# 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

hyperactivity is children are always moving, for examples, they trying to do many things at once and bouncing around from one activity to the next activity. The most obvious sign of impulsivity is children are usually having problems with their self-control, for example, they are invade the space of other people, ask irrelevant questions in class, interrupt conversations, make tactless observations, and ask overly personal questions. As a result, other people assume that the child as disrespectful, weird, or needy. Children with only inattentive symptoms are often overlooked, but, these symptoms have consequences such as getting in hot water with parents and teachers for not following instructions, underperforming in study, or clashing with other kids over not playing by the rules (Robinson, Smith, Segal & Ramsey, 2012).

Approximately 60% of young children with ADHD tend to develop oppositional disorder characterised by noncompliance behaviour (Parker, 2002). Noncompliance behaviour is one of the most common disruptive behaviour conditions among children who diagnosed with ADHD (Hinshaw & Lee, 2003; Swanson, 2003). As reported by Goldstein et al. (2007), there were 50% of children with ADHD experience noncompliance behaviour. When examining the failure of a child to complete a given instruction even after educated and trained him or her, the child still noncompliance. According to Barkley (2012), the term noncompliance behaviour refers to three categories of child behaviour. First, a child is unable to perform behaviours requested by parents within a reasonable time 15-second after a command given. Second, the child is unable to sustain compliance to a direction from parents until the requirements stipulated in the command have been fulfilled. It may consider this behaviour category as a form of attention span or sustained attention to on-tasks behaviour. Third, the child is unable to follow previously taught rules of conduct in

any situations which parents or teachers consider to be violation. The examples of the behaviour such as, leaving one's table in class, running off in a hypermarket without parents' permission, lying, stealing, hitting, kicking, biting or aggressing against other people.

Moreover, according to Barkley (2012) the term defiance can also be used for many instances of noncompliance behaviour where the child not only fails to obey a command or rule, but also displays active verbal or physical resistance toward the commands. This is an active resistance to command rather than a passive one as might be conveyed by the term noncompliance behaviour. For example, when parent attempts to impose compliance with a directive on the child, the child will engage in verbal refusal, temper outbursts, and even physically aggressing against the parent. The examples of noncompliance behaviours can be referred in Table 2.1. All these behaviours can be considered as belong to a larger class of noncompliance behaviour. This inter-related form of behaviour has also been termed as disruptive behaviour disorders that include conduct disorder, social aggression, hostile-defiance behaviour, and externalising behaviour problems. Some of these behaviours are direct efforts of the child to avoid the imposition of the command (Patterson, 1982).

*Table 2.1: Examples of Noncompliance Behaviours*

| | | |
|---|---|---|
| Yells | Steals | Fails to complete chores |
| Whines | Lies | Destroys property |
| Complains | Argues | Physically fights |
| Defies | Humiliates/Annoys | Fails to do school homework |
| Cries or holds breath | Teases | Disrupts others activities |
| Tantrums or screams | Ignores requests | Ignores self-care routines |
| Throws objects | Self-injury | Runs off |
| Argues or sarcastic | Swears | Physically resists |

*Source: Defiance Children: A Clinician's Manual for Assessment and Parent Training, Barkley (2012)*

### 2.2.1 Poor Quality Parent-Child Interaction

Many researches repeatedly demonstrate that the quality of parent-child interaction is reliably and strongly associated with noncompliance behaviours during childhood. Some studies indicated that poor parent-child interaction tends to sustain or increase the occurrences of noncompliance behaviour in children (Barkely, 2012; Beauchaine, Hinshaw, & Pang, 2010; Burke, Waldman, & Lahey, 2010). A very poor attachment relationship with parents and the family members is showed by children with noncompliance behaviour along with their significantly higher rates of stubbornness, temper outbursts, arguments, verbal defiance, and even physical aggression in their interactions. One of the poor quality parent-child interactions is disrupted parenting. Disrupted parenting is repeatedly identified in many research studies has been found as a major proximal contributor to noncompliance, defiance, and social aggression (Barkley, 2012; Harvey & Metcalf, 2012; Mokrova, O'Brien, Calkins, & Keane, 2010). The essential features of disrupted parenting are ineffective, inconsistent, lax or even timid child management methods being employed by parents which often combined with unusually harsh and inconsistent disciplinary methods (Deater-Deckard, Wang, Chen, & Bell, 2012; Harvey & Metcalf, 2012). Disrupted parenting also includes disrupted parental behaviours, low parental warmth, and poor parental monitoring of the child activities inside or outside the home (Ellis & Nigg, 2009; Harvey & Metcalf, 2012; Mokrova et al., 2010).

A 4-year longitudinal study conducted by Harvey & Metcalf (2012) was to examine the interaction pattern between preschool children and parents in predicting later disruptive behaviours. There were 138 boys and 120 girls of 3-year-old children and their parents from diverse backgrounds included in the study and 199 of these

children had problems of hyperactivity and 59 children with no behavioural problems. Mothers and fathers independently completed the Disruptive Behaviour Rating Scale-Parent Version (Barkley & Murphy, 1998). The interaction between children and their mother were coded during 5-minute play and clean-up tasks. Global warmth ratings such as parents positively attentive to child (praise, supportive, conveyed interests and affection in interaction with child) were coded. Results indicated that lower parental warmth (negatively attentive, not used praise to the child, laxness, and depression) predict more externalising problems of hyperactivity in children. The study suggested that hyperactivity behaviour may develop and sustain through a negative interaction between parent and child across the preschool year.

Another study conducted by Mokrova et al. (2010) to examine links between disrupted maternal and paternal behaviours and their ADHD symptoms on children behaviours. The participants were 311 mothers and 149 fathers of young children have been assessed through self-reports to identify the ADHD symptoms, level of home chaos and parenting practices. Then, teachers were asked to identify the child ADHD symptoms. The results found that, mothers tended to report higher home chaos when they or their children had higher levels of ADHD symptoms. The parenting practices of mothers have been found to be inconsistent discipline and non-supportive responses to ADHD children's negative emotions, and these associations were mediated by home chaos. The parenting practices of fathers have been found to be more inconsistent discipline, lower involvement with children, and non-supportive responses to children's negative emotions. The research indicated that ADHD parents and living in a chaotic home environment were linked to inconsistent discipline and non-supportive responses to children.

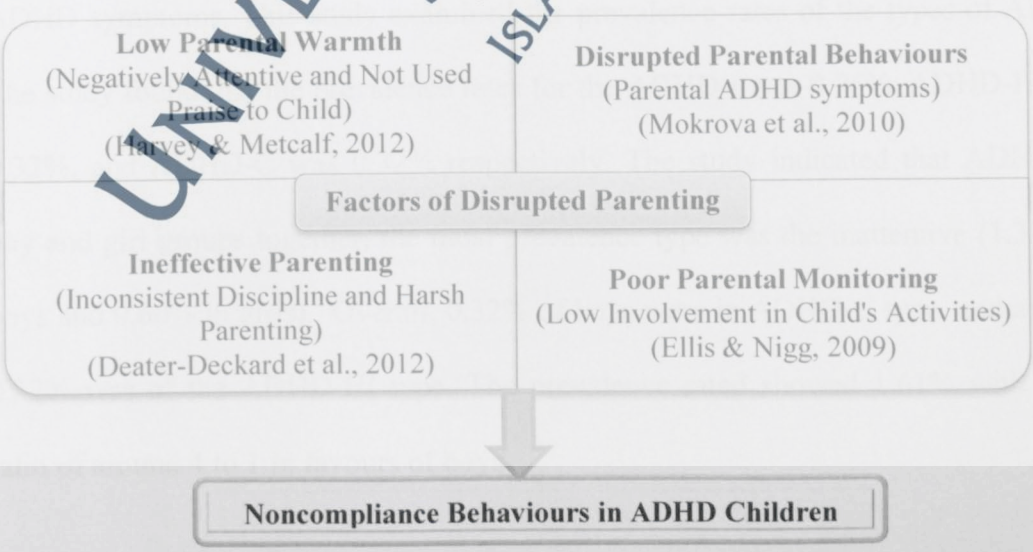
A study conducted by Deater-Deckard et al. (2012) was to examine the association between challenging child disruptive behaviour (noncompliance, anger, impulsivity) and harsh parenting. The participants were 147 mother-child dyads in which mothers' age (*M=32.80 years*, SD=*6.17*) and children's age (*M=57.29 months SD=15.54*). The negativity scale of Parent Feelings Questionnaire (PFQ) was used to measure the maternal self-reported of harsh parenting (Deater-Deckard, 2000). For assessing the child disruptive behaviours, each mother also rated her child's challenging behaviours problems. The study found that mothers with poor parenting practices have higher levels of harsh negativity and associated with child disruptive behaviour (noncompliance, anger, impulsivity). In contrast, mothers with better parenting practices, the child disruptive behaviour was not associated with maternal harsh negativity. The harsh parenting influence on children's behaviours development in part through its impact on parenting behaviours and interactions.

Another study conducted by Ellis and Nigg (2009) was to examine the relationship between ADHD diagnosis and symptoms domains in children with parenting practices. The parenting practices were included parenting monitoring, involvement with children and disciplinary practices. The study was conducted among 181 children aged six to 12 years old. The DSM-IV was used to category the ADHD presentation: ADHD-HI (*n*=52), ADHD-I (*n=24*), and ADHD-C (*n*=71), and ADHD not otherwise specified (ADHD NOS) (*n=34*). For assessing parenting practices, the six domains were included in APQ assessment: involvement, positive parenting, poor monitoring, inconsistent discipline, corporal punishment, and other discipline practices. The results found that parents' inconsistent discipline, parents' low involvement, and poor monitoring were meeting DSM-IV criteria for ADHD in

children and developed children's disruptive behaviours. The ADHD-I symptoms were associated with paternal inconsistent discipline and low involvement, and ADHD-C was related to maternal inconsistent discipline. The study indicated that lack of father's participation and involvement in family could increase the likelihood of maternal ineffective parenting and monitoring of the child's activities, and also deprived the need of socialisation opportunities in children.

Based on the researches above, there are four factors of disrupted parenting associated with children's disruptive behaviours (noncompliance) especially among those children who have ADHD symptoms. These factors are, low parental warmth, ineffective parenting (inconsistent discipline and harsh parenting in managing child's behaviour), disrupted parental behaviours, and poor parenting monitoring on child's activities (see Table 2.2). These four factors of disrupted parenting are among the major contributor to noncompliance and defiance behaviours in line with the child's ADHD features, and affect the quality of parent-child interactions. According to Danforth et al. (2006), some researches have shown that treating noncompliance behaviours using appropriate intervention often results in significant improvements.

*Table 2.2: Factors Affect the Quality of Parent-Child Interaction*



## 2.3 Issues on ADHD for Malaysian Children Population

Several studies conducted to examine the issues of ADHD among children in Malaysia (Burns et al., 2006; Gomez & Hafetz, 2011; Narkunam, et al., 2012; Wan Salwina, Nik Ruzyanei, Tuti Iryani, Shamsul Azhar, Aniza & Zasmani, 2010).

A study conducted by Burns et al. (2006) was to examine whether the symptoms of ADHD exhibited in Malaysian preschool children (*n=928*) were demographically similar to those found in preschool children American paediatric sample (*n=1,015*). The study indicated that both Malaysian and American boys had significantly higher scores for ADHD-I and ADHD-HI than girls, whereas only in the American sample boys score significantly score higher in ODD than girls. This study was supported by Visser, Bitsko, Danielson, Gandhour, Blumberg, Sobieve, Holbrook, Wolraich, and Cuffe (2015) in which among all children aged four to 17, boys were more than two times likely to have been diagnosed with ADHD as compared to girls. The finding stated that the prevalence of ADHD was high in boys than girls.

