CHAPTER 5

DISCUSSION AND CONCLUSION

5.1 Introduction

This present study was designed to examine the effect of Abbreviated Intensive PCIT on noncompliance behaviours among preschool children who diagnosed with ADHD. To understand the effect of the treatment on noncompliance behaviours among preschool children with ADHD, descriptive analysis was conducted to integrate both quantitative and qualitative data. The findings from instrument data (assessments) can be explored further with qualitative interview to better understand personal experiences of individuals about the treatment (Nutting, Miller, Crabtree, Jaen, Stewart & Stange, 2009).

The three main instruments measured repeatedly to asssess the effect of the treatment on targetted behaviour. First, the ECBI was administered to measure the level of disruptive behaviour among child respondents. Second, the DPICS-III instrument was administered to measure parent's verbalisation and child compliance behaviour toward parent's commands. Third, the TAI instrument was administered to measure parents' satisfaction with the treatment provided. Then, the comparison made between pre-treatment and post-treatment for each variable within same respondents. This allowed the researcher to compare the changes during and after the treatment to the preceding baseline condition. The semi-structured interview was employed to

explore parents' perceptions and experiences with the aim of gaining more insights into how the treatment affected them and their child. The parents' perceptions and experiences about the treatment have been explored using four open-ended questions. These questions were to reflect on parents' experiences about Abbreviated Intensive PCIT in term of its useful aspects and application, and to reflect parents' perceptions about the cultural issues and the including of religious elements in the treatment.

5.2 Discussion on Research Questions for Child Respondents

The study revealed that Abbreviated Intensive PCIT has decreased noncompliance behaviour among the child respondents. As expected, parent's verbalisation and child compliance behaviour toward parental commands have improved over the course of treatment. The results showed that there was a difference in stage of behaviour changes in the post-tests between B-IT and B-MT with F_1. Discussion on these findings regarding the effect of Abbreviated Intensive PCIT will be presented under the four subheadings as the following.

5.2.1 Effects of Abbreviated Intensive PCIT on Level of Disruptive Behaviours

In terms of the first research question on the effectiveness of the Abbreviated Intensive PCIT, the treatment was effective in reducing the level of disruptive behaviours among preschool children with ADHD. Across B-IT and B-MT, each dyad's mean scores of ECBI were lower than A_1 mean scores. There was a difference between baseline and post-treatment outcomes in which a decrease in number of child respondents being above the clinical significant ECBI cut-off points (<156). ECBI was administered weekly during B-IT, B-MT and F_1 in which week-by-week

improvement data were compared. Among the 36-item, the most items rated by parents in ECBI reflected the frequencies of child disruptive behaviours were: *Item-5:* refuses to do chores when asked, *Item-8:* does not obey house rules on his own, *Item-9:* refuses to obey until threatened with punishment, Item-10: acts defiant when told to do something, *Item-11:* argues with parents about rules, *Item-12:* gets angry when does not get own way, and *Item-13:* has temper tantrums. Based on the comparison, the child disruptive behaviours in these seven behaviour categories have decreased.

The consistent treatments gained across dyads were also reflected in parent ratings of child disruptive behaviours. All six children had lower mean ECBI percentages at post-treatment (B-IT and B-MT) as compared to the mean ECBI percentage at A_1. Decline in disruptive behaviour were varied among the children. Dyad 2 displayed the least decline in ECBI scores, with a decrease of 11.4% from A_1 to F_1. Dyad 6 achieved the greatest decline in ECBI scores, with a decrease of 22% from A_1 to F_1. The remaining dyads' exact change in ECBI scores from A_1 to F_1 was as follows: Dyad 1, 17.9%; Dyad 3, 18.1%; Dyad 4, 15.7%; and Dyad 5, 11.6%.

The visual analyses revealed that all ECBI scores declined dramatically when B-IT began until B-MT. During A_1 assessments, all dyads ECBI mean scores were above the clinical cut-off (>156) in which showed that they displayed severe range of behaviour problem. Some of the child respondents' ECBI scores increased after one month F_1 assessment. Of all dyads that completed F_1 ECBI assessment, the ECBI mean score of Dyad 5 remained higher than his B-MT from moderate to severe range of behaviour problems. The ECBI mean scores of Dyad 4 also increased, while Dyads 2 and 3 were maintained over time and they were in moderate range of behaviour

problems. The ECBI mean scores of Dyads 1 and 6 were declined greater and showed the mild range of behaviour problem.

