CHAPTER 1

INTRODUCTION

1.1 Background

A successful experience in preschool period may contribute to a solid foundation for cognitive, emotional and social development throughout adolescence and adulthood (Head, 2007). According to National Education Act 550, the schooling for preschool children in Malaysia begins earlier from four to six years old in kindergarten (Laws of Malaysia, 1996). In Malaysia, preschool education usually last for two years before children proceed to the primary school at age seven. The behavioural issues during preschool can limit and diminish academic and social abilities in children that may last throughout adulthood. A disruptive behaviour problem in preschool children is one of the most salient behavioural issues in child mental health (Shaw, Dishion, Supplee, Gardner, & Arnds, 2006). Disruptive behaviour in early childhood refers to a cluster of externalising behaviour such as noncompliance, aggression, destructive behaviour (Keane & Calkins, 2004). One of the most common types of disruptive behaviour disorder is Attention Deficit Hyperactivity Disorder (ADHD) that can continue through adolescence and adulthood (American Academy of Pediatrics (AAP) (2013).

The Diagnostic and Statistical Manual, Fifth Edition (DSM-5) categories ADHD into three-presentation: ADHD-Hyperactive-Impulsive (ADHD-HI), ADHD-Inattentive (ADHD-I), and ADHD-Combined (ADHD-C) (American Psychiatric

Association (APA), 2013). The Table 1.1 shows the criteria for ADHD based on DSM-5.

Table 1.1: DSM-5 Criteria for ADHD

1. Either A or B Six or more symptoms persisting for at least 6 months to a degree that is maladaptive and inconsistent with developmental level	
A. Inattention	**B. Hyperactivity-Impulsivity**
• Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	**Hyperactivity**
• Often has difficulty sustaining attention in tasks or play activities	• Often fidgets with hands or feet or squirms in seat
• Often does not seem to listen when spoken to directly	• Often leaves seat in classroom or in other situations where remaining seated is expected
• Often does not follow through on instructions; fails to finish schoolwork, chores or workplace duties (not due to oppositional behaviour or failure to understand instructions)	• Often runs or climbs excessively where inappropriate (feelings of restlessness in young people or adults)
• Often has difficulty organising tasks and activities	• Often has difficulty playing or engaging in leisure activities quietly
• Often avoids, dislikes, or is reluctant to do tasks requiring sustained mental effort	• Is often on the go or often acts as if 'driven by a motor
• Often loses things necessary for tasks or activities	• Often talks excessively
• Is often easily distracted by extraneous stimuli	**Impulsivity**
• Is often forgetful in daily activities	• Often blurts out answers before questions have been completed
	• Often has difficulty awaiting turn
	• Often interrupts or intrudes on others (for example, butts into conversations or games)
2. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 12 years.	
3. Some impairment from symptoms is present in two or more settings (for example, at school or work and at home).	
4. There must be clear evidence of significant impairment in social, school or work functioning.	
5. The symptoms do not happen only during the course of a pervasive developmental disorder, schizophrenia or other psychotic disorder. The symptoms are not better accounted for by another mental disorder (for example, mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).	

Source: DSM-5 (APA, 2013)

The ADHD diagnosis should be made cautiously for children younger than six years of age. Based on DSM-5, at least five criteria must be exhibited by an individual in order to be diagnosed with ADHD symptoms: (i) persistent pattern of inattention or hyperactivity or impulsivity that more frequent and severe than others of same age or developmental level, (ii) symptoms present before the age of 12, (iii) symptoms present in two or more than one setting, (iv) symptoms cause problem in academic, social, school or work settings, and (v) the rule out that other psychological disorders are causing symptoms. Children with ADHD-HI expressing hyperactivity commonly unable to stay in seat or play nicely, act as if driven by a motor, and will appear fidgety, whereas children displaying impulsivity often unable to participate in tasks that require taking turns. Usually, children with ADHD-I show mainly inattentive symptoms and fewer hyperactive symptoms. The inattention affects the educational experience because ADHD causes these children to have difficulty in sustaining attention for the duration of the task, misplacing needed items and attending to detail in directions. These children often avoid the tasks that need to sustain mental effort, make careless mistakes, and fail to give close attention to details. Children with ADHD-C tend to show both hyperactivity-impulsivity and inattention (APA, 2013).

All children can be impulsive, defiance and naughty from time to time, which is actually normal. However, some children have extremely challenging behaviours that are beyond the norm of their children age. In clinical practice, behavioural problems among ADHD children are considered as a cause of their ADHD symptoms. The main feature of ADHD is a persistent pattern of hyperactivity, impulsivity or inattention that is more frequently displayed and more severe than is typically

observed in individuals at a comparable level of development. According to AAP (2013), the disruptive behaviour disorders can closely resemble ADHD, particularly where impulsivity and hyperactivity are involved. It is about one third of all children with ADHD have coexisting Oppositional Defiant Disorder (ODD), and up to one quarter have coexisting Conduct Disorder (CD). ADHD children with comorbid ODD or CD are associated with delinquency, increased in social maladjustment, risk of substance abuse, lower self-esteem, aggressiveness, and academic under achievement (Waschbusch, Pelham, Jenning, Greiner, Tarter & Moss, 2002) and antisocial behaviour disorder in adulthood (Katragadda & Schubiner, 2007).

ADHD is classified under learning disabilities in Malaysia education system (Ministry of Health, 2013). The screening and diagnostic procedures used in identifying children with ADHD are based on the criteria and guidelines as determined in DSM-5. Legally, the procedure is done by a clinical psychologist or medical professional and endorsed by medical practitioners who are specialised in ADHD. Screening for hyperactivity and inattentiveness (the hallmark symptoms of ADHD) in a community survey among Malaysian children and adolescents between ages of five to 15 years showed prevalence rate of 3.9% (Toh, Ding & Peng, 2006). The prevalence of attention problems and academic under achievement among children are often a result of having ADHD. This condition is reported to be around 9% to 12.5% of Malaysian children aged four to eight years old (Teoh & Kasmini, 2000). Teoh and Kasmini (2000) reported that the prevalence of behaviour problems in children is ranges between 3.3% for aggression to 30.9% for somatic complaints.

Addressing behaviour problems among preschool children with ADHD is important because disruptive behaviours appear to reach their peak levels by the time

children enter the primary school. Parents often need relevant information about positive parenting techniques, support groups at school or in community to understand appropriate expectations for behaviour and school works in their affected child. The Ministry of Women, Family and Community Development (MWFCD) (2013) stated that counselling interventions such as family counselling, psychological assessment, psycho-education programme and behavioural parent training can lead to decrease disruptive behaviour in ADHD children. The combination of these counselling interventions is helpful in teaching parents to improve their parent-child interaction and behaviour management in order to reduce the child disruptive behaviour (Danforth, Harvey, Ulaszek, & McKee, 2006).

1.2 The Prevalence of ADHD among Children in Malaysia

The Ministry of Health (2013) under Family Health Development Division collated the statistics on the number of children with disabilities through registration data compiled from hospitals and health clinics. However, the data is not conclusive as it is dependent on the child's disability being apparent or manifesting during a medical examination. Children with mild or non-apparent disabilities are unlikely to be identified and registered as such. The Table 1.2 shows a tabulation of the number of children and teenagers below than 18 years old with special needs detected and registered in the registration database of Ministry of Health in 2012. The special needs include hearing impairment, visual impairment, physical disabilities, cerebral palsy, late development, Down syndrome, autism, ADHD, mental disabilities and other specific learning disabilities.

