic of the broader Chinese culture in stressing the centrality of relationships between individuals as well as those between individual and society (Bond, 2010). While adopting the strengths of the original NFPP program, we also need to pay attention to the cultural context. Rather than just focusing on teaching parents to "praise" the child's positive behaviour, more work needs to be done in the Hong Kong context of how to help the parents to place positive connotation of the broader context of imbuing the child with values of mutual respect in relationships. **More**

importantly perhaps, the adequacy of praise in the Chinese culture also depends on how parents and children perceive parental authority, social compliance and behavioural control. Thus, the adequacy of praise would need to take account of these relating cultural factors. The challenge, therefore, would be to find ways of identifying and building upon culturally adequate and appropriate praising.

The NFPP was delivered in Hong Kong in a group format. When compared to Western parents, Chinese parents often exert more control over their children. Moreover, Chinese parents' parenting self-esteem is more contingent on academic performance. This may be related to the Chinese culture of interdependence in which parents are held responsible for their children's achievement and the individual's sense of worth is largely based on other's respect (Ng, Pomerantz & Deng, 2014). Chinese parents also tend to socialize their children to be compliant and self-regulated at an early age. Chinese parents expect their toddlers to exert a higher level of behavioural regulation than Western parents. When children fail to do so, Chinese parents also become relatively more concerned and dissatisfied (Chen & French, 2008). With globalization, Western values may be adopted, but Chinese values are still dominant. A pilot evaluation of NFPP has just been completed. We now discuss the cultural challenges of implementing NFPP in Hong Kong

Our Hong Kong Chinese parents have found the following components of NFPP to be most helpful. First, they valued the structure of NFPP; second, they appreciated the specific examples and instructions; third, they found the use of quiet time and time-out a very civilized and effective way of dealing with undesirable behaviours of their children. The therapist, however, found that they had to make considerable effort with the following aspects when leading the NFPP groups. First, praise was problematic with concerns that too

much praise would spoil the child. The therapists had to emphasise that praise should be given for specific behaviours. More importantly, parents had to be constantly reminded of the importance of giving positive attention to the child. Role-plays and practice in the group were of value for this. Second, some parents did not relate immediately to the importance of play. They thought they had come to learn strategies to discipline the child and play might upset this important agenda. Some parents said they did not know how to play games and did not have the time. Moreover, some parents thought play meant less time for homework. The therapists had to reinforce constantly the multiple benefits of play including its role in building social and cognitive skills. Third, parents were concerned about the execution of specific tasks like packing schoolbags, doing homework and finishing meals. Therapists found the need to incorporate these elements into practice and when reviewing diaries.

Fourth, parents were often much stressed. Therapists found it important to let parents talk about themselves to help them get in touch with their emotions to facilitate an understanding about how their own emotions could affect parenting. Some parents expressed great difficulty in controlling their own negative emotions and expressed concerns about the impact of their own experiences of parenting when they were children and the impact of these. Therapists gave extra time to discuss this and tried to relate this back to the principles of NFFP. Fifth, in explaining the principles of paying positive attention to the child, therapists often found it necessary to help parents get in touch with the emotional world of their child. Rather than just focusing on disciplining, parents were encouraged to engage in inter-personal perspective taking. Sixth, the majority of participating parents were mothers. There were concerns that fathers might have a

different perspective. Some discussion was needed on how to share what had been learnt in the group with spouses who had not attended.

NFPP in Japan

In Japan, like in Hong Kong, NFPP is being implemented as a group programme for mothers of children with ADHD. This format was selected in response to the stated preferences of mothers who participated in a focus group/pilot program and the shortage of specialists trained in the provision of evidence-based psychosocial treatments in Japan (Yamashita et al., 2010). Together with the NFPP developers, we have faced a number of challenges in adapting the programme for use in a Japanese context. These can be thought of as falling into three broad categories: language, parenting practices and expectations, and Japanese culture more broadly. We briefly review these challenges and our solutions to date. In translating and implementing NFPP in Japan, the lack of equivalent terms and language use in English and Japanese became clear. In Japanese punishment is a stronger/harsher construct than in English, while the term reward has several translations some of which are akin to gambling. In some instances, there are no words in Japanese that convey the same meaning as in English, for example the direct translation of the term respect has no place in the parent-child relationship, with respect being unidirectional towards those more senior. We have endeavoured to translate the important constructs of the NFPP, rather than relying on direct translation. Additional time is given to explaining the ideas presented to parents together with the use of multiple examples to ensure understanding.