Some of the decline in the mean ECBI scores moving from A_1 to B-MT may be not accounted for differing time-frames over which parents provided the reports. Current findings have contradicted to the statement made by Lewis (2010) that it is logical to assume that much of this decline can be accounted for differing time-frames over which parents provided the reports. Children simply have less time in one day, as compared to one full week, to engage in as many problem behaviours, thus, producing lower ECBI scores. In Lewis (2010) study, the ECBI was administered daily during Intensive Treatment and consequently, parents completed the measure based on their child's behaviour during the previous 24-hour. In contrast, this current study, the ECBI was administered weekly during the treatment (B-IT, B-MT) and parents completed the measure based on their child's behaviour during the previous week. Although children simply have much of time in one full week to engage in as much disruptive behaviour, however, children showed decreased in that behaviour. One might not have predicted ECBI scores to decrease simply due to each parent's return to reporting their child's behaviour during one week periods instead of one day periods. Thus, the present study indicated that different in the time frame of measurement did not markedly change reported outcomes.

Some of the increase in the mean ECBI scores from B-MT to F_1 may be accounted for by the absence of coaching and therapist contact. The dyads were not receive coaching and assistance in mastering the parenting skills in reducing noncompliance behaviour in their child. Thus, the repeated administration of ECBI produced the different scores at F_1 assessment for some dyads. The increasing in

length of follow-up has been cited as a way of reducing the effects of the mere measurement effect (Chapman & Chapman, 2001). However, a short length of follow-up may increase the probability of detecting behavioural change as a result of the mere measurement effect that dissipates over time (Chandon, Morwitz, & Reinartz, 2004). Although, all dyads showed improvement from A_1 to F_1, however, Dyads 4 and 5 continued to report increasing in their ECBI scores during F_1, suggesting that follow-up length did not markedly change reported outcomes.

Overall, the findings of the study indicated that Abbreviated Intensive PCIT was effective in decreased the level of disruptive behaviour in ADHD preschool children (mean ECBI scores during the F_1 remained lower than A_1). These findings supported Abbreviated Intensive PCIT in a relation to Patterson's Coercive Theory which focuses on enhancing compliance or diminishing disruptive behaviours in children (Leung, Tsang, Heung & Yiu, 2009).

5.2.2 Effects of Abbreviated Intensive PCIT on Parent's Acquisition of CDI Skills

With regard to the second research question on the effect of Abbreviated Intensive PCIT on parents' acquisition of CDI skills, the quantitative results indicated that this treatment was effective in improving CDI parenting skills in parents. The DPICS-III observational data of parent's acquisition on CDI skills reflected the improvement on parent's verbalisation of Do Skills and reduction of Don't Skills.

First, in relation to CDI Do Skills, the visual analyses revealed that all parents increased their proficiency in using the Do Skills from A_1 to F_1. Parents of Dyads 1 and 6 were continued to show greater improvement in their usage of the Do Skills

across the treatment phases. The parent of Dyad 6 was the only who achieved the mastery criteria of CDI skills (10:LP, 10:RF, and 10:BD) and the parent of Dyad 1 almost achieved the skills (10:LP, 9:RF and 9:BD). The study indicated when comparing the outcomes between pre-treatment and post-treatment, most parents increased their verbalisations of expressing favourable judgment of an attribute, product and behaviour of the child by praised appropriate the child behaviour occasionally. Parents were also increased in their verbalisations of reflective statements that have the same meaning with child verbalisations by repeating with some elaboration on what the child has just said. For declarative statements, parents were also increased their verbalisation of the child's specific play activities with toy.