Table 1.2: Detected and Registered Special Needs Cases among Children and Teenagers in Malaysia in 2011 & 2012

Year 2011

Age Group(Yrs)	HI	VI	PD	CP	LD	DS	A	**ADHD**	MD	SLD	SL	O	Total
0 - < 1	2	10	44	25	58	220	-	**-**	-	-	-	75	434
1-2	13	7	47	61	155	78	9	**4**	2	5	4	79	464
3-4	12	5	13	31	44	34	37	**11**	7	11	5	60	270
5-6	18	2	11	24	20	18	43	**24**	19	32	30	36	275
7-12	15	7	20	18	16	19	26	**45**	71	168	213	54	671
13-18	15	2	8	11	5	6	2	**3**	19	19	29	7	125
Total	73	27	143	170	298	375	117	**87**	118	235	281	311	2239

Year 2012

Age Group(Yrs)	HI	VI	PD	CP	LD	DS	A	**ADHD**	MD	SLD	SL	O	Total
0 - < 1	4	12	57	44	96	274	-	**-**	-	-	-	135	622
1-2	13	14	37	59	169	102	14	**7**	-	12	8	62	497
3-4	21	4	20	43	93	26	54	**14**	2	14	13	49	353
5-6	9	10	11	30	21	24	58	**28**	6	59	38	37	321
7-12	17	7	31	36	16	26	133	**43**	9	251	205	47	771
13-18	5	8	10	13	5	18	11	**4**	50	50	44	14	202
Total	69	55	166	215	400	470	170	**96**	87	386	308	344	2766

Source: Family Health Development Division, Ministry of Health (2013)

Note:

HI: Hearing Impairment
VI: Visual Impairment
PD: Physical Disabilities
CP: Cerebral Palsy
LD: Late Development
DS: Down syndrome
A: Autism
ADHD: Attention Deficit Hyperactivity Disorder
MD: Mental Disabilities
SLD: Specific Learning Difficulties
SL: Slow Learner
O: Others
Yrs: Years

Based on the Table 1.2, it has been found that the detected and registered cases with Ministry of Health involving ADHD in year 2012 (96) have been increased 9% if compared to year 2011 (87) for children with different categories of age. In Malaysia, clinician reported that based on the sample of admission to a child psychiatric unit, the prevalence of children diagnosed with ADHD were 25% cases (Toh, Ding, Peng, Maniam, Lim, Abdullah & Sararaks, 1997). ADHD is characterised by three core behaviours, hyperactivity, impulsivity and inattentive which are at inappropriate level. Among Malaysian preschool children, hyperactivity and inattentive symptoms are the most common. These children are observed to be hyperactive, unable to sit in a classroom setting, always on the move, frequently lost in public places, and unable to focused or pay attention in tasks, and unable to learn and understand mental tasks or activities (Muhammad, Wan Ismail, Tan, Jaffar, Sharip & Omar, 2011).

Some of the studies conducted in Malaysia in a relation to ADHD among children in Malaysia (Burns, Walsh, Gomez, & Hafetz, 2006; Gomez & Hafetz, 2011; Narkunam, Aili Hanim, Sachdev, Pillai & Ng, 2012; Supiah, 2003). A study conducted by Burns et al. (2006) was to examine whether the symptoms of ADHD exhibited in Malaysian preschool children *(n=528)* were demographically similar to those found in preschool children American paediatric sample (*n=1,015*). The finding concluded that the prevalence of ADHD symptoms was high in boys than girls. In understanding the most influential type of ADHD among children in Malaysia, Gomez and Hafetz (2011) conducted a study among parents and teachers on their agreement for ratings of their children on a scale comprising the DSM, Fourth, Text Revision (DSM-IV-TR) for ADHD symptoms. The findings indicated that the most prevalence type of ADHD was the inattentive and the prevalence rated showed boys were more

likely to develop ADHD than girls. Another study conducted by Supiah (2003) to identify whether the impact of ADHD symptoms in relation to classroom events in inclusive setting. This study suggested that an inclusive education for preschool pupils with ADHD should be provided with well-trained teachers and action research should be carried out for better understanding the appropriate provision for pupils with ADHD in inclusive settings. A study conducted by Narkunam, Aili, Sachdev, Pillai and Ng (2012) to examine the impact of children with ADHD on their parents among 95 parents with children diagnosed as having the symptoms of ADHD. Their parenting stress was assessed using the Parent Stress Index. The findings of this study concluded that the stressed parents acknowledged that having a child with ADHD was their biggest worry and concern. Therefore, it is particularly important to address ADHD in a very beginning of early childhood which can start with preschool children.

1.3 Screening ADHD in Children

The early identification and intervention are the most efficient and effective methods for addressing child behaviour problems. The ADHD screening is important for high-risk children which allows for further assessment, evaluation, and referral for appropriate psychological and counselling treatment (Holmberg, Sundelin, & Hjern, 2013). Thus, affected children can be detected and received early intervention services before the problems become severe. In screening and diagnosing the symptoms of ADHD, the clinician will perform a detailed interview with the parents about each of the symptoms based on DSM-5 in term of its severity, duration, and frequency. There are 18 symptoms covering inattention (nine symptoms) and hyperactivity or impulsivity (nine symptoms), and three presentations of ADHD: ADHD-C (at least six

inattention and six hyperactivity or impulsivity symptoms), ADHD-I (at least six inattention symptoms), and ADHD-HI (at least six hyperactivity or impulsivity symptoms). According to American Academy of Child and Adolescent Psychiatry (AACAP) (2007), children with ADHD have learning impairment, and usually the child's interview session will be conducted concurrently with the parent's interview, and the child must be at least five years old. This interview allows the clinician to review the patient's intellectual progress, and look for learning disorder symptoms.

For an accurate diagnosis, children must have difficulties in at least two settings, such as at home and at school, and the symptoms must be impairing their daily functioning (APA, 2013). The best way to find out whether or not the child has ADHD is to have the child evaluated by paediatrician, psychiatrist, psychologist, or neurologist who is familiar with ADHD. The general physician is the first port of call if ADHD is suspected. Then, he or she may refer the child to child psychiatrist who specialises in children's mental health, specialist paediatrician who specialises in children's illnesses or clinical psychologist who specialises in children's behaviour. The most important is that a screening data must be referred to the practitioners in the areas of DSM-5 and they must be certified as the expert in ADHD. This is to get a firm ADHD diagnosis (Counselling Directory, 2014) before the child get an appropriate treatment.

1.4 The Psycho-stimulant Medical Treatment in Children with ADHD

The most common treatment for ADHD is medication (Faber, 2013; Karen, 2011). The primary drug used to treat ADHD is a psycho-stimulant which is known as

Methylphenidate and Dexmethylphenidate. These two drugs stimulate the central nervous system and have a calming effect on people with ADHD. Methylphenidate drugs (Ritalin, Metadate, Concerta, Daytrana) and Dexmethylphenidate (Focalin) are the most commonly used for treating ADHD in children and adults. These drugs increase dopamine, a neurotransmitter that is important for cognitive functions such as focus and attention. For children, the Methylphenidate (Ritalin brand) is the most commonly prescribed medication to treat their ADHD symptoms. This psycho-stimulant acts by reducing the core symptoms of inattention, hyperactivity, and impulsivity and has a good effect on aggression, conduct problems, academic performance, executive functioning and social skills (Faber, 2013).

Despite the efficacy of psycho-stimulant medication in improving behaviours in ADHD children, many of them who receive the treatment do not demonstrate fully normal behaviour. For example, Methylphenidate does not help to reduce the problematic behaviours in affected children. However, it does increase the probability of the child to display behaviours that are already in their repertoire (Jadad, Boyle, Cunningham, Kim, & Schachar, 1999). For some ADHD children, they may be intolerant to the effects of psycho-stimulant medication (Safren, Otto, Sprich, Winett, Wilens, & Biederman, 2005). Furthermore, the questions over the long-term effects are raised. Some studies indicated that the psycho-stimulant medication is state-dependent-effects that only last for as long as the person is receiving the medication. Then, the improvement is not maintained for the longer term because it may not generalise to situation in which the treatment is absence (Cortese, Holtmann, Banaschewski, Buitelaar, Coghill, Danckaerts, Dittmann, Graham, Taylor, & Sergeant, 2013; Kraemer, Uekermann, Wiltfang, & Kis, 2010).