In understanding the most influence types 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-IV-TR for ADHD symptoms. This study examined the prevalence rates of the types of ADHD. The study found that the prevalence rates for the ADHD-I was 0.96%, ADHD-HI was 0.32%, and ADHD-C was 0.32% respectively. The study indicated that ADHD for boy and girl groups together, the most prevalence type was the inattentive (1.37% in boys and 0.60% in girls). Overall, 0.32% of boys were in ADHD-C type, and another 0.32% was of the ADHD-HI type. The prevalence rated showed 1.61% with a sex ratio of around 4 to 1 in favours of boys.

A study conducted by Narkunam et al. (2012) to examine the impact of children with ADHD on their parents. A total of 95 parents with children diagnosed as having the symptoms of ADHD attending the Psychiatry Adolescent and Child Unit, University Malaya were included in this study. Their parenting stress was assessed using the Parent Stress Index. The proportion of parents who reported significant stress in this study was much higher than in most studies (n=69, 73%) and mothers were significantly more stressed than fathers. Significant correlation was found between the severity of the child's disorder and the parents' stress level and non-Malay parents more stressed than the Malay parents. Parents with children older than 12 years of age were six times more stressed than parents with children younger than 12 years old. The findings of this study were consistent with the study conducted by Ramli and Zasmani (2007) in which it has been found that 63% of mothers with ADHD children had significant stress levels compared to mothers of children with non-ADHD. Overall, it has been understood that, the stressed parents acknowledged that having a child with ADHD was their biggest worry and concern.

Wan Salwina et al. (2010) examined the association between the symptoms of ADHD and bully-victim problems among Malaysian children attending primary schools in Kuala Lumpur. A total of 410 children from seven randomly selected schools were assessed with regards to bully-victim problems and ADHD symptoms using self-reported questionnaires. Malaysian Bullying Questionnaire was used to rate bully-victim problems, while ADHD symptoms were assessed using Conners-Wells' Adolescent Self-report Scale. The findings indicated that ADHD symptoms were found significant in relation to bully-victim problems. The ADHD symptoms reported by students were significant among bullies (OR=0.59,

CI=0.42-0.83, p<0.01) and bully- victims (OR=0.55, CI=0.37-0.81, p<0.00). Parents reported significant ADHD symptoms only in victims (OR=1.260, CI=1.02-1.56, p=0.03). ADHD symptoms were significantly present among bullies, victims and bully-victims. These findings open new perspective in managing disruptive behaviour related to ADHD among children in Malaysia.

In addition, the symptoms of ADHD are usually overlooked by many, especially parents. With more ADHD children being enrolled in mainstream education system instead of receiving specialised programmes, they are lacking behind their typically developed counterparts (Ramli & Zasmani, 2007). Thus, there is a need for parents and teachers in increasing their awareness of children's problems and looking for the professional helps. Counselling can help parents with ADHD child to address the issues in which they are coping with their affected child. Forming a counselling alliance with psychotherapy is important to develop an empirically supported therapy relationship for dealing with these problems. The majority of children with ADHD do not exhibit difficulties requiring intensive psychotherapy in the absence of comorbid problems, (Goldstein, 2014). Moreover, the public awareness on ADHD in children itself is minimal and most parents regard these behaviours exhibited by these children as naughty behaviours (Ramli & Zasmani, 2007). Therefore, there is a need to increase a public awareness about ADHD, thus, the early intervention and prevention from professional counsellors can be instituted in these children.



## 2.4 Roles of Relevant Authorities and Counsellor towards ADHD Children

The Ministry of Women, Family and Community Development (2013), categories ADHD as one of learning difficulties which is means intellectual capabilities that do

not confirm with biological age. Those individuals who are fall within this category considered as having the condition that affects their learning disabilities. The relevant authorities include Ministry of Health (Family Health Division) and Ministry of Education (Special Education Department) and Ministry of Women, Family and Community Development (Social Welfare Department) have responsibilities in dealing with ADHD children in Malaysia.

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. In dealing with ADHD, the main responsibility of Ministry of Education is to provide Special Education Integrated Programmes (SEIP) which is specific class in mainstream schools for children with learning disabilities. The trained teachers in special needs and school counsellors can help to cater for these children' learning needs. The main aim of SEIP is to ensure that these children can learn in a least restrictive environment. This enables them to learn in a normal learning environment and to help them to develop their social and communication skills (Ministry of Education, 2013).

Basically, specific development of screening test is conducted to screen and diagnose the symptoms of ADHD. These engage both parents and healthcare providers to look out for and act on the early signs of potential disabilities. With United Nations Children's Emergency Fund (UNICEF) support in 2008, Ministry of Health piloted a programme that included specific development of health screening 4-year. The programme strongly encouraged health professionals to take note that of parental concerns of developmental delay and incorporated a child developmental checklist, ADHD or Learning Disorders screening at four years (Amar-Singh, 2008).

In 2012, this programme was launched and implemented at national level as a health monitoring programme which targeted at identifying the earliest signs of potential disabilities (ADHD) (Ministry of Health, 2013). Apart from early detection, Ministry of Health provides healthcare programme for ADHD children such as, Community Based Rehabilitation centres (CBR) to provide awareness training to parents and affected children on their symptoms. Parents are recommended to send their affected child at CBR centres for screening, intervention and rehabilitation. The CBR is developed under Social Welfare Department and is meant to be a one-stop centre for individuals with disabilities (children and adults). The services provided by CBR for ADHD such as diagnosis, behavioural treatment, and social development skills.

In addition, the roles of counsellor in dealing with ADHD also highlighted as important. A study conducted by Supiah (2003) to explore the roles of trained teachers toward ADHD among Malaysian preschool pupils and to identify whether the impact of ADHD symptoms in relation to classroom events in inclusive setting. The ADHD checklist was used to screen 533 preschool pupils in 28 mainstream classrooms from whom a sample of 10 pupils were identified as potential individual case studies. These pupils were more likely to be rejected or neglected during classroom activity or interaction owing to their behaviours. In examining the way teachers dealt with ADHD symptoms, several constraints faced by teachers were uncovered including lack of knowledge and skills although they were positive towards pupils with ADHD. They predominantly used traditional methods in teaching and hence less pupils' involvement in activity. This study suggested that inclusive education for ADHD children should be provided with well-trained teachers who are specialised in ADHD and the action research should be carried out for better understanding about ADHD.

Another study conducted by Aili, Norharlina, Manveen and Wan Salwina (2015) in one young girl aged 12 who diagnosed with ADHD. She has been treated with psycho-stimulant medication (Methylphenidate) and her mother was involved in parent training programme which more emphasised on positive parenting style and family attachment. Apart of the treatment was play therapy session provided for the girl and her mother to apply parenting skills. After several repeated treatments (medication and parent training programme), the girl was noted to be less impulsive, and her relationship with her mother has been improved. There is no specific type of parent training programme has been applied and mentioned by the therapists. However, this study indicated that parent training programme is recommended to be applied among parents in coping with their ADHD child.

A study conducted by Noor Azimah, Wan Salwina, Tan, Aida, Shalisah and Khairani (2011) in a boy who was diagnosed with ADHD. He was treated using the Methylphenidate and supported with parental counselling and training. The parental counselling and training are not only about the diagnosis and medication given to the child, but also emphasised parents on the importance of having clear expectations and regulations at home, reinforcing positive behaviours and building the child's competence and success. Similar to the study conducted by Aili et al. (2015), there was positive outcome of the implication of parental counselling and training with medication in improvement of child's behaviour problems. However, Noor Azimah et al. (2011) were also not mention the specific application of parent training applied.

A study conducted by conducted by Marziyeh and Khaidzir (2009) 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. Both the child and her mother were involved in filial therapy or similar to play therapy. In simple, the primary goal in child-centred play therapy is self-directed growth and change in the child. Inspired by this method, filial therapy aims at helping parents become the agents of change in their children's lives through conducting play therapy sessions with their own children (VanFleet, 2005). Filial therapy is parent-child relationship building intervention which mainly focused on two aspects: (i) reducing children' problem behaviours, and (ii) ameliorating parent-child dysfunctional relationships through improving parenting knowledge and skills. The outcomes of this one-month long case study 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.

Therefore, it has been found that, parent training programmes on rebuilding parent-child relationships through teaching the parents skills necessary for coping with the behaviour problems in ADHD children in Malaysia (Aili et al., 2015; Marziyeh & Khaidzir, 2009; Norazimah et al., 2011) have been documented. There are various types of parent training are implemented to deal with behavioural issue of ADHD children in Malaysia. However, there is a lack of uniformity access into a specific parent training programme (Amar-Singh, 2013). Without specific and adequate training, it is difficult to deal with children with learning disabilities include ADHD (Amar-Singh, 2013). The parent training programmes conducted by Aili et al. (2015), Marziyeh and Khaidzir (2009), and Norazimah et al. (2011) were showed some improvement in children's behaviour, however, these programmes were too general with no specifically employed a specific type of parent-child intervention. In addition, the effectiveness of these programmes are intervened with psycho-stimulant

medication which are directly addressed the child's behaviour problem due to ADHD symptoms (Aili et al., 2015; Norazimah et al., 2011). The study conducted by Marziyeh and Khaidzir (2009) was more concern on promoting positive parenting skills to improve a supportive relationship between parent-child rather than directly involved on treating behavioural problems in ADHD children. According to Marziyeh and Khaidzir (2009), based on filial therapy, the child's behaviour problems later can be addressed by parents who learned these parenting skills.

## 2.5 Overview Parent-Child Interaction Therapy

Since the medication treatments have side effect in preschool children, other types of therapy, particularly behavioural therapy can be effective in the long-term reduction of the core ADHD symptoms for this age group (British Psychological Society, 2009). Many studies found that the most recommended parent-child intervention at improving behavioural symptoms among ADHD children is Parent-Child Interaction Therapy (PCIT) (Counselling Directory, 2014; Eyberg, & Funderburk, 2011; Thomas & Zimmer-Gembeck, 2011). The PCIT 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 effective for children who behavioural problems.

The PCIT progresses through two distinct phases: CDI and PDI parenting skills. In CDI phase, the parenting skills that parents learn are represented in the acronym, PRIDE, which stands for Praise, Reflection, Imitation, Description, and Enjoyment. In PDI phase, parents are learn how to give appropriate, clear, and direct commands in order to maximise chances for child's compliance. Parents are also

learned specific discipline method by using time-out to deal with child's noncompliance behaviours. These strategies provide parents with appropriate tools to manage their children's behaviour and avoid parents from using physical power, and to promote children's emotional regulation (Urquiza & Timmer, 2014). The live coaching and monitoring the parental acquisition skills from therapist are the main method of training in PCIT (Eyberg et al. 2008). There is a growing trend in the psychological literature describing implementation of PCIT intervention format. There are two formats of PCIT can be delivered, (i) standard and (ii) abbreviated.

### 2.5.1 Abbreviated Intensive PCIT Format

Traditionally, the standard PCIT is delivered in weekly one hour sessions and families' average time in treatment ranges from 12 to 14 sessions (Nixon, Sweeney, Erickson, & Touyz, 2003) or 12 to 16 sessions (Thomas & Zimmer-Gembeck, 2012). The abbreviated or brief PCIT intervention is popular because the perception by consumers that treatment is excessively demanding has been shown to interfere with therapeutic change (Lewis, 2010). It has been found that early intervention programme with fewer treatment sessions was more effective than those with higher treatment sessions. These evidences have been documented in several studies (Abrahamse, Junger, Chavannes, Coelman, Boer, & Lindauer, 2012; Graziano et al., 2014; Lewis, 2010; Nixon et al., 2003; Nixon et al.,2004) in which four to five sessions of PCIT treatment was effective in treating behavioural issues in children.