Second, in relation to CDI Don't Skills, the visual analyses revealed that all parents decreased in their inappropriate verbalisation using the Don't Skills from A_1 to F_1. Parents of Dyads 1 and 6 were continued to show greater improvement in their usage of the Don't Skills across the treatment. Similar to Do Skills, parent of Dyad 6 was the only who achieved the mastery criteria of Don't Skills (3 IQ/DQ, 3 IC/DC and 3 NTA) and Dyad 1 almost achieved the skills (3 IQ/DQ, 3 IC/DC and 4 NTA). The study indicated when comparing the outcomes between pre-intervention and post-intervention, most parents reducing their inappropriate verbalisations practices and avoided from giving commands, criticism or negative words regarding the child's behaviour and play ideas. Parents also showed improvement in how to praise the child for being calm and quiet as soon as the child stopped yelling. The findings of the current study were consistent with the research conducted by Bagner et al. (2013) in which parents showed greater improvement in their interactions with the child when they used praise to reinforce the child positive behaviour.

Overall, the findings of the study indicated that Abbreviated Intensive PCIT was effective in increasing parents' proficiency in using positive verbalisation and reducing their negative verbalisation when interacting with their child during child led the play session. The results showed that parents were improved in CDI skills by remained increase in their Do Skills scores and decrease in their Don't Skills scores from A_1 to F_1.

5.2.3 Effects of Abbreviated Intensive PCIT on Parent's Acquisition of PDI Skills

With regard to the third research question on the effect of Abbreviated Intensive PCIT on parents' acquisition of PDI skills over the course of treatment, the quantitative results indicated that this treatment was effective in improving the PDI parenting skills in parents. The DPICS-III observational data of parent's acquisition on PDI skills reflected the improvement on child compliance behaviour towards parental commands. In relation to PLP and CU situations, the current findings indicated, the visual analyses revealed that all parental commands were obeyed by the children have been increased from baseline to follow-up. First, during PLP, parents of Dyads 1, 2, 3 and 6 were continued to show greater improvement and maintenance in their using of single, clear and positively stated instructions across the treatment phases. Second, during CU, parents of Dyads 1, 2 and 6 were continued to show greater improvement in giving effective commands to their child. The mastery criteria of PDI skills in this study at least nine out of 12 commands given by parent must be performed by the child. The parent of Dyad 6 was the only who achieved the mastery criteria of PDI skills (9 commands) and the parents of Dyads 1 and 2 almost achieved the PDI skills (8 commands) for both PLP and CU situations.

The study indicated when comparing the outcomes between pre-intervention and post-intervention, most parents increased their proficiency of in giving appropriate commands that were clear, single and positively stated which provide an opportunity for the child to comply. These results consistent with the statement made by Wagner and McNeil (2008) that child compliance with a command is immediately followed by a praises from the parent, thus, positively reinforcing the compliance. It has been observed during coding segment, parents were increased in their using of labelled praise after the child kept on performing the commands. For noncompliance towards the command, parents basically issued a warning and allowed for 5-second for the child to perform the commands. Then, if the child still did not comply after an additional 5-second, parents putted the child in time-out. Parents displayed their acquisition of PDI parenting skills even they lead and direct their child's activity during play session. Parents also showed effective disciplinary practices for child's noncompliance behaviour by implementing time-out.

Overall, the findings of the study indicated that Abbreviated Intensive PCIT was effective in increasing parents' proficiency in giving effective commands when interacting with their child during parent led the play session in both PLP and CU. Some of dyads' PDI scores decreased after 1-month F_1 assessment. Of all dyads, Dyads 4 and 5 declined in their PDI scores during PLP situation and during CU situation, the PDI scores for Dyads 3, 4 and 5 were declined. However, the results showed that parents were improved in PDI parenting skills by remained increase in their scores from A_1 to F_1.

5.2.4 Parent's Satisfaction towards Abbreviated Intensive PCIT

With regard to the fourth research question about parents' level of satisfaction toward the Abbreviated Intensive PCIT, the quantitative results indicated that most parents have high level of satisfaction toward the treatment. Satisfaction with the treatment gained was related to changes in observed child compliance behaviour, whereas, satisfaction with the treatment process was related to changes in parent behaviour ratings. The TAI assessment has conducted at post-treatment sessions after B-MT and F_1. All dyads except Dyad 5 found to score high level of satisfaction for process and outcomes of the treatment in both B-MT and F_1.

Based on TAI Factor 1 and Factor 2 results, the study indicated that parents appeared to be sensitive to the changes on the impact and frequency with which their child display noncompliance behaviour. It means that, the greater they perceived change, the greater is the parents' satisfaction with treatment outcome and process. The outcomes may be related to parents' own efforts in treatment which a primary behaviour targeted were training sessions. Thus, the improvement resulting from parent training suggested that parents were sensitive to the level of changes in their child's behaviour and these changes were reflected in their attitudes and treatment satisfaction about therapy.