Parental expectations and strategies for managing behaviour differ in Japan compared to Western countries. Japanese culture values sensitivity to interpersonal cues and self-

monitoring (Davis et al. 2012). Praise is used sparsely to avoid complacency while the use of criticism to promote self-improvement is a normative expectation (Heine et al, 2001). In introducing the NFPP to Japanese mothers, additional time is required to explain, demonstrate and practice new approaches, in particular the importance of using praise (see Matsumoto et al. 2007), but also less familiar strategies including the use of quiet time and time out, modulating tone of voice when upset, and the use of pronouns, e.g., we and us. Communication skills training has been introduced to enhance parent-child communication and to assist mothers in communicating the NFPP skills to other family members. This has been especially important in families where grandparents share caregiving duties and mothers and fathers differ in their perception of the child's difficulties. Education on the nature of ADHD is critical; highlighting that failure to follow societal rules is not deliberate.

We have observed amongst Japanese mothers participating in NFPP a strong desire for certainty regarding how and when to apply the skills taught coupled with a lack of confidence in their ability to use the skills outside of the programme. The leaders are seen as experts with participants expecting solutions to all parenting difficulties that might arise. To manage this discomfort with ambiguity while maintaining engagement with the programme, NFPP skills are taught in a linear fashion rather than concurrently, with a more didactic approach. The use of in-session role-play has been increased and we have introduced a session on problem solving to provide a framework and encouragement to mothers to develop their own problem solutions.

Mental health continues to be a taboo subject in Japan, reducing the personal support available to mothers of children with ADHD. Running NFPP as a group programme provides

a supportive network for, sometimes, otherwise isolated mothers. Some mothers report the program provides a first opportunity for them to open up to others about their difficulties. This may help explain the stated preference for a **group for** mothers only. We address the stigma of ADHD through increased psycho-education and the introduction of a session on cognitive restructuring to help mothers appreciate how their thoughts **influenced** their emotions and behaviours. Attitudes toward mental health in Japan also contribute to difficulties in recruiting families to our research studies, with greater success through word of mouth than more traditional approaches.

As a culture, Japanese value harmony. This adds to the difficulties of those parenting children with ADHD, whose behaviour often does not conform to expected standards. It also **affects** the dynamics of the parenting groups and the willingness of participants to provide honest feedback to group leaders. Participants do not wish to offend the group leaders or other participants and are cautious about talking in the group so as not to “waste” the time of other group members. Our group leaders give explicit permission for participants to disagree and actively encourage the involvement of hesitant participants.

In adapting the NFPP for use with Japanese families in Japan, the six session group-based NFPP (Laver-Bradbury & Thompson, 2013) has been front loaded with five additional sessions designed to increase mothers understanding of ADHD and address their psychological well-being and readiness to participate in the NFPP program (e.g., Treacy et al. 2005). These extra sessions include further psycho-education about ADHD, stress management training (also a problem highlighted by parents in Hong Kong), cognitive restructuring, and teaching of effective communication and problem solving skills. An initial proof of concept study using a simple before and after design indicates a positive response

in Japanese mothers to the modified NFPP (Shimabukuro et al., in press). In our ongoing randomized control trial, the content of the six session NFPP sessions has been extended over 8 sessions to accommodate the need for additional explanations and practice.

NFPP in China

A number of barriers limit the availability of therapist-led parenting interventions for ADHD in mainland China. Firstly, access may be dependent on referral to secondary or tertiary services, which often have long waiting lists (Prinz & Sanders, 2007); during this time, behavioural problems may escalate (Enebrink et al., 2012). Once intervention is offered, parental adherence to treatment is often problematic. In a parenting programme focused on prevention of conduct problems, the average attendance rate was approximately 60% (Baker et al., 2011). To this end, there is growing interest in the development of self-help (SH) parenting interventions, which provide parents with the materials necessary to teach behavioural strategies to themselves, at home and at a time most convenient to them. Several studies have demonstrated the efficacy of self-help. The self-help version of NFPP (Laver-Bradbury et al (2010) contains the majority of the same strategies as the therapist led (individual and group) versions of the intervention, with the exception of video modelling.

A pilot trial of a self-help intervention for parents of children with ADHD based on the New Forest Parenting Programme (Daley & O'Brien 2013) showed that self-help intervention reduced parent's ratings of their child's ADHD symptoms, and enhanced parenting self-esteem, but did not significantly alter objective measures of ADHD. A second trial of NFPP self-help (NFPP-SH) is currently underway in Shanghai. To enhance the impact of

intervention the self-help programme has been augmented with minimal telephone therapist support in the form of six 15-minute telephone calls to families to ensure they have understood and are able to implement the strategies from the self-help programme. To enhance the cultural suitability of the intervention both parents and grandparents are being specifically targeted in the intervention. Most parents in Shanghai need to work long hours so Chinese children spend the majority of their day being cared for by their grandparents.