According to National Institute for Health and Clinical Excellence (NIHCE) (2008), for preschool children, the psycho-stimulant medication is not recommended as the long-term effects for this age group are not known. A study conducted by National Institute of Mental Health (NIMH) (2006) found that low doses of Methylphenidate (Ritalin brand) are safe and effective to treat ADHD symptoms in children. However, the study also found that very young children are more sensitive to the psycho-stimulant effects than the older children. Furthermore, Food and Drug Administration (FDA) does not approve the psycho-stimulant used as the treatment for children less than six years. Thus, for this age group of children, a good treatment is the inclusion of counselling intervention (Hoffman, 2009; Portie-Bethke, Hill & Bethke, 2009) such as behavioural therapy can be effective in the long-term reduction of core ADHD symptoms (British Psychological Society, 2009). Research conducted by Fabiano, Pelham, Coles, Gnagy, Chronis, and O'Connor (2009) found that medication if utilised it as the only form of treatment, it has not been shown to produce positive and long-term outcomes for children with ADHD.

1.5 Counselling Intervention in Treating ADHD Children

In Malaysia, only the children with severe hyperactivity or behaviour problems are included in special education programmes, either they are studying in special schools or integrated special programmes in regular schools (Supiah & Lindsay, 2010). The treatments for ADHD children and their families basically involved a combination of medication and working with the parents to understand, support and help them to handle their child, social skills and focus training (Lee & Aili, 2007). In Malaysia, a study conducted by Aili, Norharlina, Manveen and Wan Salwina (2015) in one young

girl age 12 who diagnosed with ADHD symptoms. Her behavioural problem (hyperactive) has been treated with psycho-stimulant medication and her mother has involved in parenting skills. The girl's behaviour has been improved, but, there is no specific type of parent training programme has been mentioned by the therapists in their study. A study conducted by Noor Azimah, Wan Salwina, Tan, Aida, Shalisah and Khairani (2011) in one boy who diagnosed with the symptoms of ADHD. He was treated using the Methylphenidate and supported with parental counselling and training. Similar to the study conducted by Aili et al. (2015), there was some improvement in the child's behaviour problems. However, Noor Azimah et al. (2011) were not mention the specific application of parent training used to treat the affected child. A study conducted by Marziyeh and Khaidzir (2009) using Filial therapy in one preschool child aged 5-year old who has been diagnosed with the symptoms of ADHD included tantrums, anger, moodiness, poor peer-relationships, and manipulative and crying behaviours. The outcomes revealed that filial therapy has the potentiality in enhancing and rebuilding parent-child relationships through teaching parent the skills necessary for coping with the childhood problem behaviours.

Moreover, according to MFWCD (2013), parent training is one of the counselling intervention programmes that teach parents how to manage ADHD children. Through these interventions, parents are able to learn the parenting skills and the affected children are also able to learn appropriate behaviour skills to overcome their behavioural impairments. In a relation to parent training programmes, treating ADHD children has been addressed for several decades (Bowley & Walther, 1992; Schwiebert, Sealander, & Tollerud, 1995) and more recent success seen by including the counselling interventions such as behavioural therapy (Counselling Directory,

2014; Hoffman, 2009; Schottelkorb & Ray, 2009) and play therapy (Portrie-Bethke et al. 2009; Marziyeh & Khaidzir (2009). These suggested that professional counsellors can assist ADHD children with their families through a variety of counselling interventions. Furthermore, researches in counselling children with ADHD also suggested that action-oriented approaches such as play therapy (Portrie-Bethke et al. 2009; Marziyeh & Khaidzir (2009) and behavioural therapy (Hoffman, 2009) are effective in working with young children with ADHD.

Historically, in the 1960s, parent training originated based on play therapy and behavioural learning theory (Scott, 2002). The main goals of parent training are to teach the principles of child behaviour management, increase parental competence and confidence in raising children and to improve the parent-child relationship by using good communication and positive attention to aid the child's development (Eyberg, 2005). According to National Resource Centre on AD/HD (NRCA) (2004), the scientific literatures of the National Institute of Mental Health (NIMH) agree that early interventions beyond the talking therapy may helpful in demonstrating their effectiveness in treating ADHD children. These children encounter problems in their daily life that go beyond their symptoms of hyperactivity, impulsivity, and inattentiveness, such as poor relationships with parents, sibling or peers, poor learning performance and behaviour at school, and failure to follow adult commands. The useful counselling interventions that can reduce the symptoms of disruptive behaviour in ADHD children must be identified. Working with teachers, parents and children should be integrated to yield the best outcomes; however, teaching parents in dealing with their ADHD children is more effective way (Fabiano et al, 2009).

In addition, Parent-Child Interaction Therapy (PCIT) is one of the behavioural parent training programmes that can be applied by affected parents with ADHD children. The objective of PCIT intervention is to focus on enhancing the relationship between parent and child and reducing behaviour problems among ADHD children (Eyberg & Funderburk, 2011). According to Dawson and Ashman (2000), early relationships between parents and children have powerful impacts on children's behaviour and emotional development. When parents are responsive and sensitive to child's cues, they contribute to the coordinated back and forth of interaction with the child. This kind of interaction helps children develop self-sense and emotional regulation skills such as self-control and self-calming (Tronick & Beeghly, 2011). Furthermore, in order to help young children to develop lifelong motivation in their self, parents are encourage to participate in everyday learning and playing activities (Dunst, Bruder, Trivette & Hamby, 2006). Therefore, this study interested to investigate the intervention effect of PCIT in helping parents to cope with their ADHD children with disruptive behaviour problems.

1.6 Parent-Child Interaction Therapy (PCIT)

The PCIT is an empirically-supported treatment for conduct-disordered for young children aged two to seven that highlights on improving the quality of the relationship between parents and child and changing inappropriate pattern of parent-child interaction (Servaty-Seib, 2009). It is originally developed by Eyberg (1998). Parent training for children with behavioural problems has historically involved enhancement approaches on parent-child relationship (Guerney, 1964) and behavioural approaches (Patterson, 1994). The PCIT is based on Two-Stage Treatment Model developed by

Hanf (1969) which integrates the parent training and behavioural approaches. Moreover, the PCIT consists both of behavioural parenting training and family counselling (Canadian Mental Health Association (CMHA), 2012). Behavioural parenting training teaches parents how to cope and guide the ADHD child. The training involves learning how to understand the main problem situations, solve problems, enforce rules and give constructive feedback. Family counselling helps family members to learn how to deal with disruptive behaviour and encourage positive behaviour in affected children (CMHA, 2012). Therefore, PCIT progresses through two distinct phases: (i) Child-Directed Interaction (CDI), and (ii) Parent-Directed Interaction (PDI) to help parents to cope with their ADHD child.

The CDI is similar to play therapy in which parents engage with their child in a play situation with the goal of strengthening the parent-child relationship. It also emphasises PDI which empowers the parent with behaviour techniques through a therapeutic model (Eyberg & Funderburk, 2011). In PDI phase, parents learn to use specific behaviour management techniques as they play with their child (Eyberg & Funderburk, 2011). During PCIT, therapists coach parents while they interact with their child, teach them the strategies that will promote positive behaviours in children. As a result of PCIT, researches have shown that parents gained more effective parenting skills, improved in parent-child relationship and decreased in behaviour problems among affected children (Bagner & Eyberg, 2007; Eyberg & Funderburk, 2011).

One of the researches has shown empirical support for the application of PCIT for families of children with ADHD. Bagner and Eyberg (2007) conducted PCIT to treat disruptive behaviours of children ages three to six years old with mental

retardation and comorbid ODD. There were 30 female primary caregivers and their children were randomly assigned to an Immediate-Treatment (IT) or Wait-List (WL) control group. Caregivers reported that PCIT helped to decrease disruptive behaviours in their children at home, reduce the parenting stress, increase positive interaction between parents and their children, and children were more compliance. The PCIT is a form of counselling intervention for parent training as a way to treat young children with serious behavioural problems that have been used for many years and have been found to be very effective. The PCIT used a unique combination of counselling elements of play therapy and behavioural therapy to address many child behaviour problems effectively (Counselling Directory, 2014).