The high levels of parent's satisfaction with the intervention parallels with the declining in parents' ECBI and DPO ratings reported between pre-intervention and post-intervention outcomes. However, Dyad 5 has been found that, the parent was reported moderate level of satisfaction toward the treatment and this was consistent with the parent's ECBI rating in which during final assessment at post-intervention of F_1, Dyad 5 scored severe range noncompliance behaviour as compared to his score of

moderate range of noncompliance behaviour during B-MT. Overall, the findings indicated that parents reported high level of satisfaction on Abbreviated Intensive PCIT at post-intervention except for Dyad 5. The outcomes suggested that greater satisfaction was related to greater efficacy of treatment in reducing noncompliance behaviour among those children. Then, after effective treatment, the TAI scores represented reliable attitudes that may contribute to the maintenance of parenting skills and child behaviours.

5.3 Discussion on Research Questions for Parent Respondents

The qualitative data in this current study have been collected by using semi-structured interview. The formulation of research questions was close connected to what researcher want to gain an additional insights into the efficacy of Abbreviated Intensive PCIT. The semi-structured interview responses seemed highly influenced by the respondent's own context. Thus, the development of the open-ended questions was to examine parents' perception and experiences about the treatment was related to the research questions of the study.

Based on the semi-structured interview, parents reported more positive change in parent-child relationship, positive attitudes towards their child, better communication when interacting with the child and found that the PCIT programme content, format delivery and therapist very helpful. This part discusses two different outcomes that based on interview analysis: (i) factors contributing to the effectiveness of Abbreviated Intensive PCIT, and (ii) cultural and religious issues.

5.3.1 Factors Contributing to the Effectiveness of Abbreviated Intensive PCIT

In this study, Abbreviated Intensive PCIT has been found to help parents to reduce noncompliance behaviour in their ADHD child by improving parent-child interaction. It can be seen from a set number of sessions when parents showed some improvement in their verbalisation and the child scores below clinical cut-off points on measures for noncompliance behaviour problems. Based on the first interview question analysis regarding parent's personal opinion about the useful aspects of Abbreviated Intensive PCIT, the current study suggested some factors contribute to the initial success among parent-child dyads.

First, the contributing factor to the effectiveness of treatment was the live coaching for both CDI and PDI skills. Live coaching provides immediate prompts to parents while they interact with their child. Therapist can correct parent's errors and misunderstandings on the spot. During the course of this hands-on treatment, parents were guided to demonstrate specific relationship-building and discipline skills. In CDI, parents reported that therapist coached them to bond with their children and develop more effective verbalisation when interacting with the child to better meet their child's needs. Parents reported that PDI parenting skills was helped them not to use physical punishment on child's misbehave and not to spoil or indulge the child. Both Attachment Theory (Bowlby & Ainworth, 1991) and Coercion Theory (Patterson, 1991) suggest that a child's maladaptive behaviours can be learned and reinforced by the behaviour of the parent. Thus, the findings suggested that change in the parent was instrumental in altering noncompliance behaviour in the child. Thus, the therapist support with one-to-one coaching on-the-spot regarding CDI and PDI skills was a key factor mentioned by the parents.

Second, administering the treatment at home setting was contributed to the effectiveness of the intervention. According to Lanier et al. (2011), receiving PCIT in-home is potentially removing many of the barriers that may contribute to attrition. In this current study, the therapist was more interested to conduct the sessions at the respondents' home. Thus, the study found that by conducting the treatment at respondents' home helped them completed all treatment phases without any drop-out case. The additional strategies were utilised in this study, treatment was provided at no cost, flexible appointment times including evening or weekend were offered for treatment sessions, all toys and treatment materials provided by therapist. The therapist also maintained a liberal absence policy by continuing to see cases even when families had cancellations and meeting them after repeated absences. By administering at home, the treatment delivery approach with its client-centred made the participating parents feel respected, empowered and very positive during and after the intervention. The finding of this current study can be added to the growing literature aimed at improving the quality of home-based intervention.