Psychological interventions for ADHD are highly valued in China, in part because parents are very concerned about the impact of ADHD on their child's future education (as in Hong Kong), but also because medication use for ADHD is often considered inappropriate by Chinese parents. This means that Chinese parents are often considerably more motivated than western parents **are**, to acquire new strategies to help modify their child's environment and alter their symptoms expression.

There have been some considerable challenges to overcome in implementing the self-help intervention in China. Close attention to detail and forward and backward translation have been necessary to ensure a high quality Mandarin version of the self-help intervention was created. Training of the therapists and the creation of scripts for the brief telephone support has helped to structure and unify the additional telephone support component. The self-help intervention has been well received by parents and grandparents in Shanghai, who in particular appreciate the expert psychoeducational component, as well as the focus on strategies to enhance the use of eye contact as well as strategies to enhance children's understanding of time.

However, there are also potential barriers to the efficacy of self-help intervention for ADHD. For example, despite the possible positive benefits of self-help intervention, parents of children with ADHD in Shanghai consider the intervention insufficient for their child's needs. As a low intensity intervention, it may not appear to impact sufficiently on attentional control or behavior at school to remedy parental concerns about their child's future development. One potential explanation for this may be the need to use grandparents as a mediator of change to alter their grandchild's environment. Evidence from our study in Shanghai suggests that while parents of children with ADHD were willing to take onboard and implement the behavioral strategies included in NFPP-SH, grandparents whose views of parenting were more conservative found it more difficult to understand and implement the strategies. This may limit the potential of self-help interventions within a Chinese context and may indicate that a therapist led intervention is required to help Chinese grandparents to understand, tailor and implement strategies needed to help alter the developmental trajectory of their grandchild with ADHD.

Conclusions and lessons learned

The NFPP programme is a manualized intervention with a clear training structure and ordering that nurtures therapists while they gain experience and confidence in delivering the intervention. Unlike some other interventions for ADHD, NFPP **can be tailored to the needs of the parent. Thus the programme can be** flexible both in terms of the order in which strategies can be delivered, but also in terms of additional pull out components that can be introduced on the basis of the needs of either the parent or child **(McEwan et al, 2015)**. The intervention has evolved over time in response to the results of evaluations of

the intervention, feedback from therapists who have been trained and understanding of the programme developers about both the strengths and limitations of the original intervention. These incremental improvements have helped to support the implementation of NFPP **into** other cultures.

The above accounts highlight a number of common themes that need to be achieved for successful adaptation of NFPP for use in different cultures.

Accurate translation of manuals to produce conceptual equivalence is the first step. The starting point for successful implementation of an intervention in another cultural setting is high quality translation and back translation of the training manuals. In doing so, great attention needs to be paid to ensure the translation is accurate and culturally appropriate and the key therapeutic concepts survive from one language to another. When similar words or phrases do not exist, additional content or examples need to be inserted into training materials to ensure the translated version contains similar content and **conveys** the same messages as the original documents. Consultation with the programme developers and brain storming alternative solutions when similar words are not available in another language is crucial for the successful translation of materials.

Culturally appropriate training and supervision come next. Access to high quality training for NFPP that includes time to discuss the potential need for cultural adaptations is also important. Where possible the training should take place in the cultural setting the intervention is being implemented in as this allows the trainers to appreciate and understand the cultural challenges that may **influence** successful implementation. Identification and discussion of therapists' core competencies is also relevant so that

training can be tailored to compensate for any lack of skills or understanding among staff being trained.

Consideration of the cultural appropriateness of NFPP strategies and modes of delivery is the third step. It is important to implement the NFPP in a culturally appropriate way. In terms of its mode of delivery, NFPP has proven flexibility - implementable in both the clinic and home setting in Denmark; as a group based intervention in Japan and Hong Kong; and as a self-help intervention in Shanghai. The cultural acceptability of key NFPP strategies is often challenging but a key issue to overcome. The challenge is to identify strategies that are acceptable in the UK, but may not be easily understood, accepted or implemented by parents in other cultures. The starting point to finding solutions to this begins during the training phase with a discussion of cultural challenges, continues into supervision as therapists adapt explanations and examples to overcome cultural challenges, and bring challenges and potential solutions to the supervisory process, while always seeking to bring examples and additional explanations back to the core NFPP strategies.