1.6.1 Play Therapy

Play therapy has long been used as one of the therapy tools to treat children with behaviour problems such as ADHD (Kingsley & Mailloux, 2013). Play therapy is a child-centred, in which play is the primary medium and speech is the secondary medium. The British Association for Play Therapist (2009) has defined play therapy as the dynamic process between child and trained counsellor in which the child explores at his or her own pace. In addition, the therapists who are among child psychiatrists, psychologists and trained counsellors have long believed that playtime can be used for children to connect, learn, provide reassurance, and improve self-esteem. When meaningful discourse is not possible, children express themselves through play. Conversely, play is an indirect way for therapists to recast children's cognitions, perceptions, and behaviours (Kingsley & Mailloux, 2013). The therapists watch for patterns in children's play in order to make responses that produce

therapeutic movement (Landreth, 2002). As Lipsky and Gartner (1997) stated that the difference between play and therapy is the counsellor's ability to think analytically about everything that is going on in the session verbally, nonverbally, and symbolically in the child's play and artwork.

Play therapy developed out of the realisation that traditional talk forms of counselling does not seem to be effective with young children due to their developmental levels and capabilities (Schottelkorb & Ray, 2009). Children under the age of 10 have not yet developed the cognitive and verbal abilities to participate fully in talk forms of counselling and instead their natural form of communication occurs through play. In the small single-case design study, play therapy counsellor conducted play therapy with four elementary school students with ADHD. During the intervention, children received 30-minute session of play therapy during the school day twice a week. Researchers monitored the children's on-off task behaviour with Direct Observation Form for a three times a week. Schottelkorb and Ray (2009) found that children showed behavioural improvement after 12 play therapy sessions.

In PCIT, two types of treatment are used to teach parents positive ways to interact with their child. First, parents learn to give attention to the child's positive behaviours while the child plays. Second, therapists coach parents in parent-child sessions to praise appropriate and ignore inappropriate play behaviours (Homeyer & Morrison, 2008). The main focuses of play therapy during the CDI phase, parents learn nondirective play therapy skills and engage their child in a play situation with the goal of strengthening the parent-child relationship (Zisser & Eyberg, 2010). The nondirective play therapy is similar in many respects to other child-centred models. The therapists demonstrate the use of the core skills of unconditional regard, empathy,

and congruence, together with some of skills in Child-Lead Play (CLP). Congruence is a specific skill has a special emphasis in nondirective play therapy. Play therapist believes that these three core conditions are sufficient to bring about change by activating self-actualisation toward emotional health (Rye, 2010).

In addition, PCIT consists of the structured play therapy, theoretically based approach to expressive therapy that builds on the normal communicative and learning processes of children. Therapists use play to help children express what is troubling them when they do not have the verbal language to express their thoughts and feelings. In play therapy, toys are like the child's words, and play is the child's language (Homeyer & Morrison, 2008). During PCIT, the therapists provided nonverbal responses such as appearing relaxed and comfortable in the playroom, appearing interested in the child and using tone and expression congruent with the child's affect. The therapists provided appropriate verbal responses to communicate understanding to the child such as tracking behaviours, reflecting content and feeling, facilitating responsibility or creativity and enlarging the meaning of play (Rye, 2010). Thus, PCIT emphasises on play to improve parent-child relationship by teaching parents the necessary skills for managing children's behavioural problems.

1.6.2 Behavioural Therapy

Behavioural therapy has been shown to be a successful treatment that helps change potentially disruptive behaviours in children with ADHD (Counselling Directory, 2014). It involves reinforcing desired behaviours through praise, rewards, and decreasing behaviour problems by setting the limits and to help a child behave better (Block & Smith, 2014). Some studies show that it may be able to lower a child's

medication dosage if behavioural therapy is working well. However, it is a full-time commitment and many parents find that the best way to learn how to use these techniques is to work directly with a therapist (AAP, 2013). The main aim of behavioural therapy for ADHD children is to cut down on the disruptive behaviours that cause these children to trouble at school, have difficulty to make friends, and turn family life into a combat zone (Karras, 2013).

During PDI phase, parents are taught to use specific behaviour management techniques as they play with their child (Harwood & Eyberg, 2006). The specific behaviour management techniques are the effective time-out procedures and the management children's behaviours in real-world settings. Time-out is an effective strategy for ADHD children and works better if it is used less as a punishment and more as a way to cool down. If the child becoming frustrated or is about to lose his temper, send the child to sit quietly in a boring area for a few minute with no interaction from parent. If the child is able to calm down, give him or her time in by praising his or her effort and welcome the child back into parent's company. Using a time in as a reward for good behaviour is an important complement to time-out (Karras, 2013). In that sense, parents learn to direct the child's behaviour with clear, age-appropriate commands and consistent consequences with the aim of increasing child compliance.

Another behavioural therapy element is positive reinforcement. The positive reinforcement for disruptive behaviours is central to behavioural therapy in PCIT. Parents have to practice positive reinforcement for desired behaviours, and, when a child fails to obey the parents' commands, there is a strict series of consequences in the form of escalating time-out. Parents are taught how to use both reinforcement and

punishment techniques contingent on the child's behaviour, to provide consequences consistently, to ignore inappropriate behaviours and to attend to appropriate behaviours. Parents learn to model positive behaviours that children can learn from and trained to act as agents of change for their children's behavioural or emotional difficulties (Herschell & McNeil, 2005).

In most behavioural parent training, the therapists maintain close telephone contact with the parent. These contacts are used for several reasons include to encourage parents to ask questions about the home programmes, to provide an opportunity for the therapist to prompt compliance with the behaviour change programmes and to reinforce parents' use of the skills, to strengthen the therapeutic alliance, and to allow the therapist to problem-solve when programmes are not modifying child behaviour effectively (Karras, 2013). Furthermore, parents are assigned with homework tasks between sessions to practice skills such as giving praise for good behaviours and using time-out. Stimulated by more positive reinforcement, children learn to control their behaviour and have more rewarding relationships with parents and teachers (Karras, 2013).

1.6.3 The Connection between Play Therapy and Behavioural Therapy with PCIT

Parent-Child Interaction Therapy (PCIT) is a behaviour-based, family-oriented therapy designed to help improve the parent-child relationship through interaction. In this modality, it's combined both play therapy and behavioural therapy to help facilitate the development of effective parenting techniques and reduction in behaviour issues and may also lead to a stronger familial relationship. This approach is often effective for children who have conduct issues or other behavioural concerns.

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1.6.3 The Connection between Play Therapy and Behavioural Therapy with PCIT

Parent-Child Interaction Therapy (PCIT) is a behaviour-based, family-oriented therapy designed to help improve the parent-child relationship through interaction. In this modality, it's combined both play therapy and behavioural therapy to help facilitate the development of effective parenting techniques and reduction in behaviour issues and may also lead to a stronger familial relationship. This approach is often effective for children who have conduct issues or other behavioural concerns.

According to Thomas and Zimmer-Gembeck (2011) play therapy alone is not enough to reach, treat and resolve the difficult issues facing children today. For example, filial therapy is not to focus on any particular child's behaviour problem, but to promote lifelong skills for parents to maintain a supportive relationship with their children (Ceballos & Bratton, 2010). Throughout play therapy, children's maladaptive behaviours can be properly addressed by parents who have learned to empathise with their children (Ceballos & Bratton, 2010).

Thus, the experienced counsellors have discovered that a diverse range of methods and modalities are the treatment of choice with children. Some have learned to merge the effectiveness of the play therapy environment with behavioural therapies in response to the variety of childhood behaviour problems (Eyberg & Funderburk, 2011; Thomas & Zimmer-Gembeck, 2011). There are many forms of behaviour therapy, but all have a common goal to change the child's physical and social environments to help the child improve his behaviour. According to American Academy of Paediatrics (2014), behaviour therapy focuses on how the important people and places in the child's life can adapt to encourage good behaviour and discourage unwanted behaviour. It is different from play therapy that focuses mainly on the child and his or her emotions. Under this approach, parents, or caregivers learn better ways to work with ADHD children that include how to set and enforce rules, help the child understand what he or she needs to do, use discipline effectively, and encourage good behaviour.