Third, another factor was the programme content itself that based on authoritative parenting. Parent respondents reported that the child management techniques and the play elements were useful and enjoyable and these served to reinforce the parents' confidence in applying PCIT. Parents reported that CLP was good situation to be included in the treatment and the child enjoyed having special play time at home with parents. Allowing the child to lead play emphasised the significance of giving the child the chance to lead in activities and conversations. During this time, parents practiced how to praise wanted behaviours, like sharing and to ignore unwanted or annoying behaviours, such as whining. Parents were also

practiced to avoid criticisms or negative words, such as "No," "Don't," "Stop," "Quit," or "Not" and instead concentrate on positive direction. The time-out chair was effective as reported by parents to issue a warning to child noncompliance behaviours instead of punishment that may disrupted the child's emotional growth. Time-out works well when the time spends with the child is warm and loving. Thus, authoritative parenting style (responsive and firm limit) as proposed by Baumrind (1969) can be applied through play and behavioural therapies. The finding of this study was consistent Matos et al. (2009) in which parents who practiced the authoritative parenting showed significantly greater improvement to manage the behaviour in their ADHD children.

5.3.2 Cultural and Religious Issues

Several cultural issues were identified in the process evaluation. Based on the third and fourth interview question analyses regarding parent's personal experiences about the Abbreviated Intensive PCIT which include cultural and religious issues, the current study suggested some impressions that this intervention could enhance their improvements in its implementation.

First, although all parents showed improvement in increasing their positive verbalisations by praised child's appropriate behaviour and positive in reflective or declarative in their statement. However, some of the parent respondents were not happy to use praise as a technique for increasing their child compliance behaviour. Some of the parents thought that praise if continuously given, it might spoil the child and that there was no need to verbalise labelled praise for the child positive behaviour. Other parents thought that children should perform well and be respectful toward

parents without need of praise. Furthermore, some parents had a tendency to lead and control the child during CLP situation. This issue might stem from Malay values such as parental authority, parental control and overprotection. In addition to increase labelled praise, some parents suggested more subtle forms of praise such as pleasant facial expressions toward child appropriate behaviours.

Second, a cultural issue concerns the technique of ignoring negative child behaviour. In Malay society, a child's misbehaviour is thought to reflect the inadequacy of the parents in disciplining their child. Thus to avoid a public display of their inadequacy, parents try to end such behaviour as quickly as possible using methods such as criticism, physical punishment, or force. When children misbehave or have more serious behaviour problems, such as violent outbursts and tantrums, it is easy for parents to react with anger and frustration or harsh limits. At first, most of parents reported that it was very hard to actively ignore the child because the cultural practice before, they often responded to misbehaviour by verbally correcting the child and doling out consequences. They overlook disruptive behaviour and either focus on a child who is behaving, or wait until the misbehaving child exhibits a desirable behaviour. However, most parents who successfully completed the PCIT intervention were able to use the ignoring technique competently.

Third, cultural issue related to the use of PCIT in Malay society was the concern of parents that extended family members might complaint about their new child management techniques. A few of the parent respondents suggested that to include their spouse into the treatment. They faced difficulties in convincing their spouses to share their views. Some asked their significant others to participate in the treatment with them but resource constraints did not allow the service to be provided

to more than one parent–child dyad. According to Kim, Atkinson and Yang (1999), parents from Asian background maintain strong bonds with the extended family members and would think about one's group before one's self and consider the needs of others in the family before one's own. This is consistent with the current study in which most parents asked for including their extended family members especially their spouse into the treatment. According to parent respondents, in rearing the problematic child, the mutual cooperation between spouses is very important in determining the successful in future life of the child. In addition, it had been proposed by parent respondents that parent sharing groups should be established so that the family members who joined PCIT training can get some exposure of PCIT through sharing from other families, or through witnessing improved children behaviour across different settings and social occasions.