A study conducted by Abrahmse et al. (2012) was to investigate the effects of PCIT in short format (5-session) in decreasing the intensity of disruptive behaviours in Dutch children. This study was based on the data of 37 referred families in

Netherlands. The participants were 17 children (45.9%) met the DSM-IV diagnostic criteria for ODD and ADHD. It was assumed that PCIT (short format) will produce positive effect on the pattern of disruptive behaviour of these young children. The CDI and PDI sessions began with a didactic parental teaching in which parents were coached by the therapist. The study found that there were 73.9% mothers reported a significant decreasing in their child's disruptive behaviours with the scores showed within the mild ranges of behaviour problems. The study supported the hypothesis that PCIT (short format) has positive effect in reducing the disruptive behaviour among preschool children with ODD and ADHD.

Graziano et al. (2014) conducted a study to investigate the feasibility of implementing a brief and intensive format of PCIT to treat behaviour problems in young children. The participants were 11 children (*M*=5 years old who displayed elevated externalising behaviour include aggression, defiance, and ADHD. Children were referred from paediatricians (36%), school personnel (28%), and self-referred (36 %). The adaptation of PCIT involved changing the length of the intervention but no changes to the principles of treatment and the core skills. Each family received 10 total sessions which required 90-minute session for five days in a week for two weeks concurrently. The study found that parents reported decreased in child externalising behaviour and increased in child compliance behaviour. This brief and intensive version of PCIT was acceptable to all enrolled families with zero attrition rates. Based on TAI assessment, most parents reported highly satisfied (*M=48.10*) out of 50. The study concluded that parents were more convenient to enrol in brief version of PCIT.

A study conducted by Lewis (2010) to evaluate the efficacy of an Abbreviated Intensive PCIT protocol with a population of preschool aged children displaying mild

to moderate levels of disruptive behaviour. The Intensive Treatment included two hour sessions across five consecutive days. This Intensive Treatment was followed by Maintenance Treatment which was comprised of three weekly 30-minute telephone calls and finished with 1-hour booster session. The study hypothesised that parents would report improved in child behaviour across baseline and post-treatments. Six families with children who have mild to moderate disruptive behaviour involved in the study. The results found that all children have higher mean alpha compliance percentages at post-treatment (Intensive Treatment, Maintenance Treatment, and Follow-up) as compared to the mean alpha compliance of the three baseline observations. The results contributed to the additional growing body of literature on the efficacy of short term format of PCIT to address childhood disruptive behaviour.

A study conducted by Nixon et al. (2003) was to compare between standard format of PCIT (STD) and the abbreviation format of PCIT (ABB) in reducing behavioural problems in preschool children. For the STD group, 17 families (14 boys and 3 girls) and the ABB group, 20 families (13 boys and 7 girls) completed the treatment. The STD treatment consisted of 12 one to two hours weekly sessions. For the ABB treatment, therapists discussed and modelled the parenting skills on videotape and gave a copy to the family to watch at home. The face-to-face sessions were alternated with the 30-minute telephone consultations. Both STD and ABB treatments included 1-hour booster session of face-to-face after 1-month post-treatment. In term of treatment hours, STD took 15.5 hours and the ABB took 9.5 hours to administer. The findings indicated that children in the STD and ABB groups were not significantly different in terms of their behavioural improvement. Thus, the study suggested that ABB was effective to cope with child's behavioural disorders.

Nixon et al. (2004) extended the research in ABB format whether it maintained short-term gains in reducing behavioural problems in preschool children at 1- and 2-year follow-up. The participants were 67 Australian children who met the diagnostic criteria for ODD were randomly assigned to three groups STD, ABB and WL. The samples were 54 children consisted of (STD=17), (ABB=20) and (WL=17). On average, children in the final sample were 46.8 months old with 70.4% (boys) and 29.6% (girls). Children in the STD and ABB groups required to participate in a follow-up study that assessed children's behavioural functioning at 6-month, 1-year, and 2-year post-treatment. Data were collected for participants in the STD and the ABB at all time-points. For the WL, data were only collected at pre-test and post-test, as this group was a WL control group that entered treatment following post-test. Results indicated that immediately following treatment (post-test) children in STD and ABB groups had significantly less oppositional and conduct behaviours than children in the WL. The analysis of follow-up data indicated that there were no significant differences on any outcomes for both children in STD and ABB groups. The findings suggested that abbreviated form of PCIT has long-term advantages similarly to standard PCIT for families with young children displaying behaviour problems.

As can be found, many researches supported the impact of empirically based treatment of abbreviated format of PCIT on producing positive treatment outcomes for both parents and children with disruptive behaviours. This study also has made the considerable advances in the areas of PCIT format of delivery which included home-based services its implementation in different cultures.

### 2.5.2 Home-Based Services of PCIT

The PCIT basically conducted in a clinic-based setting. Therapists conducting PCIT in a home setting may help to reduce some common barriers to treatment such as transportation or availability (Masse, & McNeil, 2008). In-home PCIT is an alternative to the clinic-based model because it allows therapists to observe, assess, and change behaviour in the natural environment. Although a degree of clinical control is lost by conducting in-home, the ability to troubleshoot live is an advantage for therapist and family. In this way, what therapists lose in the lab (control), they gain in the home (generalisation). In-home PCIT benefit eliminates the artificial nature of sessions by giving parents hands-on coaching and feedback on the very behaviours that parents try to describe and therapists try to visualise. For this reason, home-based PCIT is a viable and effective alternative to the clinic-based model (Ware, McNeil, Masse, & Stevens, 2008). Some of the empirical investigations revealed that home-based PCIT produced comparable results (Lanier et al. 2011; Ware et al., 2008).

Lanier et al. (2011) conducted a study to compare between PCIT in-home based and standard clinical-based in a community setting. By using a quasi-experimental design, the standardised measures at three time points were collected from 37 parent-child dyads. The study indicated that families with transportation difficulty and disabled family members were more benefited from the convenient of home-based therapy with no cancellation rate. The disadvantage to home-based was difficulty to work with one parent and one child at a time if there is chaos in the home and several children present during the treatment. However, the study suggested that receiving PCIT in-home is convenient to many participating families and potentially remove the barriers that may contribute to attrition.

Another study conducted by Ware et al. (2008) to investigate the effectiveness of in-home PCIT using AB of single-case design across five subjects. Children included in the study were between the ages of two and seven and met the DSM-IV criteria for significant behaviour problems as measured by parents. The baseline data for CDI were obtained by assessing the parents' positive behaviours (LP, RP and BD). A minimum of three consecutive data points were collected during baseline with no upward trend before the treatment began. The two criteria were used to determine when to change from CDI to PDI phase: (i) parents had to meet the mastery criteria of CDI parenting skills, and (ii) achieved the determined proportion of direct commands during DPICS observation. These data must be consistent for three consecutive sessions with no notable upward change. Then, the treatment was terminated once the family met PDI criteria. The follow-up data were collected for each dyad 1-month after the post-treatment. The study found a decreasing in parents' use of negative behaviour and increasing in use of positive behaviour, and contingent praise. The study provided preliminary evidence supporting the use of in-home PCIT similar to the effects observed in-clinic setting. By demonstrating the effectiveness of an evidence-based treatment in-home setting, the study also added to the growing literature which aimed at improving the quality of home-based intervention.

### 2.5.3 Implementation of PCIT in Different Cultures

PCIT was originally developed based on behavioural strategies known to be acceptable to European-American families in the United States (U.S). Additional researches have specifically focused on PCIT outcomes with different cultural groups to help understand how to maximise treatment efficacy while maintaining cultural

sensitivity. Although PCIT have been examined among Latino and Mexican Americans (Matos, Torres, Santiago, Jurado, & Rodriguez, 2006; McCabe, Yeh, Lau, & Argote, 2012), there is increasing recognition of examining child behaviour outcomes as a results of PCIT intervention among Asian (Leung & Tsang, 2012).

Matos et al. (2006) employed adapted version of PCIT among Puerto Rican parents and children aged four to six years with hyperactivity and high rates of noncompliance behaviour and defiant as measured by Disruptive Behaviour Scale for Children (DBRS) (Barkley, 1997). There were nine children in which seven children met diagnostic criteria for ADHD. The treatment manual of PCIT and the parent hand-outs were translated into Spanish. The in-depth interviews with parents (*n=15*) and clinical psychologists (*n=5*) were implemented to provide feedback on treatment processes and components. Parents and psychologists were asked to evaluate the CDI and PDI parenting skills, to examine the structure and content of PCIT, and to identify cultural barriers. The results suggested that PCIT seems to be an acceptable intervention for this ethnic group. Parents reported a significant reduction in children's hyperactivity and noncompliance behaviour, lower parenting stress and improved their parenting practices. Parents also reported high level of satisfaction with the treatment and work done by therapists. The low attrition rate of 10% was a good indicator of parents' satisfaction. The results suggested that Puerto Rican families with younger children may be responsive to this type of treatment. This finding indicated that Latino parents tend to use more warm and nurturing child-rearing practices (Gross, Fogg, Webster-Stratton, Garvey, Julion, & Grady, 2003).

Another study conducted by McCabe et al. (2012) to examine the PCIT treatment effects over a 6- to 24-month period post-treatment in young Mexican

American children. The participants were 58 families of children with clinically significant behaviour problems at a community mental health clinic between September 2003 and February 2006. A culturally modified version of PCIT, called Guiando a Niños Activos GANA (*n=21*) and standard version (STD) (*n=19*), and Treatment as Usual (TAU) (*n=18*) were employed in the study. GANA retained the core features of PCIT, but modified the delivery format to optimise cultural fit. The three TAU therapists were described their orientations as Person-Centred Cognitive Behavioural, Trauma-Focused Cognitive Behavioural, and family systems. The study compared the long-term effectiveness of culturally adapted GANA, STD with TAU. The long-term follow-up assessments were collected via telephone interview between February 2006 and July 2007. This study found that all treatment approaches (GANA, PCIT, and TAU) produced significant parent-reported improvements in young Mexican American children with behaviour problems. The GANA programme produced results that significantly superior to TAU on 4 out of 10 parent-report measures. These data suggest that both STD and GANA produce treatment gains that maintained over time, and GANA had similar effect as STD. Therefore, PCIT has been found to be effectively adapted to different cultures.

Another study conducted in Asia region by Leung and Tsang (2012) was to investigate the effect of PCIT among Chinese parent-child dyads in Hong Kong in reducing significant behaviour problem. The participants were 48 parents of 2- to 8-year-old children consisted in the intervention group and 62 parents for comparison group. The intervention group was assessed using the DPICS which translated in Chinese version on three occasions: before treatment, after treatment, and follow up. The treatment was conducted in Cantonese. The intervention group participants

completed the outcome measures at pre- and post-intervention, and 3- to 6-month follow-up assessment points. The comparison group participants completed the pre- and post-intervention measures at an interval of 4- to 5-month. The results indicated that PCIT was effective in reducing child behaviour problems among young Chinese children in Hong Kong. The majority of the intervention group children whose ECBI intensity scores were above the cut-offs before treatment fell below the clinical cut-offs at the post-intervention assessment. PCIT had been found to be effective in reducing inappropriate parenting practices, and increasing in positive parenting practices. These results were consistent with those of other PCIT studies with ethnic minority groups in which PCIT was found to be an effective treatment in reducing child behaviour problems (Matos et al., 2006; McCabe et al., 2012).

However, there is no PCIT study is conducted from religious perspective. Thus, this study aimed to understand the PCIT from cultural and religious aspects among Malaysian culture from parents' perspectives based on their experiences and perceptions about the treatment (Abbreviated Intensive PCIT) implemented.