Therefore, a standard PCIT programme involves two phases: (i) relationship enhancement via play therapy, and (ii) discipline and compliance child's behaviour via behavioural therapy. The relationship enhancement phase of PCIT teaches parents

how to minimise any negative characteristics within the relationship. It also guides them in developing new behaviours and communication skills that provide support and encouragement. The discipline and compliance phase of the approach emphasises effective and safe disciplinary techniques that can then be used to help the child improve behaviour by addressing and managing symptoms and issues leading to a negative behaviour. Children who are exposed to PCIT often learn how to adapt their behaviour, and many families experience vast improvement in child behaviour and the parent-child relationship (Eyberg & Funderburk, 2011).

1.7 Roles of Relevant Authorities and Counsellor towards ADHD Children

The core symptoms of ADHD are inattention, hyperactivity, and impulsivity require creative counselling approaches that are dynamic, action-oriented that beyond the scope of traditional talk therapy. The involvement from various mental health professionals such as child psychiatrists, clinical psychologists and counsellors in treating ADHD is important. Both child psychiatrist and clinical psychologist are trained in the diagnosis, treatment of mental and emotional illnesses in children and the difference is child psychiatrist can prescribe medication. According to Malaysian Board of Counsellors (MBC), counselling practitioners refers to those who receive formal training from recognised universities and have accredited certificate of practice by MBC under the Act of 1998 (Zakaria & Asyraf, 2011). /"In Malaysia, most counselling practitioners are in the educational settings. This was approved by the study conducted by Zakaria and Asyraf (2011) among 241 randomly selected counselling practitioners who are a member of Counselling Association of Malaysia (PERKAMA). It has been found that, most of the counselling practitioners are

working in educational sectors. This indicated that the task of counsellors is still concentrated in the field of education even though it begins to spread in the private sectors and other. In 1996, there was a directive from the Malaysia Ministry of Education clarified the roles and functions of school counsellors. One of the emphasis issues is psychosocial and mental-health-related issues. The counsellors have to focus a considerable amount of their time and effort in improving the quality of their services and creating awareness for mental health services (See & Ng, 2010).

According to American Mental Health Counsellors Association (AMHCA) (2011), a critical development in mental health counselling has been defining the functions and roles of the counsellor. Mental health counselling is the provision of professional counselling services such as the application psychotherapy, learning theory, human development, aetiology of mental illness and dysfunctional behaviour to individuals, couples, families and groups, for the purpose of promoting optimal mental health, and treating psychotic. Mental health counsellors often work closely with other mental health practitioners, such as child psychiatrists, clinical psychologists, clinical social workers, psychiatric nurses, and school counsellors (Bureau of Labour Statistics, 2013). The responsibilities of counsellor and clinical psychologist vary in which counsellors pursue a more humanistic approach in therapy, while clinical psychologists deal with mental illness and behavioural problems. However, both can typically offer counselling services and alternatively, a counsellor may use a specific form of psychotherapy to help client with mental and behavioural problems.

The school counsellors should take an active role in providing support and implementing counselling interventions for behavioural symptoms of ADHD in

children. These behavioural problems likely to affect children performance and the school counsellors have to emphasis the learning and behavioural issues found in children ADHD attentively (American Counsellor School Association (ASCA), 2005). School counsellors should be able to deliver mental health counselling and intervention to problematic children. For the purposes of providing appropriate mental health services, they are trained to apply the assessment instruments to detect or diagnose the disorders and conducting the psychotherapy to treat dysfunctions and disorders (Teachers College of Columbia University (TCCU), 2005). The ASCA (2005) published a position statement that strongly encourages the involvement especially school counsellors in the multidimensional treatment of ADHD children.

ADHD is a difficult to diagnose in young children and unfortunately many of them are not receive the relevant mental health services after schools (ASCA, 2005). Thus, it is important for all counsellors to aware of their licensure and certification in counselling profession before providing the intervention. In Malaysia, the role of counsellor in mental health services is needed in managing disruptive behaviours problems among children. According to See and Ng (2010), research is needed to help counsellors further define and refine its purpose and directions, theory and practice, and training framework. The empirical findings are needed to improve the professionalism of counselling. The Malaysian Board of Counsellor (2008) stated that counsellors should evaluate and increase their knowledge, competencies and skills in the counselling profession, and monitor their effectiveness as professional. Thus, to deal with mental and behavioural issues in ADHD children, counsellors are expected to increase their competency beyond talking therapy and alternatively, counsellors may use a creative form of counselling intervention to help the affected clients.

1.8 Statement of the Problem

First, many researches pointed to associate the disruptive behaviours in early childhood with later negative social and developmental outcomes. Studies found that the presence of early disruptive behaviour is main predictor of juvenile delinquency and criminal behaviours, substance use disorders, and antisocial behaviour and can continue through adolescence and adulthood (AAP, 2013). The negative effects of psycho-stimulant medication in which many children who receive them do not display positive behavioural outcome. Meta-analysis research evidences have demonstrated that some medication when employed was not shown to improve long-term outcomes for children with ADHD (Faber, 2013; Fabiano et al., 2009). For some ADHD children, they may be intolerant to the effects of psycho-stimulant medication (Safren et al., 2005).

Some studies indicated that the psycho-stimulant is state-dependent-effects that only last for as long as the person is receiving the medication (Cortese et al., 2010) and increased the probability of the child to display behaviours that are already in their repertoire (Jadad et al., 1999). Alternatively, the use of counselling intervention is needed to achieve positive outcome (National Collaborating Centre for Mental Health (NCCMH), 2009). The counselling interventions such as family counselling, psychological assessment, psycho-education programme and behavioural parent training can lead to decrease disruptive behaviour in affected children (MWFCD, 2013) and these components are established in the treatment of ADHD (Danforth, Harvey, Ulaszek, & McKee, 2006). Thus, there is a need for effective counselling interventions to address disruptive behaviour in young children.

Second, in Malaysia, a child who diagnosed with mental health illness will be first recommended to get the medical treatment to reduce their symptoms (See & Ng, 2010) without giving the priority to parents to undergo the psychosocial treatments. Both parents and child have no opportunity to be involved in psychosocial treatment provided by hospital due to lack of professional mental health practitioners (See & Ng, 2010). The statistics showed that only 2,540 counselling teachers registered with Malaysian Board of Counsellor (MBC) under the MFWCD in year 2014. According to Fadzil (2014), many cases of counselling teachers failed to perform their responsibilities effectively because they are not registered counsellor and do not have a practicing license from MBC. This issue may affect their professionalism and accuracy of methods given in school counselling. Furthermore, the practicing in view of difficulties with diagnosis and special requirements of management, ADHD children would be referred to a child psychiatrist or a paediatrician. Therefore, psycho-stimulant medication is the main solution to treat of ADHD.

However, according to Aili et al. (2015), medication alone cannot serve to be the sole modality of treatment. There is increasing evidence has demonstrated the role of multi-modal treatment for effectively addressing the diverse difficulties of children with ADHD. A lack of professional mental health practitioners such as allied health personnel, assessment tools and intervention prevent any children and their families to be assessed. The roles of assessment, testing, and intervention needs further clarification and delineation for counsellors to incorporate them into their functions appropriately (See & Ng, 2010). Thus, there is a need for professional and well-trained counsellor to deal with ADHD children and their parents.

Third, in Malaysia, there is no specific of appropriate parent-child intervention which combined both play and behavioural therapies in one treatment to educate parents on how to manage behaviour problems among ADHD children. Several studies have conducted to examine the effects of parent training programmes on rebuilding parent-child relationships through teaching parents the skills necessary for coping with the childhood problem behaviours (Aili et al., 2015; Marziyeh & Khaidzir, 2009; Norazimah et al., 2011). However, all these parent training programmes are too general with no specifically employed a specific type of parent-child intervention. In addition, these programmes are intervened by psycho-stimulant medication (Aili et al., 2015; Norazimah et al., 2011), and more concern with promoting positive parenting skills to improve relationship between parents and child rather than directly involved in treating children' behavioural problems (Marziyeh & Khaidzir, 2009). The child's behaviour problems later can be addressed by parents who learned the positive parenting skills. Many studies found that, the most recommended parent-child intervention is PCIT (Counselling Directory, 2014; Eyberg & Funderburk, 2011; Thomas & Zimmer-Gembeck, 2011). Parents who participated in PCIT typically learn consistent, predictable techniques for parenting and may experience greater confidence when dealing with behavioural concerns, whether publicly or in the home (Allen & Marshall, 2011). The PCIT effectiveness has been demonstrated through a number of studies over the world especially in Western cultures. Therefore, this study took an initiative to understand the effect of PCIT whether it is applicable to meet the appropriate needs in both parents and children in Malaysia.