Fourth, the PCIT manual was translated into Malay language using back-to-back translation procedure and revised and preliminarily adapted following a framework of cultural sensitivity of interventions (Bernal, Bonilla & Bellido 1995). In accordance with the dimension of language, some examples given in the original manual were modified to make them more attuned to the daily experiences of Malaysian children. For example, a chimney and snowman were replaced by stove and animal doll. In addition, simple terms were used instead of technical psychological concepts. For example, disruptive parenting was replaced with ineffective parenting (*keibubapaan yang tidak berkesan*), negative talk was replaced with bad words (*perkataan yang tidak baik*). The Malay translation edition was provided to each parent in a form of handout. This handout reflected the provision of additional time for parents to discuss the content of the handout and sometimes the

issues were not directly related to the child's problem. It has been found that on average each family and therapist typically spent around 20-minute (instead of the 5-minute proposed in the original manual) discussing contextual issues that were perceived as stressors and that could interfere with family progress.

Fifth, in play therapy, toys are the words for children (Landreth, 2012). Most of the parents agreed that it is very important to carefully select the toys that can be used by parent-child dyads during play therapy. For example, many toys are imported from Western countries, thus it is easy to find baby doll with brown or grey hair but not with black hair. Parents recommended the use of toys that represent Malaysian and Muslim people, such as the toys wearing Muslim dress instead of using the animal toys. For example, Mr. Bear has been used in the current study as it was one of the original types of toy used in PCIT. In addition, some of the parents recommended that a creative and fun Islamic games such as "Alif, Ba, Ta" (Arabic alphabet letters) can be used during the play therapy session. Instead of playing, child has the opportunity to learn in playful manner.

Sixth, another issue related to the PCIT in Malay society was the concern of some parents to include the Islamic parenting technique in the treatment approach. For example, some of the parents suggested that in the beginning of each treatment, therapist can teach not only parents but the child love Allah, the Prophet, Islam and Islamic values by see all things and understand all things from the perspective of Islam. Some of the parents recommended that a soft form of physically punished (beaten) can be applied as a last resort if the child do not correct the wrong behaviour after third times the gentle instruction does not result in the child. Instead of no

interaction with parents during the time-out, this session can be added with the time for child to be taught to recite simple surahs from the Al-Quran.

Apart from the above, especially the cultural issues faced by the parent respondents which made the achievement of CDI and PDI parenting skills mastery criteria difficult. Parents reported that of all the PCIT skills, ignoring the negative behaviour exhibited by the child, avoiding asking questions and giving labelled praise were the most difficult to master. During the treatment sessions, the researcher observed some of the parents questioned their child too much and in some occasions such as during PLP and CU situations, parents were not used ignoring when the child behaved aggressively. These children behaviours such as threw small objects, broke things when they were angry and upset, temper tantrums, kicked parents and screamed. Then, parents left all these to the researcher to stop their child behaviour. Some parents displayed ineffective parenting style such as authoritarian, controlling, harsh or coercive parenting style and even overindulgence parenting style.

Nevertheless, other researchers working with families who have child with disruptive behaviour have also found that ignoring and praising the child's appropriate behaviours are difficult technique to implement (Leung et al., 2009), which may rule out any cultural interpretation. Despite these problems faced by some parents to achieve CDI and PDI parenting skills mastery criteria, the subjective impressions of the researcher suggested that extra support is needed initially to encourage parents to use the labelled praise and ignoring techniques.

5.4 Implications of the Research

This section discusses the implication of research based on findings which obtained from the following: (i) contribution of the research to theory, (ii) national treatment policies on children with ADHD, and (iii) mental health counselling practice.

5.4.1 Contribution of the Research to Theory

This study indicated that there were several researches which could contribute to the theoretical basis as the core of this study. The foundation of PCIT is based upon developmental theories of parenting which draws on both attachment (Bowlby & Ainworth, 1991), and social learning (Patterson, 1982) theories to achieve an authoritative parenting (Baumrind, 1966). These contributions could be viewed in three situations that are known as the effectiveness of psychosocial approach, the pattern of changes in targeted behaviour and research designs.

Results of the study showed that psychosocial approach, particularly when it was executed on family based therapy, was effective in reducing noncompliance behaviour among preschool children with ADHD which was measured based on the parent's verbalisation when interacting with the child and child compliance behaviour toward parental commands. These findings contributed to the verification of these three developmental theories of parenting recommendation which indicated that authoritative parenting approach was most suitable to be used in interventions for family with young children with disruptive behaviours. The authoritative parenting stressed that to promote optimal child positive behaviour outcomes, the focus must on promoting optimal parenting styles and parent-child interactions. In relation to the three developmental theories of parenting, parents engaged in a two-phase training

CDI and PDI that helps them to replace maladaptive interactions with their children with more effective practices.