## 2.6 Rationale for Abbreviated Intensive Parent-Child Interaction Therapy

The Abbreviated Intensive PCIT is not as other parent training programmes which have been implemented in Malaysia because this type of intervention is directly addressed child's behaviour problems and building supportive relationship between parents and child. Many of parent training programmes are specifically focusing on helping parents to improve their parenting skill such as teaching parents an appropriate parenting skills in coping with disruptive behaviour in ADHD children by encouraging positive behaviour between parents-child (Aili et al., 2015; Marziyeh &

Khaidzir, 2009; Norazimah et al., 2011) rather than focusing on treating disruptive behaviour problems. For example, filial therapy as conducted by Marziyeh and Khaidzir (2009) was a type of play therapy and it was lacked of behaviour therapy components that important in disciplining behaviours in children. Behavioural therapy involve helping parent to directly improve the child's behavioural problems using related methods such as time-out and discipline action at home or in public (Block & Smith, 2014). The Abbreviated Intensive PCIT is one of counselling interventions that integrated both of play and behavioural therapies. It is emphasises on improving parent-child relationship and helping parents to build effective parenting skills to increase their positive verbalisation and decrease their child's negative behaviours.

The PCIT (standard or abbreviated formats) have demonstrated its effectiveness through a number of studies over the world such as in Western (European-American) and Asian (China) cultures. This study took an initiative to understand the effects of Abbreviated Intensive PCIT whether it is applicable to meet the appropriate needs in both parents and children in Malaysia. Parents can learn better ways to deal with the 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. Several studies investigated the element of play therapy (Harwood & Eyberg, 2006; Ku Suhaila Bruce & Mohamad Isa, 2014; Schottelkorb & Ray, 2009) and behavioural therapy (Block & Smith, 2014; Karras, 2013).



### 2.6.1 Play Therapy in PCIT

According to British Association of Play Therapy (2009), play therapy is a child-centred in which play is the primary medium and speech is the secondary medium.

Most of the young children express themselves through play, when meaningful discourse is not possible to them. Conversely, play is an indirect way for therapists to recast children's perceptions, cognitions, and behaviours (Kingsley & Mailloux, 2013). Play therapy counsellors or therapists observe for patterns and themes in children's play to make responses that produce therapeutic movement and ultimately catharsis related to the children's problems (Landreth, 2002). The difference between play and therapy is the counsellor's ability to think analytically about everything that is going on during the session in a form of verbally, nonverbally, or symbolically in child's play. Play therapy also is acknowledged educationally and clinically as an effective intervention to improve the mental health of child clients (Landreth, 2012).

For children below 10, their cognitive and verbal abilities to involve in fully talk form of counselling are not properly developed. Their natural form of communication occurs through play. Thus, 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 limitation in developmental levels and capabilities (Schottelkorb & Ray, 2009). During CDI phase, child will lead play situation in which parents coached by therapist to learn to follow their child's lead. Parents required to model appropriate play behaviours such as sharing the toys with their child. Typically, at the completion of treatment, parents show decrease in negative talk, increase in pro-social talk, and physical warmth toward their child. Several studies of play therapy (Harwood & Eyberg, 2006; Schottelkorb & Ray 2009) have shown positive impacts on children with behaviours that required counsellors to improve their profession.

A study conducted by Schottelkorb and Ray (2009) was to examine the effects of play therapy and teacher consultation for four young children diagnosed with

ADHD symptoms. Of the four participants, one child had received a formal diagnosis of ADHD and none took psycho-stimulant medication at any time throughout the study. The play therapy that employed by researchers was known as Child-Centred Play is a child-centred, in which play is the primary medium and speech is the secondary medium. In the study, all play therapy sessions were conducted in playrooms set up with toys by two trained counsellors. The teacher consultation provided the core conditions required of person-centred counselling: unconditional positive regard, genuineness, and empathy. The researchers used the Direct Observation Form (DOF) three times per week to assess student on-task behaviour throughout the baseline, intervention, and post-intervention phases. The study found that two students demonstrated a substantial reduction in their ADHD symptoms due to participation in play therapy sessions with trained counsellors. The results also indicated that play therapy demonstrated effective results than teacher consultation. Thus, the study suggested that it is important for counsellors to know how to use play therapy to help ADHD children to be fully functioning in their lives.

Another study conducted by Harwood and Eyberg (2006) was to examine the first phase of PCIT, called CDI among 100 mother-child dyads. The CDI is similar to play therapy in which parents and their child engaged in a play situation with the aim to strengthen the parent-child relationship. There were 69 boys and 31 girls aged between three to six years and diagnosed with disruptive behaviour disorders. After the pre-treatment assessment, families participated in weekly, 1-hour CDI sessions. Therapists included games that facilitate discussion and social skills development whether play with the toys and games are child directed. Therapists had a sound theoretical rationale for selecting and placing toys and materials in a play therapy

playroom. Toys allow for creative and emotional expression, testing of limits, and role-playing reality. After the CDI phase of PCIT, mothers reported significant reduction in parenting stress, dysfunctional parenting practices, and child disruptive behaviour, and nearly half the mothers rated their child's disruptive behaviours within normal limits. These findings illustrated the powerful influence of contingent positive parental attention during play therapy on the transactions of mother-child dyad.

However, play therapy in Malaysia is still in the early stages of development (Ku Suhaila, Bruce & Mohamad Isa, 2014). A study conducted by Ku Suhaila et al. (2014) to investigate the effectiveness of play therapy by conducting 3-day training sessions in different part of Malaysia for a total of 116 participants including mental health students and practitioners. The participants in this study were counselling students (undergraduate, masters and doctoral) and practitioners in Malaysia and some of them registered with Malaysian Board of Counsellor. The training covered various learning experiences including lectures, readings, discussions, role playing with the instructor and peers, live demonstrations, and observation of the instructors' and peers' play therapy sessions. Four research questions guided the study in exploring the differences on the three subscales: attitude, knowledge, and skills in play therapy. The study found that, there were no differences between the students (without experiences) and practitioners (with experiences) in gains on scores in attitude, knowledge, and skills throughout the training. Although practitioners have more general working experiences than students, the training provided the same overall consequence for both groups. This study indicated that play therapy is beneficial and important to who work and deal closely with the affected children in support of their well-being.

### 2.6.2 Behavioural Therapy in PCIT

Although several studies have documented the effectiveness of play therapy during CDI phase, however, some studies also documented that children participating in behavioural therapy during PDI phase increase in their compliance behaviours toward parental commands and decrease in their disruptive behaviours (Bagner & Eyberg 2007). Thus, the main objective of behavioural therapy in PDI for children is to cut down the disruptive behaviours that can get them into trouble at school, and to turn family life into a better zone (Karras, 2013). Thus, PDI teaches parents to use specific behaviour management techniques as they play with their child. The specific behaviour management skills are include how to discipline the child by using the effective commands and time-out procedures.

First, PDI focuses on giving children effective commands, and teaches parents how to give commands appropriately (Eyberg et al., 2009). If a child is noncompliance with a command, parents is taught to wait, issue a warning, and then proceed to an effective time-out if the child remains noncompliance. Eyberg et al. (2009) offers eight rules for issuing commands. Commands should be direct, not in question form, given one at a time, positively stated, specific, age appropriate, polite and respectful. If a child disobeys a command twice, he or she is brought to a time-out chair or room, if the child does not want to remain sit on the chair, then parent reissued the command until compliance is reached. One reason of effective command issuing is that although parents may assume that a disobedient child is being oppositional, it may just be that the child does not comprehend the vague commands of the parents (Johnson et al., 2000). For clinical practice, it may be recommended to start the intervention with the discipline stage of PDI before the play therapy of CDI

for certain children especially those with behaviour that is extremely out of parental control and potentially dangerous (Johnson et al., 2000). The important concept behind PDI is no matter what occurred beforehand, compliance with a command is immediately followed by a labelled praise from the parent, thus, it is positively reinforcing the compliance behaviour in children (Wagner & McNeil, 2008).

Second, the time-out procedure is a form of non-harmful punishment that involves temporarily separating a child from an environment where unacceptable behaviour is intended as extinction of the offending behaviour. In PCIT, it is an effective form of child discipline (Stassen, 2014). Parents learn to use specific time-out procedure when their child does not comply with command given or demonstrates other rule-breaking behaviours. Time-out is an effective strategy to deal with ADHD child because it is used less as a punishment and more as a way to cool down the child. If the child becoming frustrated or is about to lose his or her temper, the child is bring to sit quietly in a boring area for a minute with no interaction from parent. If the child is able to calm down, welcome the child back into parent's company and provide the child time in by praising his or her effort (Kurtas, 2013). For children, a time-out is very effective in reducing behavioural problems if parents follow the procedure appropriately, give the child opportunity to comply and provides time for them to make decision when the child is ready to return to the activity (Eyberg et al., 2009).

A study conducted by Donaldson, Vollmer, Yakich, and Van Camp (2013) was to evaluate a time-out procedure to increase compliance with the verbal time-out instruction among children aged three to five years old. Six children had been referred by their preschool teachers because they exhibited behaviour problems at school. The time-out location on the playground was a chair on the perimeter of the playground,

whereas the time-out location at home took place in the bedrooms. The behaviour problem was defined as breaking playground rules or house rules. The effects of time-out were demonstrated using an ABAB reversal design. The two time-out procedures were compared using a multi-element design during the treatment phases: 4-minute and 1- or 4-minute. Results showed that time-out was effective in reducing problem behaviour of all six participants. Both the 4-minute and the 1- or 4-minute time-out procedures decreased problem behaviour to zero or near-zero levels. Therefore, time-out is effectively reduced problematic behaviour and increase compliance.

Other elements in PDI phase are positive punishment and positive reinforcement that is central to behavioural therapy (Karras, 2013). Parents practice positive reinforcement for desired behaviours, and when a child fails to comply with an instruction, there is a strict series of positive punishment in the form of escalating time-outs. The behavioural therapist details the concepts and procedures derived from positive reinforcement such as contingent delivery of attention, praise, points and punishment such as time out from reinforcement, loss of privileges, and reprimands. The positive reinforcement for pro-social and positive punishment for non-deviance behaviour is central to treatment. During PDI phase, parents are taught how to use positive punishment and reinforcement techniques contingent on the child's behaviours, to provide consequences consistently, to attend to appropriate behaviours, and to ignore inappropriate behaviours.

In Malaysia, however, research in parental behaviour training and their relation to children behaviour improvement still lack and attending counselling also stigmatised. According to Malaysia Psychiatry Association (2011), behavioural therapy conducted with the aim to help ADHD children to control aggression,

modulate social behaviour, and be more productive. Behaviour therapy can be used to help parents improve their parental behaviour, (CMHA, 2012) or manage their behaviour and parenting skills (Harwood & Eyberg, 2006) inreducing disruptive behaviours in children. However, many parents are reluctant to seek counselling services for their problematic children (Low, Kok & Lee, 2013). Since many researches show the behavioural therapy work well for the symptoms of ADHD among children (Bagner & Eyberg 2007; Donaldson et al., 2013; Harwood & Eyberg 2006; Karras, 2013), parents need to be trained with the behavioural parenting skills and how to use them all the time. Therefore, the current study employed behavioural therapy that may contribute to improve counselling or mental health practicing in dealing with parents and ADHD children.