1.9 Research Objectives

The main objective of this study was to examine the effects of Abbreviated Intensive Parent-Child Interaction Therapy on noncompliance behaviour among preschool children who were diagnosed with Attention Deficit Hyperactivity Disorder. Thus, based on the main objective, this study outlined eight specific research objectives.

1. To examine the effects of Abbreviated Intensive Parent-Child Interaction Therapy on the level of disruptive behaviour in Attention Deficit Hyperactivity Disorder preschool children.
2. To examine the effects of Abbreviated Intensive Parent-Child Interaction Therapy on parents' acquisition of Child-Directed Interaction parenting skills over the course of treatment.
3. To examine the effects of Abbreviated Intensive Parent-Child Interaction Therapy on parents' acquisition of Parent-Directed Interaction parenting skills over the course of treatment.
4. To examine parents' satisfaction with Abbreviated Intensive Parent-Child Interaction Therapy in decreasing noncompliance behaviour in preschool children with Attention Deficit Hyperactivity Disorder.
5. To explore parents' experiences about the useful aspects of Abbreviated Intensive Parent-Child Interaction Therapy.
6. To explore parents' experiences in the application of Abbreviated Intensive Parent-Child Interaction Therapy.

7. To explore parents' perceptions about the cultural issues related to the use of Abbreviated Intensive Parent-Child Interaction Therapy.

8. To explore parents' perceptions about the including of Islamic religious element in Abbreviated Intensive Parent-Child Interaction Therapy.

1.10 Research Questions

This study outlined eight research questions:

1. What are the effects of Abbreviated Intensive Parent-Child Interaction Therapy on the level of disruptive behaviour in Attention Deficit Hyperactivity Disorder preschool children?

2. What are the effects of the Abbreviated Intensive Parent-Child Interaction Therapy on parents' acquisition of Child-Directed Interaction parenting skills taught over the course of treatment?

3. What are the effects of the Abbreviated Intensive Parent-Child Interaction Therapy on parents' acquisition of Parent-Directed Interaction parenting skills taught over the course of treatment?

4. What are the parents' levels of satisfaction toward the Abbreviated Intensive Parent-Child Interaction Therapy in decreasing noncompliance behaviour among preschool children with Attention Deficit Hyperactivity Disorder?

5. What are the parents' experiences about the useful aspects of Abbreviated Intensive Parent-Child Interaction Therapy?

6. What are the parents' experiences in applying the Abbreviated Intensive Parent-Child Interaction Therapy?

7. What are the parents' perceptions about the cultural issues related to the use of Abbreviated Intensive Parent-Child Interaction Therapy?

8. What are the parents' perceptions about the including of Islamic religious element in Abbreviated Intensive Parent-Child Interaction Therapy?

1.11 Significance of the Study

First, according to Ministry of Women Family and Community Development (2013), the counselling interventions such as family counselling, psychological assessment, psycho-education programme and behavioural parent training can lead to decrease disruptive behaviour in affected children. The outcomes of this study would provide valuable information and guidelines in designing the family counselling intervention that adaptable to Malaysian culture in future. Thus, this study may benefit related organisations such as Ministry of Health, Ministry of Education, Non-profit Organisations, and Community-Based Rehabilitation (CBR) in developing parent-child intervention module related to managing disruptive behaviour problems in children. In addition, the finding of this study can contribute toward the development of training module as one of the prevention strategies to cope with more potentially upcoming issues in children behavioural and mental health.

Second, this study intended to provide valuable information and guideline for school counsellors, teachers, parents and community about early symptoms of ADHD in children and relevant intervention used to treat affected children (See & Ng, 2010).

The teachers and school counsellors are resources for initial identification, screening and assessment for ADHD symptoms, they must have good working knowledge of typical symptoms and well-trained in conducting early interventions for ADHD problems either psychological or behavioural issues. Thus, the findings of this study can be a resource for screening, assessing and treating ADHD behavioural symptoms in young children. Furthermore, in this study parents were taught how to develop more effective parenting styles such as positive interaction between parents and children to better meet the children's needs and demands. Parents are also learned positive behaviours that can be a model for the children and they are also trained to act as an agent of change for their children. By understanding this, there is an opportunity for researcher to tailor the parents' needs in coping with their child's behaviour problems based on Malaysian culture.

Third, the findings of the study would also support the awareness on children mental health and the need for mental health counselling and intervention services (Zakaria & Asyraf, 2011). There is an increased need for counselling practitioners to be involved in gifted children management, intellectual ability development, social and emotional learning, psychological testing and assessment (See & Ng, 2010). This is parallel with the policy of Malaysia National Mental Health Policy (MNMHP) (1998) in improving the availability of mental health services by integrating psychiatric services in mainstream general health care with the view to provide psychosocial treatments. Thus, the empirical findings of the study can integrate contributions among multidisciplinary professional staff comprising psychiatrists, clinical psychologists, and counsellors in helping ADHD or related problems.

Fourth, the significance of this study is to add the theoretical understanding. The foundation of the PCIT is based upon developmental theory of parenting which draws on both attachment (Ainworth & Bowlby, 1991) and social learning (Patterson, 1982) theories to achieve an authoritative parenting (Baumrind, 1966). Many of disruptive behaviours originate from multiple interacting child and family factors. This study focused on the effects of authoritative parenting (parent-child relationship) and (discipline) in reducing noncompliance behaviours in children. It would not only purvey additional insights into the efficacy of PCIT as counselling intervention but would also contribute towards better understanding of these three parenting theories that underpinning the study.

1.12 Limitations of the Research

The potential impact in this study was generalisability which out of researcher controls that may limit the findings. Factors due to the restriction of generalisability included small number of samples, non-probability sampling, and research design.

First, the sample of children is relatively small due to the limited number of preschool children who registered as having ADHD. Based on statistics from Family Health Development Division (FHDD), the total numbers of preschool children with ADHD aged between five to six years old were 24 in the year 2011 and 28 in the year 2012 who were registered with MOH and most of them from Selangor state (Ministry of Health, 2013). It may impossible to recruit a large number of respondents since the total numbers of ADHD children registered were 52 cases from 2011 until 2012. The respondents were recruited from the population of 28 preschool children with ADHD in 2012 who aged 6 years old in the year 2013 and limited to state of Selangor only.

Second, this study employed preschool children with ADHD as homogeneous sampling, thus, researcher had to use the purposive sampling rather than random sampling. The purposive sampling is a type of non-probability sampling which relies on the researcher's judgement when it comes to select the units that are to be studied. Basically, if compared with probability sampling, the sample being investigated is quite small (Mangal & Mangal, 2013). The homogeneous sample is people or cases that share similar traits or characteristics. Basically, homogeneous sampling is often chosen when the research question is highlight on specific characteristics of the particular group of interest, which is subsequently examined in detail (Zimmerman, 2014). The main goal of purposive homogeneous sampling in this study was to concentrate on special characteristics of ADHD in child respondents that are of interest, which allow the researcher to provide the answer for the research questions.