A real focus on the needs of parents in different cultures is vital: Cultural expectations (Trommsdorff, 2012), the perceived responsibilities of parents and stigma associated with mental health (Chronis et al. 2007 ;Sonuga-Barke et al ,2002) make it imperative to consider the needs of parents when implementing NFPP into other cultures. As the intervention uses the parents as agents of change to help address their child's difficulties, also considering the needs and the background of the parents is very important (Byng-Hall, 1985; Trommsdorff, 2012). A key example of this would be the creation of NFPP-J, which front-loads the NFPP programme with five additional sessions, which aim to support mothers of

children with ADHD before they engage with NFPP; these sessions target mothers' psychological well-being and support engagement with NFPP.

It is important to consider wider systemic issues: The NFPP is usually delivered to one parent with support provided by therapists in how to share the information and strategies with other adults who play an important role in their child's life (spouses, grandparents etc.) (Sonuga-Barke et al, 2001; Thompson et al, 2009). Parents in Hong Kong, for example, struggled to understand the value of play, and additional support was required from therapists so that parents attending the group were confident in understanding the value of play and be able to share their understanding with spouses and grandparents (Chen et al. 2009; Chan et al, 2012). The Implementation of NFPP self-help in Shanghai highlighted how grandparents in particular found it more difficult to overcome their more conservative approaches to parenting, which were barriers to understanding and implementing NFPP strategies.

In summary, the NFPP is an evidenced based-intervention that continues to evolve and be adapted to the needs of different parents with ADHD children across the globe. This UK intervention has been implemented into other diverse cultural settings with careful consideration of the translation of materials, sensitive training of therapists; of cultural challenges during training and supervision; and of the cultural suitability of strategies and the impact of culture on parents and systemic issues.

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Table 1: The issues that have risen during the implementation of NFPP into other cultures, how the issues were discussed in supervision and the resulting changes in the delivery of the intervention.

Training	Delivery	Supervision	Cultural
Background of therapists – their ‘model’ of understanding ADHD and ability to integrate models of the NFPP delivery. (biological, psychodynamic, cognitive, behavioural and systemic)	Different delivery options 8 week, 12 week, group, self-help and on line (new). Flexibility in approach e.g. shorter sessions more frequently	Encouraging a culture of curiosity and openness, not right or wrong, but clarity in why something was done and what adaptations were necessary during the sessions with parents and how to progress with the program.	General cultural adaptations – language, understanding, hierarchy and power concepts as well as familiarity with UK concepts and models Recruitment and motivation.
Experience and knowledge of therapists	Understanding the likely familial relatedness of the families, when they are working with the parents, who themselves may have ADHD- Flexibility in approach e.g. shorter sessions more frequently	Scaffolding the clinicians with whom you are working - what is their zone of proximal development; how open are they to viewing what they are doing	What are the underlying cultural expectations of children and families and the services involved in treating children with ADHD
Understanding the process of the program and the experience of this for each family	Keeping to task in complex family situations and weaving the strategies into real life situations for the parents	Re-emphasis on points each clinician finds challenging in a supportive way. Positive reinforcement of the work they are doing well	Educational expectations of the program and its delivery
Experiencing the concepts within the program and becoming familiar with them	Adapting and emphasizing areas that are relevant to the child they are working with, based on their observations of the child	Commitment to supervision emphasized and agreed. Shared experiences with others being supervised and ideas to motivate parents	NFPP, not just a behavioral program, it looks at the parent child dyad as well as the family as a system. It works with above –and considers how acceptable is this in different cultures and the ability of the parents discuss this

<p>Ability to adapt the program to meet the needs of the family they are working with</p>	<p>Videoing sessions and reviewing these to help them in the delivery</p>	<p>Supervision agreement set up with clear objectives outlined</p>	<p>Again, NFPP looks at the system supporting the child with ADHD. This includes the Parental relationship, the parents own experience of being parented and their experience of parenting this child</p>
<p>Working with two manuals: one containing the principles and the other with week by week tasks</p>	<p>Managing issues that impact on the delivery, parental illness, unexpected events</p>	<p>Technical issues - Watching DVDs: the secure transfer of data. Giving feedback When working across time zones e.g. UK time versus Japan, USA, HK and Denmark</p>	<p>Cultural difference regarding the strategies e.g. praise eye contact, respect, parental engagement, use of games, interpretation of time out.</p>