## 2.7 Need for Professional in Mental Health Counselling

The Abbreviated Intensive PCIT is a counselling intervention which combined both elements of paly and behavioural therapies to assist parents to deal with disruptive behaviours in ADHD children effectively. Thus, the involvement of mental health professionals in treating behavioural problems due to ADHD symptoms is significantly important. A crucial development in mental health counselling has been defining the roles and functions of the profession (AMHCA, 2011). Due to the chronic nature of ADHD and the associated functional problems that manifest in the school setting, mental health and school counsellors are in an optimal position to facilitate and implement evidence-based interventions to support children with ADHD as they transition through school. There is a need for well trained counsellors to provide support for ADHD students.

A study conducted by Shen and Herr (2003) was to investigate the role of school counsellors in providing play therapy in the elementary schools of Taiwan. There were two male and two female counsellor educators participated in the interviews. Two of them had been offering play therapy courses but none of them had formal schooling in play therapy. The third counsellor educator did not offer play therapy courses, but had advocated play therapy in the counselling literature in Taiwan. The fourth counsellor trainer did not offer play therapy courses or advocate play therapy in the professional literature. The first interview focused on a structured interview approach, along with a half-hour telephone interview was sequentially conducted with each individual participant. The second interview focused on discussing the participants' reactions to the analysed results. The findings indicated the following recommendations: (i) conceptual understanding about play therapy and child counselling needs to be established through parenting education, (ii) to provide play therapy and child counselling to children, parents, teachers, school administrators, government officers, and policy makers, (iii) the providing of more courses related to basic knowledge in child development, counselling, and play therapy can enrich the foundation of the prospective counselling personnel, (iv) mental health counselling in needs to be professional, and (v) educational resources in Taiwan need to be allocated with a proactive approach for school counselling concerning the manpower, and empirical foundations related to child counselling. The study recommended that there is a demanding need for counselling professionals to include the development of play therapy in school and community settings.

An analysis study conducted by Hamilton and Astramovich (2014) stated that well trained and professional counsellors play a central role in helping children with

ADHD. Research on counselling children with ADHD suggests that action-oriented approaches are vital and play therapy is effective when working with ADHD children (Portrie-Bethke et al., 2009; Schottelkorb & Ray, 2009). Based on Hamilton and Astramovich (2014) analysis, when counselling children with ADHD, there are three importance areas of focus include conflict resolution, self-esteem, motivation and self-efficacy. First, professional counsellors can help parents to develop skills for facilitating parent-child interactions by understand the biological and environmental factors that may lead to conflict among them (Ghanizadeh, 2007). Ultimately, helping children with ADHD develop conflict resolution skills helps to minimise social alienation and improves their self-esteem. Second, professional counsellors can address motivation and self-efficacy by helping ADHD children to engage in successfully complete activities at school and home. In particular, helping children develop intrinsic motivation through the counselling process is critical to help children to gain confidence in their abilities and desire to try new behaviours. Hamilton and Astramovich (2014) concluded that, there is a need for professional counsellors who can help provide comprehensive behavioural support when working with ADHD children and their families. This is to ensure the lifelong success of children with ADHD by focusing on the three areas of conflict resolution, motivation and self-efficacy, and self-esteem, professional counsellors.

Furthermore, 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). A study conducted by Aili et al. (2015) suggested that based on the study findings conducted in a young girl with ADHD, the interplay of roles within affected families, and the huge impact that family difficulties have on a child with ADHD warrants the need for mental health professionals such as clinicians, paediatricians, psychologists, or counsellors to look beyond the core symptoms of this disorder. A lack of professional mental health practitioners, assessment tools and appropriate intervention prevent any children and their families to be assessed. In recognising, assessing and treating family difficulties of children with ADHD, mental health professionals often need to incorporate several modalities of treatment demonstrated. The mental health professionals cannot treat children without treating their families. This study also recommended that it is important to better document the training demands for mental health professionals and follow-up resources that are required to achieve high-quality intervention for ADHD children and their parents.

Therefore, the need for professional mental health counsellors in schools or hospitals to help child clients with ADHD and their parents is highly demanded. Professional mental health and school counsellors are trained in using the assessment instruments and psychotherapy to identify, evaluate and treat dysfunctions for purposes of providing appropriate counselling (TCCU, 2005). As stated by Malaysian Board of Counsellor (2008) stated (2008) that counsellors should at all times evaluate and increase their knowledge, competencies and skills in the counselling profession, and monitor their effectiveness as counselling practitioner. Thus, in dealing with behavioural issues among 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 such as

parenting skills, play and behavioural therapies. This is parallel with the policy of 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 comprising psychiatrists, clinical psychologists, and counsellors in helping ADHD or related problems.

## 2.8 Measuring the Intervention Effect of PCIT

Basically, therapists evaluate the progress of PCIT intervention among affected families in several ways. Therapists measure the effectiveness and progressive of PCIT through CDI and PDI observation and coding. Therapists graph the score each week to monitor the child's behaviour progress towards the treatment (Zisser, & Eyberg, 2009). In CDI phase, parents are learned to follow their child's lead in play and coached to give positive attention to their child's appropriate behaviours. If the child misbehaves, parents are coached to use differential social attention and ignore the misbehaviour until it ends. In PDI phase, parents are learned to give effective commands and specific time-out procedure for highly disruptive or noncompliance child behaviour (Eyberg & Funderburk, 2011). A few studies have examined the impact of the CDI on child and parent outcomes (Bagner, Rodríguez, Blake, & Rosa-Olivares, 2013; Eisenstadt, Eyberg, McNeil, Newcomb, and Funderburk, 1993).

A study conducted by Eisenstadt et al. (1993) to evaluate the effectiveness of PCIT among 24 mothers with young child referred to psychology clinic for behavioural treatment. Families received 14 weekly 1-hour session treatments of PCIT with 12 receiving CDI training first (CDI-First group) and another 12 receiving PDI training first (PDI-First group). In CDI, parents were taught to allow their child to lead

the play activity, not to criticise the child, and not to use commands or leading questions which may make it difficult for child to lead the play. In PDI, parents were taught how to direct their child's activity by using clear, positively stated, and consistent consequences for behaviour such as praise for compliance, and time-out in a chair for noncompliance. The results found that the PDI phase resulted in significantly greater improvement on the ECBI Intensity score. The mothers participating in PDI-First group reported a significantly higher degree of post-treatment satisfaction on the TAI. A primary rationale in PCIT for CDI preceding PDI has been that an enhanced parent-child relationship sets an important foundation for use of more effective disciplinary practices. However, there was no evidence in the study that beginning with the discipline stage adversely affected parent and child.

A study conducted by Bagner et al. (2013) was to examine the feasibility, acceptability, and initial outcome of a home-based adaptation of PCIT. Participants were seven mothers and their child who displayed elevated problems of social-emotional functioning. All mothers then received the intervention weekly for approximately 1-hour for an average of six sessions. During the first CDI session, therapist conveyed important developmental expectations for child behaviours and described the specific effects of the parents' behaviour on the child. Specifically, the therapist helped the parent to appropriately ignore the child when yelling and praise the child for being calm and quiet as soon as the child stopped yelling. Mothers reported improvement in their interactions with child and decreasing in their child behaviour problems at post-treatment and at follow-up. This study provided evidence for the effect of the CDI phase on improving parent-child positive outcomes as early as possible to improve access to an intervention for at-risk children and their families.

Both these studies conducted by Eisenstadt et al. (1993) and Bagner et al. (2013) provided evidence for the effect of the CDI and PDI phases on improving parent-child positive outcomes. A vital component to CDI involves challenging parents' assumptions about their capabilities as parents (Johnson et al., 2000). An important concept behind PDI is that no matter what occurred beforehand, compliance with a command is immediately followed by a labelled praise from the parent, positively reinforcing the child's compliance behaviour (Wagner & McNeil, 2008). For PDI protocol, children are typically carried to a time-out chair if they do not voluntarily follow when instructed. The CDI is traditionally done first to create a positive context and lay a strong foundation for the subsequent discipline based of PDI. However, it is suggested for situations in which out of behaviour control is the main problem, it may be more useful to start with PDI (Eyberg et al., 2001).

### 2.8.1 Instruments Measuring Effects of Abbreviated Intensive PCIT

As an assessment-driven treatment, basically, Abbreviated Intensive PCIT is guided by weekly data from the well-standardised instruments. There were three different instruments have been employed in the study. The ECBI and DPICS-III data were collected on weekly basis, and TAI data was collected two times in two different phases of treatment.

#### 2.8.1.1 Eyberg Child Behaviour Inventory (ECBI)

The ECBI is a good choice for identifying behaviour problems in young children. It is a set of questionnaire that contains of two scales: (1) 7-point Intensity scale that

measures the frequency of child disruptive behaviour, and (2) yes-no Problem scale measures the extent to which parents experience their child's behaviour as difficult to manage. The Intensity and Problem scales of the ECBI yield inter-rater (mother-father) reliability coefficients of .69 and .61 and test-retest reliability coefficients of .80 and .85 across 12 weeks and .75 and .75 across 10 months, respectively (Funderburk, Eyberg, Rich, and Behar, 2003).

A study conducted by Funderburk et al. (2003) was to examine the test-retest reliability and convergent of the four behaviour problem measures in a community sample of 88 preschool children in North Carolina (*M=53 months, SD=12.3*). Test-retest reliability of the ECBI was calculated for 32 children for whom ECBI ratings had also been obtained 10 months earlier. Stability coefficient for these comparisons were $r$ (32) = .75, $p$ <.0001 for the Intensity score and $r$ (26) = .75, $p$ <.0001 for the Problem score. The results $t$-tests showed that the scores were as likely to increase as to decrease over time for both the Intensity score, $t$ (31) = .02, $p$ < .98, and the Problem score $t$ (25) = .30, $p$ < .76. The concurrent validity of the parenting scales was shown by the correlation, $r$ (73) = .53, $p$ <.0001 between the ECBI Intensity score and the Preschool Behaviour Questionnaire-Parent Completed (PBQ-P) total score. The ECBI Problem score was also significantly correlated with the PBQ-P, $r$ (68) = .34, $p$ < .01 suggesting modest convergent validity for these two scales. Funderburk et al. (2003) found that ECBI scores were stable over a 10-month period, suggesting that changes on this measure are likely to reflect actual changes in child behaviour rather than measurement error. The findings suggested that ECBI has demonstrated good psychometric properties including high internal consistency.

Based on the ECBI outcomes, some of the researches have shown empirical support for the use of PCIT for families of young children with disruptive behaviour. A study conducted by Bagner, Fernandez, and Eyberg (2004) was to investigate the outcome of PCIT for a child diagnosed with ODD and cancer. Robert Smith was a 4-year-old Caucasian boy with a 1-year history of bladder cancer. The primary presenting problems at home included physical aggression such as hitting his mother, noncompliance such as refusing to get dressed, and difficulty in transitioning from one activity to another. Based on Ms. Smith's reported on ECBI, Robert's disruptive behaviour was in the clinically significant range. Her report on the Child Behaviour Checklist (Achenbach, 1991) suggested aggressive behaviour in the borderline clinical range and her responses on National Institute of Mental Health Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV) suggested a diagnosis of ODD. The treatment plan was tailored to Robert's reported noncompliance in the medical setting. It was expected that this intervention in the PCIT would help Robert's mother to cope effectively in her interactions with him. At a 3-month follow-up, re-administration of ECBI remained below clinically significant levels. Results of ECBI indicated that PCIT has decreased the child's disruptive behaviours.

Another study conducted by Gallagher (2003) was a review of 17 studies that included 628 preschool-age children identified as exhibiting a disruptive behaviour disorder. These totals of 17 studies met the selection criteria and were included in the research synthesis. The 13 studies were published in peer-reviewed journals, three studies were unpublished dissertations, and the remaining study was obtained from the University of Florida's Child Study Lab website. Based on ECBI outcomes, the findings revealed that the improvement from pre-treatment to post-treatment were

statistically significant across all studies, and clinically significant in which the scores moved from the clinical range to the normal range in 14 (82%) studies.