Third, since the sample size of a study is small, thus, the researcher employed single-case experimental design (SCED) to determine the intervention effects of Abbreviated PCIT on the targeted behaviour of the respondents. According to Gay and Airasian (2003), SCED is a design that can be applied when the sample size is one or when a number of individuals are considered as one group. Researchers in health, educational, school and counselling often use SCED because they are particularly well suited to examine the processes and outcomes of behavioural interventions (Borckardt, Nash, Murphy, Moore, Shaw & O'Neil, 2008; Kazdin, 2005). This design is used to observe the pattern of behavioural change in individual as a result of same treatment. The SCED typically involves a comparison between two experimental time periods, known as baseline (pre-intervention) and treatment or intervention phases (post-intervention). The results of SCED research cannot be used to make inference

about the entire population since a small number of respondents are not a representative of the population Schweigert (2006), However, the repeated measurement with the same treatment and results, SCED is capable of receiving general pattern of behaviours (Nock, Michel, & Photos, 2007). The repeated measure can reduce the variance of estimates of the treatment effects, and allow the statistical inference to be made with small participants (Barret, 2013). Therefore, the central goal of the SCED employed in this study was to determine whether Abbreviated Intensive PCIT has meaningful change in noncompliance behaviour which measured repeatedly across and within all phases of intervention.

1.13 Delimitations of the Research

Delimiting factors in this study included the choice of study objectives, variables of interest, the population to be investigated and the methodological procedures.

First, the purpose of the current study was to examine the intervention effects of Abbreviated Intensive PCIT on noncompliance behaviour among preschool children who diagnosed with ADHD. There is a need to study specifically the PCIT outcomes among different culture groups in order to improve the treatment while maintaining the sensitivity of cultural (Cuttler & Eyberg, 2006). The PCIT is appeared to be the acceptable treatment with different Hispanic cultural groups. Borrego, Anhalt, Terao, Vargas, and Urquiza (2006) translated PCIT materials into Spanish and documented a successful case involving Mexican families. Same findings were found in a study of translating PCIT among Chinese families in Hong Kong (Tsang, Leung, Chan, & Choi, 2007). However, the PCIT format of delivery needs to be tailored slightly for widespread use in different cultures (Matos, Torres, Santiago, Jurado, &

Rodriguez, 2006; Tsang et al., 2007). Thus, the findings of the study may help in identifying other elements that may recommend by parents to be included in PCIT in order to treat preschool children who diagnosed with the symptoms of ADHD in Malaysia.

Second, regarding the variables of interest, researcher made a choice to employ Abbreviated Intensive PCIT rather than standard format of PCIT. The standard format of PCIT delivery is between 12 to 16 sessions (Thomas & Zimmer-Gembeck, 2012), whereas Abbreviated form of PCIT usually takes four to five sessions have also been successfully implemented within primary care settings (Berkovits, O'Brien, Carter, & Eyberg, 2010). A study conducted by Graziano, Bagner, Slavec, Hungerford, Kent, Babinski, Derefinko, and Pasalich (2014) suggest that a brief and intensive format of a PCIT is a feasible and effective treatment for young children with behaviour problems with clinical implications. Thus, in this study researcher conducted Abbreviated Intensive PCIT in seven sessions to examine the effect of intervention in decreasing noncompliance behaviours among preschool children with ADHD. Both CDI and PDI parenting skills with mastery criteria to be achieved by parents in order to determine their treatment progress were preserved and remained in this study. In addition, the evaluation of the effectiveness of Abbreviated Intensive PCIT was focused on changes in in parenting verbalisation skills and child compliance behaviours towards parental commands.

Third, some of the prominent disruptive behaviour disorders in ADHD children are noncompliance behaviour, defiant behaviour, refusal to comply with requests and rules and also associated with difficulty maintaining relationships (Berkovits et al. 2010). As reported by Goldstein, Harvey, and Friedman-Weieneth

(2007), there were 50% of children with ADHD experience noncompliance behaviour. The recent available treatments for children are focus on decreasing the symptoms of ADHD and improving behavioural functioning. According to Zisser and Eyberg (2010), children with ADHD are able to control their behaviours when they are getting the attention from parent or teacher and when they are involved in enjoyable activities. In this study, noncompliance behaviour defined as when the child does not perform the requested behaviour or complete something that parents have asked within the 5-second interval following the command. Therefore, researcher was able to measure the effects of Abbreviated Intensive PCIT in reducing noncompliance behaviours among preschool children with ADHD.

Fourth, due to the restriction of generalisability which includes small number of samples and non-probability sampling, therefore, selection criteria of respondents was carefully controlled by the researcher. The inclusion criteria include, children must between the ages of five and six (preschool), certified by medical doctor as having ADHD, and from moderate to severe disruptive behaviour based on ECBI scores. The exclusion criteria for children and parents include, parent or child diagnosed with a major significant cognitive or development delay, psychiatric illness or medical condition that can impair judgment. The nature of mental illness can create problems in maintaining consistent tasks or school patterns (Shaban, 2012) and can impair individual's behaviour. There are many children diagnosed with ADHD during the elementary school (Collingwood, 2013), however, the current trend is increasingly being identified in preschool children. Researcher employed preschool children with ADHD as a sample of study and all inclusive and exclusive criteria were carefully selected to achieve the objectives of the study.

1.14 Conceptual and Operational Definition of Terms

1.14.1 Abbreviated Intensive Parent-Child Interaction Therapy

Conceptual Definition

There are two formats of PCIT can be delivered: (i) standard PCIT and (ii) abbreviated PCIT. Usually, parents who enrolled in the standard format of PCIT have to complete 12 to 16 sessions over three to four months (Thomas & Zimmer-Gembeck, 2012). The abbreviated format of PCIT is the brief and intensive version than the standard PCIT format, which averages four to five sessions over one month (Berkovits et al., 2010; Graziano et al., 2014). However, Abbreviated Intensive PCIT is remained utilised all core elements as in standard PCIT such as uses live-coaching, training, and modelling to provide parents with proven behaviour management techniques. It is conducted in two stages: (i) in CDI parents are learned the parenting skills in recognising their children's positive behaviours and qualities, and coached in play time sessions to apply positive attention and ignoring negative behaviours, and (ii) in PDI parents are learned the parenting skills on how to direct their children with effective commands, and are coached how to response to child's noncompliance behaviour in safe and effective discipline.

Operational Definition

For the purpose of study, Abbreviated Intensive PCIT Protocol developed by Eyberg and Funderburk (2011) and Lewis (2010) were adapted into the treatment. The intervention effects have been assessed throughout four intervention phases: pre-treatment (A_1), and post-treatments (B-IT, B-MT and F_1). During Intensive Treatment

(B-IT), 2-hour sessions were conducted for five consecutive weeks (5-session). During Maintenance Treatment (B-MT), face-to-face sessions were alternated with 1-month weekly of 30-minute telephone consultation and two weeks Booster sessions in weeks five and six (2-session). Overall, there were 7-session of the treatment have been conducted. The effects of Abbreviated Intensive PCIT have been measured using ECBI, DPICS-III and TAI and compared between pre- and post-treatment phases.

1.14.2 Noncompliance Behaviours

Conceptual Definition

Noncompliance behaviour is occurs when children do not wish to do as they are directed. This behaviour may reflect a child's disruptive behaviour such as rebellion, difficulty in settling into a task, tendency to become over-aroused, easily frustrated, and impulsive behaviour often result in a wide variety of non-purposeful behaviours that are clearly disrupting others (Cohen, 2012). Noncompliance behaviours defined as when the child does not perform or complete something that parents have asked, when the child acts defiant when told to do something, when the child refuses to do until threatened with punishment, and when the child ignore or argue with something parents asked to do (Barkley, 2012; Lewis, 2010). Approximately 60% of young children with ADHD (hyperactivity or impulsivity or inattentive) tend to develop oppositional disorder characterised by noncompliance behaviour (Parker, 2002).

Operational Definition

In this study, noncompliance behaviour defined as when the child does not perform the requested behaviour or not complete something that parents have asked within 5-

second interval following the command. For the purpose of the study, child noncompliance behaviour towards parental commands was assessed using DPICS-III (Eyberg et al., 2009) during PDI phases in Parent-Lead Play and Clean-up situations. Basically, during DPICS-III coding, parents are requested to allow for 5-second for the child to comply the command. Noncompliance behaviour (NOC) has been coded when the child does not perform or stops attempting to perform the requested behaviour within the 5-second interval following the command.

1.14.3 Compliance Behaviour

Conceptual Definition

In psychology, compliance behaviour refers to changing one's behaviour due to the request or direction of another person. Thus, the individual will act in some way based on what other persons asked him or her to do so (Breckler, Olson, & Wiggins, 2006). Moreover, compliance behaviour is a response or submission made in reaction to a request either explicit or implicit and the target may or may not recognise that he or she is being urged to act in a particular way (Breckler et al., 2006).

Operational Definition

In this study, compliance behaviour defined as when the child was performed the requested behaviour or completed something that parents have asked within the 5-second interval following the command. The child compliance behaviour towards parental commands was assessed using DPICS-III (Eyberg et al., 2009) during PDI phases in Parent-Lead Play and Clean-up situations. In order to measure the progress effect of Abbreviated Intensive PCIT, the mastery criteria of child's compliance

behaviour (CO) has determined of at least 75% of the parental commands should be obeyed by the child (Eyberg et al., 2009). Due to time constraint of 5-minute, parents were asked to give the total of 12 commands in a form of requested behaviour for their child during the coding session (Lewis, 2010). In this study, at least 75% or 9-command from parent should be performed by the child.

1.14.4 Preschool Children

Conceptual Definition

The concept of preschool is different from day care in which it emphasis on learning development rather than caring and looking the children after the parents. Early Childhood Care and Education in Malaysia divided into two groups: (i) 1-to-3 years old comes under the MWFCD which coordinates all childcare centres and nurseries, and (ii) 4-to-6 years old comes under Ministry of Health, Ministry of Rural and Regional Development, and the National Unity Department (Ministry of Education, 2007). However, for preschool children with learning disabilities is coordinate by the Special Education Department under the Special Education Integrated Programme (SEIP). The Special Education Regulations (2013) stipulate that children with ADHD are considered as children with special needs who are educable and they are certified by a medical practitioner and psychologist to have learning disabilities.

Operational Definition

In the study, a preschool child was defined as children with ADHD aged six and below who attended SEIP for children with learning disabilities under the Special Education Department, Ministry of Education. The symptoms of ADHD affect a

child's cognitive functioning which involves difficulty a specific aspect of learning, trouble paying attention, or in finishing tasks. Researcher ruled out inclusion and exclusion criteria for preschool children to be included. They must meet the following inclusion criteria: (i) ages of 5-6 years old, (ii) certified by medical doctor as having ADHD, (iii) living with participating parents, and (iv) moderate to severe disruptive behaviour as measured by ECBI at least 131 scores. The exclusion criteria for children included: (i) have been diagnosed with a major significant cognitive or development delay, (ii) have been diagnosed with a major psychiatric illness or medical condition that impairs judgment, and (iii) the child received other psychosocial treatments.

1.14.5 Attention Deficit Hyperactivity Disorder (ADHD)

Conceptual Definition

According to DSM-5, there are three presentations of ADHD: inattentive (ADHD-I), hyperactive-impulsive (ADHD-HI) and combined inattentive and hyperactive-impulsive (ADHD-C) (APA, 2013). When diagnosing ADHD, clinicians need to specify whether a person has mild, moderate or severe level of ADHD symptoms. This is based on how many symptoms an individual has and how difficult those symptoms affect the individual's daily life and functioning. In Malaysia, ADHD has categories as children with Special Educational Needs which is grouped under Learning Disabilities in Malaysian educational system (Ministry of Education, 2013).

Operational Definition

For the purpose of the study, preschool children who diagnosed with ADHD were involved in initial screening with their parents. During this stage, the clinical interview

has been conducted with parents in two ways: (i) parents were asked to inform researcher about the symptoms of ADHD of their child at home and at school as reported by teachers, and (ii) parents were asked to rate the level of disruptive behaviour in their child based on Eyberg Child Behaviour Inventory (ECBI). The ECBI is a 36-item parent rating scale which used to measure the level of disruptive behaviours in child in terms of the frequency (Intensity Scale) of the behaviour (Eyberg & Pincus, 1999). In this study, children with scores over clinical cut-off of at least 131 would be included. The ECBI scores show between 114-130 (mild disruptive behaviour), 131-156 (moderate disruptive behaviour) and scores more than 156 (severe disruptive behaviour).

1.14.6 Cultural Issues

Conceptual Definition

Culture is the shared knowledge, behavioural norms, values and beliefs that help people to live in families, groups and communities. Cultures help define ethnic groups as people who share ideas, language and beliefs because they come from the same country place. The cultural issues such as differences in values and beliefs are the main concern when the psychotherapy which developed from Western to be applied into Non-western cultures (Zane, Nagayama Hall, Sue, Young, & Nunez, 2004).

Operational Definition

In this study, cultural issues referred to parents' perceptions of how the treatment (Abbreviated Intensive PCIT) might be accepted by Malaysian culture. This was important to understand from clients' perception whether it is suitable to use Western

therapeutic modalities with Malaysian clients who might not be familiar with the concept of psychotherapy. Therefore, by using the semi-structured interview and open ended questions, the study aimed to elicit parent respondents' perceptions about the treatment from their own perspective and in their own words.

1.14.7 Religious Elements

Conceptual Definition

Religion is a cultural system of behaviours and practices. Different religion may contain various elements ranging from divine, faith and supernatural beings. The examples of religious elements are in verbal form (prose, commentary, and conversation, delivered as song, oral recitation, writing, or through informal speech), and in nonverbal form (scripts, books, any visible religious materials). In a relation to the psychotherapy or intervention, religious element is the incorporation of spirituality in the therapeutic process (Vogel, 2013). In Islam, the religious elements are the inclusion of good aspects of mainstream counselling and incorporating the Quran, and sunnah (the hadiths of the Prophet Muhammad) (Ahmed & Amer, 2012).

Operational Definition

In this study, religious element referred to parents' perceptions of how the including of religious elements in the treatment (Abbreviated Intensive PCIT) from the Islamic view. This was important to understand from clients' perception whether it is a need to include the Islamic elements with Muslim clients. In addition, their perceptions might help to generate what are the Islamic elements that may use for the treatment to be more effective. Therefore, by using the semi-structured interview and open ended

questions, the study aimed to elicit parent respondents' perceptions about what the researcher should incorporate the Islamic elements in the treatment.

1.15 Chapter Summary

This chapter explained the behavioural issues among preschool children with ADHD in Malaysia which require attention and careful action in order to prevent it from becoming worse. Addressing behaviour problems among preschool children with ADHD is important because disruptive behaviours appear to reach their peak levels by the time children enter the primary school. With a rapid growth in the country development, Malaysia is becoming increasingly conscious the need of child mental health cares and special education services. Many parents and teachers are increasingly their awareness of children's problems and looking for the professional helps. Parents often need relevant information about positive parenting techniques, support groups at school or in community to understand appropriate expectations for behaviour and school works in their affected child. Therefore, Abbreviated Intensive PCIT has been employed to treat disruptive behaviour (noncompliance behaviours) in ADHD children. As a result, there were five main research objectives brought forward by the researcher to be achieved through this study. The findings of this study may benefit the individuals or organisations who directly or non-directly working with ADHD children and to provide preliminary guideline on the use of Abbreviated Intensive PCIT as a family-centred treatment and counselling intervention. Therefore, counsellors are expected to increase their competency beyond talking therapy and alternatively, they may use the creative form of counselling intervention to help the affected children and parents in coping with mental and behavioural problems.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter discusses seven major sections that present a review of literature that is related to the study. The literature reviews covered relevant previous researches as well as the theories and concepts. All sections discusses are as the following:

1. Overview ADHD and noncompliance behaviour in preschool children
2. Issues on ADHD for Malaysian children population
3. Overview Abbreviated Intensive Parent-Child Interaction Therapy (PCIT)
4. Rationale for choosing Abbreviated Intensive PCIT
5. Measuring the intervention effect of PCIT
6. Overview research design
7. Theoretical framework of the study
8. Conceptual framework of the study

2.2 Overview ADHD and Noncompliance Behaviour in Preschool Children

ADHD is a type of disruptive behaviour disorder that usually appears in early childhood. The signs and symptoms of ADHD typically appear before the age of seven years old (APA, 2013). Based on DSM-5, three essential features of ADHD are inattentive, hyperactivity, impulsivity, and combined (APA, 2013). The most sign of