#### 2.8.1.2 Dyadic Parent-Child Interaction Coding System-III (DPICS-III)

The DPICS is an adaptable system for coding parent-child behaviours and interaction patterns. This coding system is specifically designed: (i) to provide an observational measure of parent-child behaviours during dyadic interactions as the psychological evaluation of childhood disorders or parenting skills, (ii) to measure baseline behaviours occurring in dyadic parent-child interactions, (iii) to provide a measure of on-going progress during therapy that focuses on changing parent-child interaction patterns, and (iv) to serve as a behavioural observation measure of treatment outcome (Eyberg, Nelson, Duke, & Boggs, 2009). The DPICS-III observations are conducted in three standard parent-child interaction situations: CDI, PLP, and CU in 5-minute coding session of each situation. The observations are conducted in a playroom equipped with a table, two chairs, a time-out chair placed in a corner of the room, and five sets of toys (Eyberg et al., 2009). The majority of studies using DPICS to evaluate the progress of PCIT have focused on coding both parent-child interaction patterns (Thornberry Jr. & Brestan-Knight, 2011; Vess, 2008).

A study conducted by Thornberry Jr and Brestan-Knight (2011) was to analyse DPICS observations by comparing mean parent and child behaviour composite frequency counts obtained from a community sample of 13 mother-child dyads. Comparisons were made between pre- and post-treatment DPICS Warm-up (WU) and Typically-Coded (TC) segments. Child presenting diagnoses included comorbid disruptive disorders of ADHD and ODD. The abridged version of the DPICS-III

(Chase & Eyberg, 2008; Eyberg et al., 2009) was used to code WU and TC CLP, WU and TC PLP, and CU segments of video-recorded DPICS behavioural observations. The abridged DPICS-III collected frequency counts of various child and parent behaviours: Pro-social Behaviour, (PRO), Command (CM), Labelled Praise (LP), Unlabelled Praise (UP), and Negative Talk (NTA). The composite categories for child behaviour included Compliance (CO), Noncompliance (NC), and Inappropriate Behaviour (IB) while the composite categories for parent behaviour included IB and PRO. The study suggested DPICS was effective in coding the parent and child behaviour interaction to observe the improvement both parents and child interaction regardless the different segments of WU and TC.

A study conducted by Vess (2008) was to evaluate the effects of PCIT in improving parent-child interaction and reducing noncompliance behaviour among preschool children with behavioural disorder. The evaluation of the effectiveness of PCIT was accomplished by using the DPICS-III developed by Eyberg et al. (2009) which consists of parent and child behaviour codes that focus on changes in parenting verbalisation skills and child compliance. The behaviour variables measured included, for the parent: LP, UP, RF, BD, CO and NTA, and, for the child: CO and NC. The DPICS-III was measured the frequency of Do Skills and Don't Skills in a 5-minute CDI observation. Families remained in the PDI phase until the child complied with 75% of parental commands and parents had 100% correct follow-through of consequences during a 5-minute PDI observation. The accuracy across families was 99.3% with the treatment protocol. The reliability coding of the parent and child variables collected similarly with a research assistant being trained on DPICS-III coding to 80% agreement with the primary investigator. Based on DPICS-III coding,

the findings indicated that mothers increased the amount of positive interactions with children and they also decreased the use of negative behaviours and verbalisations.

Evaluation of the effectiveness of PCIT is accomplished typically by using DPICS which consists of parent and child behaviour codes that focus on changes in parenting skills and child compliance. The majority of studies using the DPICS to evaluate PCIT have focused on increasing child compliance and parent positive verbalisations (Vess, 2008). Basically, DPICS is used to assess and code parent verbalisation and child responses to parent commands (Eyberg et al., 2009; Naik-Polan & Budd, 2008; Vess, 2008). Assessing parent-child interactions especially among children with disruptive behaviours by using DPICS is necessary because the data provide an initial evidence of the efficacy of PCIT in impacting the parent-child relationship matters such as improving child compliance, including shared involvement in play and parent control and confidence in interactions with their child. The parent-child interaction is coded each time and therapist then tends to coach the parents regarding the behaviours targeted for change.

#### 2.8.1.3 Therapy Attitude Inventory (TAI)

The TAI is a 10-item self-report measure parent satisfaction following parent training or family therapy and has been used as a social validity measure following PCIT has been developed by Eyberg (1993). It is a brief consumer satisfaction measure parent satisfaction with the treatment as well as satisfaction with child behaviour following treatment. The TAI assesses satisfaction in such areas as the parenting skills learned, the child's behaviour changes, and the type of treatment used. Rationally, the TAI items were derived to reflect the goals of parent-child treatments to promote parent-

child relationship and to decrease negative behaviours in their interaction. Studies showed the effectiveness of PCIT measured using TAI (Brestan, Jacobs, Rayfield & Eyberg, 1999; Lyon & Budd, 2010).

A study conducted by Brestan et al. (1999) among 62 mothers of clinic-referred preschool children (*M=4.5 years old, SD=.97*) who met diagnostic criteria for ODD, ADHD, and CD participated in PCIT. The TAI score distributions were examined and descriptive statistics were calculated. The results indicated suggested that after the treatment the TAI scores represent reliable attitudes that may contribute to the maintenance of parenting skills and child behaviours. The Cronbach's alpha for the TAI was excellent (.91) and the stability coefficient across a 4-month period was also high (.85). The results also demonstrated that the TAI total score is correlated with change in mothers' ratings of their child's behaviour. Thus, the results suggested that parent satisfaction ratings on the TAI were more closely linked to symptom changes during treatment than to the absolute level of child behaviour problems after treatment, and they supported the psychometric strength of the TAI.

Another study conducted by Lyon and Budd (2010) was to investigate the PCIT implementation among families with low-socioeconomic status and ethnic minority. The families of four clinically-referred children aged two to seven years old and displayed externalising behaviour were completed PCIT course of treatment. Then, the TAI was used to measure parents' satisfaction with the therapy process. The results found that TAI generally indicated a high degree of satisfaction with PCIT treatment. Among the available reports, parents indicated a higher mean level of satisfaction than treatment dropouts. The results suggested that the treatment completers showed a trend toward being more satisfied with therapy than dropouts

(Boggs et al., 2004). The high level of satisfaction endorsed by completers was generally equivalent to that reported in other PCIT studies (Bagner & Eyberg 2007). Based on TAI outcomes, the satisfaction towards PCIT treatment suggested the influential benefits among ethnic and cultural minority families (Matos et al. 2006).

## 2.9 Overview Research Design

The Division-53 of APA has identified two types of research designs can be used by researchers to determine evidence-based interventions for children, between-group and single-case designs (APA, 2013). Nearly 50 years, the single-case designs employed in many counselling and psychology researches to evaluate the effectiveness of interventions in promoting individuals' change over time (McDougall & Smith, 2006). In studying the effect of intervention in a single or small sample of respondents, researchers usually applied the single-case designs (Kratochwill & Levin, 2014; Hatamzadeh, Pourehmad & Hassanabadi, 2010; Fraenkel & Wallen, 2006; Lewis, 2010; Sharpley, 2007).

This study involved four different phases of treatments: baseline ($A_1$) and intervention phases (B-IT, B-MT and $F_1$) and a small number of respondents. Thus, the single-case experimental design (SCED) was employed by researcher to analyse the data from these four phases. The SCED involves a comparison between two experimental time periods, known as phases. This approach involves collecting a data from baseline phase to be compared with subsequent data from treatment phases (Kratochwill & Levin, 2014). Furthermore, the baseline measurement represents one of the most crucial design elements of the SCED because respondents provide their own data for comparison, gathering a representative, stable sampling of behaviour to

accurately inferring an effect. The effect of baseline trend and intervention phases in SCED commonly analyse using the visual analysis (Parker, Cryer, & Byrns, 2006). Visual analysis method is most adept at determining intervention effects and addressing research questions pertaining to changes in level and slope. This method often using a form of graphical representation, standardised computation of a mean level or trend line within or between each phase of interest (Kratochwill, Levin, Horner, & Swoboda, 2011).

The SCED also called N of 1 research (*N=1*), behaviour analysis, or within-subjects research can be used to systematically monitor the client progress toward particular intervention (Engel & Schutt, 2012). Using the SCED, researcher tend to manipulate the independent variable (IV) or intervention across different phases to show that changes in the dependent variable (DV) or targeted behaviour are vary systematically as a function of manipulating the IV. Basically, respondent acts as his or her own control rather than using another individual or group comparison (Fraenkel & Wallen, 2006; Swanson, & Sachse-Lee, 2000). The basic measurement requirement of the SCED is a repeated assessment of the DV across each phase of the design in order to draw valid inferences regarding the effect of the IV on the DV (Kratochwill & Levin, 2014; Hatamzadeh et al. 2010).

In investigating the intervention effects of PCIT in treating disruptive behaviour disorders, a study conducted by Hatamzadeh et al. (2010) was to investigate the efficacy of PCIT for young children ages three to seven years old with significant behavioural problems. These children show clinically significant ADHD symptoms such as over activity, impulsivity, inattentiveness, and oppositional defiant. These children with their mothers were assessed six times using the ECBI. The A-B design

consists of two phases, no-intervention baseline (A) and an intervention (B) and it allows for evaluation of pre-intervention and intervention outcomes (Stocks, 2000). The comparison between assessment data during baseline and after the intervention made using the visual analysis method. The results indicated that all children showed decrease in behaviour problems from baseline to intervention and follow up phases.

Another study conducted by Lewis (2010) used SCED to examine the effects of an abbreviated intensive form of PCIT in reducing noncompliance behaviours among children with disruptive behaviour disorders. When conducting a SCED, all dyads should begin baseline at the same time. When the first family achieves a stable baseline and completes intervention then the second family begins intervention. This pattern should be followed systematically until all dyads have completed treatment. The graphical representation and visual inspection remain the predominant form of analyses in SCED (Fisher & Wells, 2008). These data were plotted for each participating dyad to allow for visual analyses of trends including: variability within a phase, changes in levels between phases, variability between phases, change in trends across adjacent phases, overall pattern of the data in a design, and comparing across similar situations. Although treatment gains differed and varied between dyads, all showed improvements on some measures. The SCED is a rigorous technique for evaluation that can typically stand alone in assessing treatment effects (Good, 2000).

## 2.10 Theoretical Underpinnings of Abbreviated Intensive PCIT

Based on the literatures review, poor quality of parent-child interaction include, low parental warmth (Harvey and Metcalf, 2012), ineffective parenting (inconsistent discipline and harsh parenting in managing child's behaviour) (Deater-Deckard et al.,

2012), disrupted parental behaviours (Mokrova et al., 2010), and poor parenting monitoring on child's activities (Ellis and Nigg, 2009) are contribute to disrupted parenting which influences higher level of noncompliance behaviour in children with ADHD. Many researches have shown that treating noncompliance behaviours in ADHD children often results in significant improvements by Abbreviated Intensive PCIT (Graziano et al. 2014; Lewis, 2010). The foundation of Abbreviated Intensive PCIT is based upon developmental parenting theories which draw on attachment and social learning theories to achieve the authoritative parenting (Baumrind, 1966). Thus, the theoretical underpinnings of Abbreviated Intensive PCIT are strongly grounded with three theoretical orientations: Baumrind's Developmental Theory of Parenting (1966), Ainsworth and Bowlby's Attachment Theory (1991), and Patterson's Coercion Theory (1982).

### 2.10.1 Baumrind's Developmental Theory of Parenting

The development of PCIT was based on Baumrind's developmental research associated between parenting practices with child outcomes. Based on Baumrind's Developmental Theory of Parenting, PCIT is an authoritative parenting style that include high levels of parental nurturance and firm limit-setting (Brinkmeyer & Eyberg, 2003) and associated with fewer child behaviour problems (Querido, Warner & Eyberg, 2002). In 1960's, during early Baumrind work, she identified four important dimensions of parenting practices after conducted a study on 100 preschool children using parental interviews and naturalistic observations. These four parenting styles were disciplinary strategies, warmth and nurturance, communication styles and expectations of maturity and control. Then, Baumrind demonstrated the importance of

parents to meet and fulfil children's dual needs for nurturance (parent responsiveness) and for limits (parent demandingness), which is known as authoritative parenting. This research found that the focus must on promoting authoritative (optimal parenting) styles and parent-child interactions in order to promote optimal child outcomes (Brinkmeyer & Eyberg, 2003).

According to Baumrind (1966) the authoritative parent attempts to direct the child's activities but in an issue-oriented and rational manner. The authoritative parent affirms the child's present qualities, but also sets the standards for future conduct and behaviour. It means that, authoritative parents are warm but firm in educating the children. They encourage their children to be independent while maintaining limits and controls on their actions. Baumrind transformed her original authoritative-authoritarian-permissive parenting model to one based on two orthogonal constructs, parent responsiveness and parent demandingness (Baumrind, 1991). Authoritative parenting is responsive and demanding in that parent provides clear standards for behaviour, communicate good expectations, monitor the child behaviour, and discipline the child based on reasoning and explanation. She demonstrated that parents who do not adequately meet children's need for both nurturance and limits were less likely to raise healthy adolescence.

A study conducted by Fernando and Enrique (2009) among a sample of 1,416 children from Spanish families to investigate parents' child-rearing practices. The parents were classified into one of four groups (authoritative, authoritarian, indulgent, or neglectful). The children were then contrasted on four different outcomes: (i) self-esteem (academic, social, emotional, family and physical), (ii) psychosocial maladjustment (hostility or aggression, negative self-esteem, negative self-adequacy,

emotional irresponsiveness, emotional instability, and negative worldview), (iii) personal competence (social competence, grade point average, and number of failing grades), and (iv) problem behaviours (school misconduct, delinquency, and drug use). The results showed that both authoritative and indulgent parenting styles were associated with better outcomes than authoritarian and neglectful parenting.

In Malaysia, a study conducted by Johari, Zulkifli and Maharam (2010) among 200 Malay families as sample and only selected from one state out of 14 states in Malaysia to examine effects of parenting styles on children behaviour. The 181 families (90.5%) had nuclear family background and only 19 (9.5%) had extended family background. The mean of mother's age in the study was 39 years and father was 40 years and all of them had various educational and occupational. There were 200 children in the study, 100 (50%) were males and 100 (50%) were females. A simple frequency and percentage were performed to determine whether parenting styles differed across mothers and fathers and sex of the target child. In this analysis, parents (mother versus father) were compared. The study found that, both Malay mothers and fathers employed more authoritarian style to their boys, and more authoritative to their girls. The authoritarian style indicated that higher degree of authoritarianism affects children behaviour negatively or in particular higher level of learned helpless behaviour. The study indicated that children behaviour is positively influenced by authoritative parenting style and negatively authoritarian style.



### 2.10.2 Ainsworth's and Bowlby Attachment Theory

Attachment is a deep and enduring emotional bond that connects one person to another across time and space. The Ainsworth and Bowlby's Attachment Theory is to

restructure the parent-child relationship and to provide the child with a secure attachment to parent (Eyberg et al. 2001). This theory proposes that the quality of care provided to the child, particularly sensitivity and responsiveness leads to secure (optimal) or insecure (non-optimal) attachment. Insecure attachment in infants and young children termed as an insecure-disorganised is strongly related to risk for psychological problems. For this reason, during PCIT parents are taught how to restructure their relationship with the child and to provide the child with a secure attachment. Furthermore, the main component of PCIT is to foster the development of secure parent-child attachment which supports healthy child development and integrated with play therapy (Graziano et al. 2014; Lewis, 2010).

The integration of play therapy with children and their parents is called conjoint play therapy. During conjoint play therapy, the play itself reveals the impairment displayed between the parent and the child and further enables the therapist to examine that impairment. The PCIT is a conjoint therapeutic model that combines behavioural therapy with play therapy and parental coaching and its focuses on the parents and child's negative behaviour. Therefore, based on Ainsworth and Bowlby's Attachment Theory, a secure attachment between parents-child is comes from a strong emotional bond from parents. If parents fail to form this early childhood parental bond, it may cause to various difficulties later in life of children, such as disorder of attachment, and juvenile delinquency. Therefore, the main aim of CDI is to develop loving and nurturing bond between parents-child through play therapy.

Ainsworth and Bowlby (1991) identified 4-type of parent-child relationship (secure, avoidant, ambivalent, disorganised-attachment) characterised by parent-child interaction patterns. Children with secure attachment styles were more likely to

feel safe exploring their environment compared to those with avoidant, ambivalent, or disorganised-attachment. A nurturing, supportive, and warmth are secure attachment paired with a parenting style that provides nurturance and firm, appropriate limits for behaviour which known as authoritative style have been linked to more positive outcomes for children (Querido et al., 2003). Abbreviated Intensive PCIT seeks to enhance warmth between parent and child while teaching parents how to set firm, consistent and clear limits for their children (Brinkmeyer & Eyberg, 2003). Studies investigated parent-child relationships have centred upon the critical role of parent in the development of child's emotional and psychological functioning (Choate, Pincus, Eyberg, & Barlow, 2005; Harwood & Eyberg, 2006). Studies by Choate et al. (2005) and Gallagher (2003) have emphasised the importance of the parent-child communication, interaction and relationship.

To conclude, the theory asserts that the degree to which the parent is sensitive and responsive to the child's needs determines the quality of attachment bond. The sensitive and responsive parent accurately receives and interprets the child's attachment signals, and responds to these signals adequately and promptly based on loving sense. Sensitive parenting fosters a secure attachment relationship, which is associated with positive child development (Sroufe, Egeland, Carlson, & Collins, 2005). For this reason, in the first phase of PCIT parents learn the CDI skills which aim to restructure the parent-child relationship and provide the child with a secure parental attachment. This phase of treatment recognise that parents can have a effect on their child's behaviour during the early preschool years when children are more responsive to parental attention and less susceptible to the influence of peers, teachers, or developmental autonomy in later years (Sroufe et al., 2005). The parental bonding

are important. Creating caring society and culture is Malaysian government mission known as National Keys Result Areas which wishes to achieve in year 2020. To achieve this vision and mission by year 2020, government must try to intensify love and caring by promoting them in every family (Ramlah, Rohaty & Noriah, 2014).

### 2.10.3 Patterson's Coercion Theory

Patterson's Coercion Theory is one of the most influential social theories. This theory provides a transactional account of early conduct disorder behaviours in children are inadvertently established or maintained by dysfunctional parent-child interactions. According to Patterson (1982), coercion is defined by an aversive event that leads to reinforcement of negative behaviour, and the coercion process is a series of feedback loops that escalates over time. For example, when a parent tries to discipline his or her child, the child responds in an aversive manner such as, crying, and throwing a temper tantrum. Then, parent returns with an escalated attempt at disciplining the child such as scolding, threating, or punishing. However, the child still returns in an escalated aversive manner. This process continues until the parent desists in trying to discipline the child. The coercion process demonstrates how negative parenting is influential in the development of deviant behaviours. In the second phase of Abbreviated Intensive PCIT parents learn PDI which specifically addresses the parenting strategies to deal with child misconduct and disruptive behavioural problems. This is by using the effective discipline such as a time-out procedure, and providing efficient commands (age-appropriate, direct, and single-stated) to protect against the development of deviant behaviours. The higher rates of harsh or lenient interaction of parents at early childhood have linked to children's problem behaviours (Scaramella & Leve, 2004).

Other parenting processes that Patterson describes as potential precursors of child externalising behaviour problems include a failure to provide positive reinforcement for pro-social and compliance behaviours. In relation to PDI, parents are taught with more effective discipline strategies to manage their child's behaviour, to issue clear, single stated and direct commands, to provide consistent consequences for child's compliance and noncompliance. Thus, Abbreviated Intensive PCIT teaches parents to utilise skills such as selective ignoring and labelled praise to increase positive behaviours and discourage undesirable behaviours.

## 2.11 Theoretical Framework of the Study

First, the development of theoretical framework for Abbreviated Intensive PCIT in this study was based on Baumrind's developmental research associating parenting practices with child outcomes. Her research showed that the optimal parenting styles are importance for parents to meet their child's dual needs for nurturance (parent responsiveness) and for limit (parent demandingness) which she described as authoritative parenting. Thus, Baumrind's theory emphasises on authoritative parenting which directly related to parent's child-rearing practise. Thus, the PCIT incorporates the Baumrind's parenting style theory into the treatment by promoting authoritative parenting styles which include high levels of parental nurturance and firm limit-setting (Brinkmeyer & Eyberg, 2003).

Second, Abbreviated Intensive PCIT draws on attachment to achieve authoritative parenting. Ainsworth and Bowlby's Attachment Theory indicated that children whose parents show greater warmth, responsiveness and sensitivity are more likely to develop a secure sense of relationships and more effective in emotional and

behavioural regulations. For this reason, in the first phase of PCIT parents learn the CDI, which aims to restructure the parent-child relationship and provide the child with a secure attachment to his or her parent. Ainsworth and Bowlby (1991) research indicated that children with secure attachment were more likely to feel safe in exploring their environment.

Third, Abbreviated Intensive PCIT draws on social learning to achieve authoritative parenting. The Patterson's Coercion Theory focuses specifically on parent and child behaviours in discipline situations. Based on this theory, PCIT is based on the idea that children's behaviour is shaped by the environment in which they live and in particular by their parents. This theory postulates that children behaviours are developed and maintained through differential reinforcement. Research has demonstrated that harsh, coercive, and over-controlling parenting contributes to maladaptive parent-child interactions (Dishion, Véronneau, & Myers, 2010). The Abbreviated Intensive PCIT addresses these patterns and instructs parents on how to positively reinforce adaptive behaviours, while decreasing maladaptive behaviours.

### 2.11.1 Authoritative Parenting, Attachment, and Social Discipline

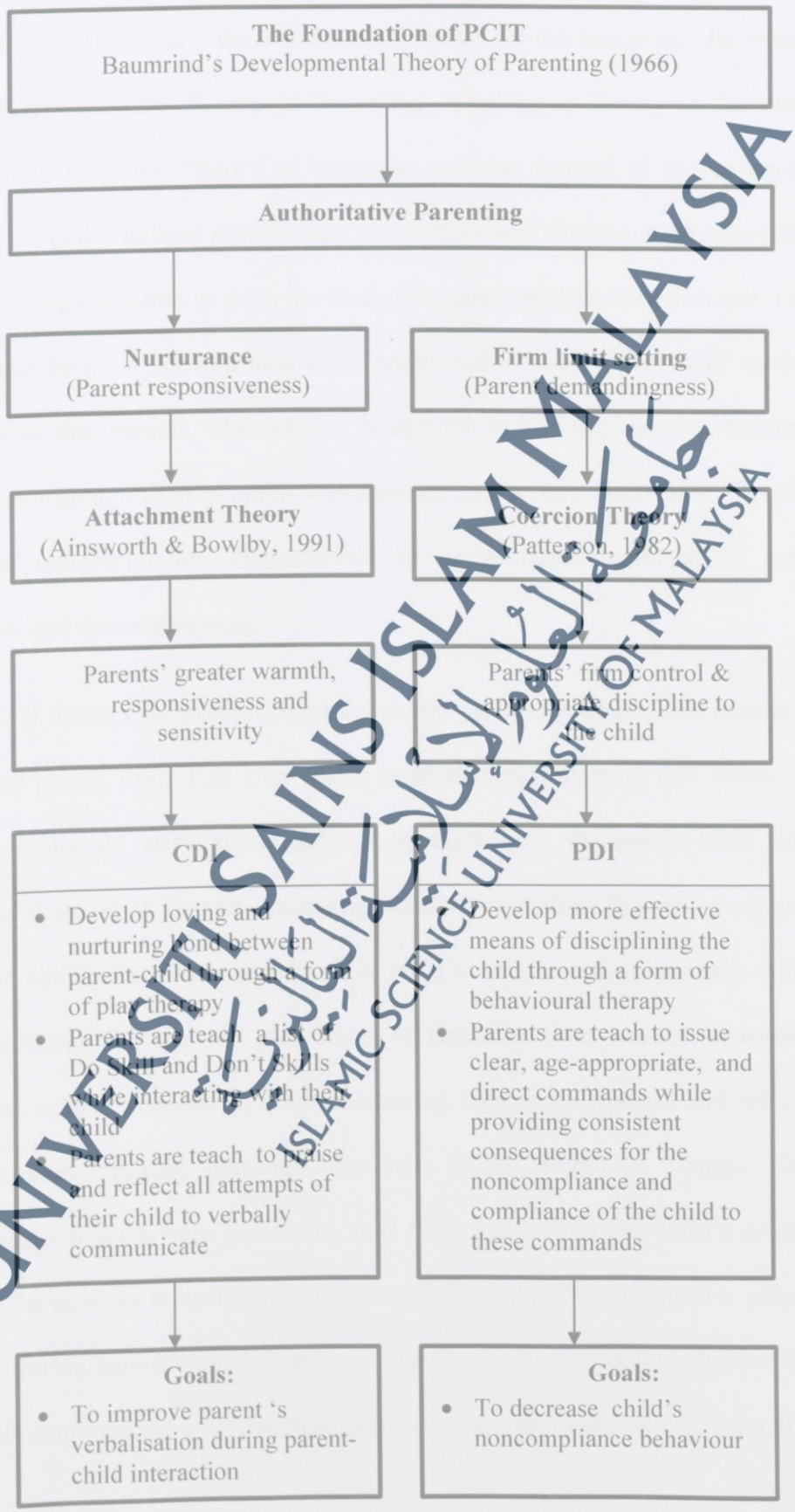
These three theoretical underpinnings of PCIT emphasise the role of parents in meeting young children's dual needs for nurturance (parent responsiveness) and for limits (parent demandingness), which is described as an authoritative parenting. Thus, based on these, PCIT teaches authoritative parenting skills as it is manifested in a combination of firm control, good communication, and nurturing behaviour. In PCIT, parents engaged in a two-phase training that helps them to replace maladaptive

interactions with their children with more effective parenting practices: CDI (parent-child positive interaction and relationship), and PDI (child's discipline training).

The Abbreviated Intensive PCIT embraces the need for a secure base, rooted in warmth and praise. In the first phase of CDI, parents are first taught and coached how to enhance their relationship with their child. Parents who show greater warmth, responsiveness, and sensitivity to the child's are more likely to develop a secure sense in their relationships and interaction with the child. In the second phase of PDI, parents learn how to give specific and appropriate commands and discipline practices, such as using time-out. By integrating the elements of authoritative parenting, attachment, and social discipline many of the studies outcomes have demonstrated clinically significant improvements in the disruptive behaviour of preschool age children. After treatment, children's behaviour is within the normal range (Matos, et al., 2009), parents interacted more positively with their children and successful in gaining their children compliance behaviour (Matos et al., 2009).

Therefore, this study employed a combination of CDI and PDI. The CDI skills aim to develop a loving and nurturing bond between the parent and child through a form of play therapy. The PDI skills aim to teach the parent more effective means of disciplining their child through a form of behavioural therapy. This discipline and compliance emphasises effective and safe disciplinary techniques that can be used to help the child to improve behaviour. PCIT is one of the treatments designed to treat early childhood disruptive behaviour by trained parents to use behavioural management skills with the aim to enhance parent-child bond, warmth, positive discipline, and child compliance (Zisser & Eyberg, 2009). Figure 2.1 shows the theoretical framework of the study.

*Figure 2.1: Theoretical Framework of the Study*



## 2.12 Conceptual Framework of the Study

For the purpose of this study, the PCIT model based on the integrated theories of Baumrind's Developmental Theory of Parenting, Attachment Theory of Ainsworth and Bowlby, and Coercion Theory of Patterson and was formed as the conceptual framework. The model utilised play therapy and behavioural therapy approaches as an intervention strategy and tool to drive the change in parent-child interaction and it was tailored to meet both parents and their child needs and demands. The PCIT model's assumption was that parents who receive both CDI and PDI phases of treatment effectively will improve their positive verbalisation and reduce their child disruptive behaviours of noncompliance, characterised by authoritative parenting of parent responsiveness and demandingness.

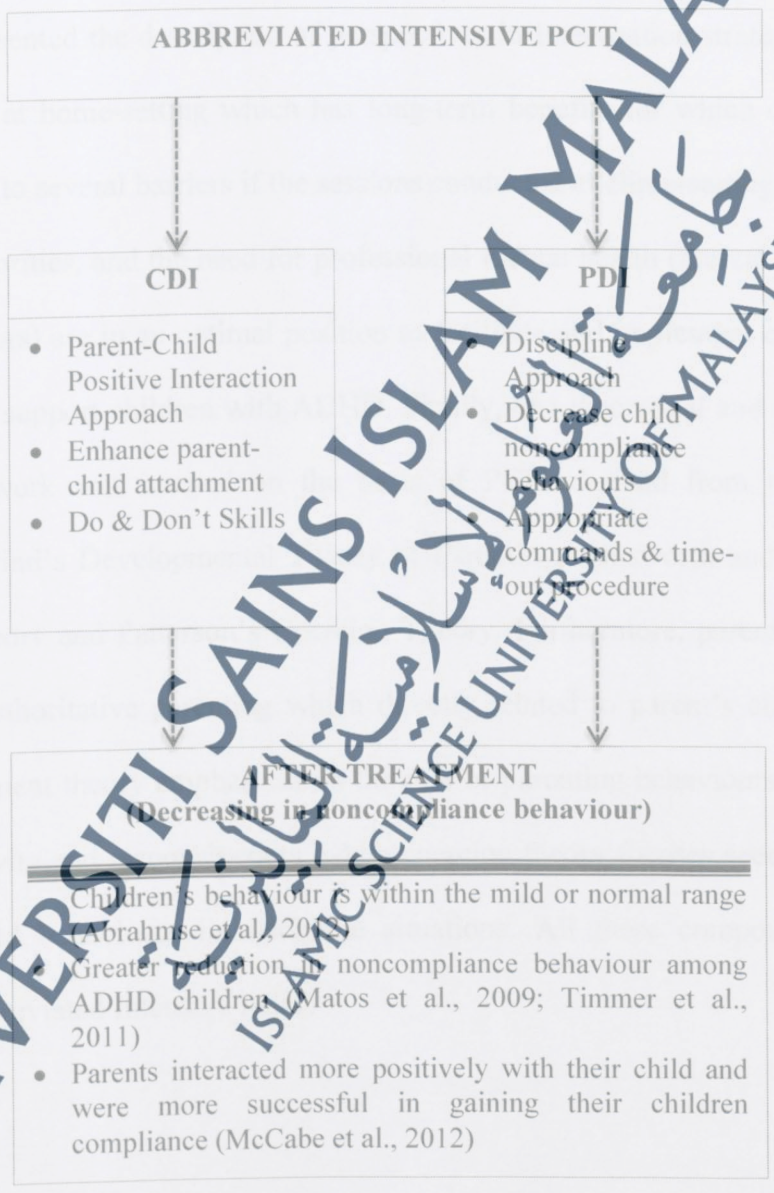
The CDI focuses on strengthening the parent-child attachment as a foundation for the second phase, PDI. This CDI phase resembles play therapy and focuses on enhancing parent-child attachments through strengthening the parent-child bond, improving child social skills and increasing positive parenting. Parents are learn to describe their child's behaviour, reflect their child's words, and praise their child's appropriate actions. Parents are also learn to decrease their use of commands, questions, and critical statements, while increasing their use of praise and selective attention (Timmer, Urquiza, Herschell, McGrath, Zebell, Porter, & Vargas, 2006). These verbalisation skills help parents to shift their focus from the child's negative behaviour to the positive behaviour. Thus, the main aim of CDI is to improve parent's verbalisation during parent-child interaction. The Do and Don't Skills helps parent to verbalise and communicate with the child positively and appropriately (Eyberg et al., 2009).

In the second phase of PCIT, parents learn the PDI skills which is formatted on social learning theory (Eyberg et al., 2009) and focuses on enhancing child compliance behaviours or diminishing noncompliance behaviours (Leung et al., 2009). This phase resembles behaviour therapy and focuses on improving the parent's ability to set limits and teaches parents the consistent use of specific discipline strategies to reduce child noncompliance, aggression and other disruptive behaviour. Parents are learned to give appropriate commands that are clear, single and positively stated which provide an opportunity for the child to comply. Then, child compliance with a command is immediately followed by a labelled praise from the parent, thus, positively reinforcing the compliance behaviour (Wagner & McNeil, 2008). For noncompliance towards the command, parents basically learn to issue a warning within 5-second for the child to perform. Then, if the child still does not comply after an additional 5-second, parents require bringing the child in time-out procedure. Thus, the main aim of PDI is to decrease the child's noncompliance behaviour through giving specific and appropriate parental commands that give the opportunity for children to comply. Then, as additional to discipline practice, the parental limit setting and consistency in discipline through the time-out procedure was taught to parents.

Overall, it is assumed that some of the important parent and child behaviours that maintain particular parent-child interaction patterns may associate with ineffective parenting styles and disruptive child behaviour (Eyberg et al., 2009). Thus, the PCIT model in this study addressed the two goals: (i) to increase parental warmth, responsiveness and sensitivity in order to establish a nurturing and secure relationship between parent-child through positive verbalisation towards the child and, (ii) to improve parental issues of giving appropriate commands and parental limit setting and

consistency in discipline through time-out procedure in order to reduce the child noncompliance behaviour. Briefly, the research conceptual framework is illustrated in Figure 2.2.

*Figure 2.2: Conceptual Framework of the Study*



## 2.13 Chapter Summary

This chapter discussed the Abbreviated Intensive PCIT as a brief and intensive format of treatment used for young children with behavioural problems by focuses on improving the quality of the parent-child relationship, changing inappropriate pattern of parent-child interaction and disciplining the child's behaviour appropriately. This chapter also presented the description of perspectives in intervention strategy such as implementation at home-setting which has long-term benefits for which can reduce the attrition due to several barriers if the sessions conducted at clinic-setting. The roles of relevant authorities, and the need for professional mental health (mental health and school counsellors) are in an optimal position to facilitate and implement counselling interventions to support children with ADHD. Finally, one theoretical and conceptual research framework was created on the basis of PCIT derived from three main theories, Baumrind's Developmental Theory of Parenting, Ainsworth and Bowlby's Attachment Theory and Patterson's Coercion Theory. Furthermore, parenting theory emphases on authoritative parenting which directly related to parent's child-rearing practise, attachment theory emphasises on the role of parenting behaviours of greater warmth, sensitivity and responsiveness, while coercion theory focuses specifically on parent and child behaviours in discipline situations. All these components were included in Abbreviated Intensive PCIT.