Patterson (1982) suggested that parents must be taught with more effective discipline strategies to manage their child's behaviour problems by issuing clear, age developmentally appropriate, direct command and to provide consistent consequences for child's compliance and noncompliance. By discouraging criticisms and commands from parent, the parent-child interactions can include more positive messages. PCIT then teaches parents to utilise skills such as selective ignoring and labelled praise to increase positive behaviours and discourage undesirable behaviours (Niec et al., 2005). Psychosocial approach using the family based therapy method which was applied on parent-child dyads took into consideration all suggestions given and listed in the theories, including the remaining of clinical treatment even conducted at respondent's home. Results obtained showed that the approach was indeed, effective.

Finally, the finding also contributed to the enrichment of developmental theories of parenting in terms of format of delivery. The abbreviated PCIT format is popular because the perception by consumers that treatment is excessively demanding has been shown to interfere with therapeutic change (Lewis, 2010; Harwood & Eyberg, 2006). According to Bakermans-Kranenburg et al. (2003), a meta-analytic study has demonstrated that early intervention programmes with fewer treatment sessions are more effective than those with a higher number of treatment sessions. The findings of the current study contributed additional evidence to the growing body of literature which highlights the efficacy of abbreviated PCIT format designed to treat a behavioural problem in young children (Graziano et al. 2014; Harwood & Eyberg, 2006; Lewis, 2010; Nixon et al., 2004).

5.4.2 National Treatment Policies on Children with ADHD

Early detection for children with disabilities aged four to six years old falls within the purview of both MOH and MOE. Specific development screening tests are conducted at various stages of the child's growth and development. The MOH under Family Health Development Division (FHDD) piloted a specific development health screening at 5-month, 12-month, 18-month and 4-year. This screening programme strongly encouraged health professionals to take note of parental concerns of developmental delay and incorporated a child developmental checklist to assess parental concerns of ADHD screening for children at four years old (Amar-Singh, 2008). This screening programme involves both parents and healthcare providers to look out for and act on the early signs of potential disabilities. Apart from early detection, the MOH provides healthcare and treatment programme for children with disabilities. Basically, the treatment goal for ADHD children is to improve disruptive behaviours, learning, social interactions and selfsworth or self-esteem (MOH, 2011).

The treatment policy for children with ADHD is categorised under the MOH Health Care for Persons with Disabilities Years 2011-2020 Plan Action (PWD Healthcare Plan of Action) is said to meet the obligations and strategies under the Committee on the Rights of Persons with Disabilities (CRPD), PWD Act and National Policy (UNICEF, 2014). According to MWFCD (2013), the health strategies under the PWD Act and National Policy are to increase health services, including prevention, detection and early intervention (primary care) and to increase the quality of medical services for the disabled (secondary and tertiary care). Therefore, these ADHD children are eligible for registration with the MWFCD to get the PWD Card. PWD Card is a mark of identification issued to people with disabilities who are registered

with the Society Welfare Department (SWD) in order to facilitate them to deal with the parties concerned. The PWD policy is based on the concept of equality of rights and opportunities for PWD to participate fully in society. Thus, based on this policy, the MWFCD established Community Based Rehabilitation (CBR) centres throughout the country. CBR centre is a one-stop centre for PWD that provides services such as diagnosis, rehabilitation, treatment, special education and vocational training (Nalasamy & Siti Hajar, 2013). Other than CBR, for children with disabilities who aged four to six years, early intervention programmes are provided by the MOE in Special Education Schools under special needs education system (Fong, 2013).

The National Special Needs Education System was introduced in the Malaysian Education Act (1996), and the Education (Special Education) Regulations (2013) provide the legal framework for special education for children with disabilities in the country. These regulations are applicable to government or government-aided schools. 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. According to PWD Act 2008, learning problem means the problem of intelligence that is not consistent with the biological age. The symptoms of ADHD affect a child's functioning which involves difficulty with a very specific aspect of learning when they have trouble paying attention, sitting still, or finishing tasks. In this regard, ADHD children are placed in SEIP. The SEIP is a specific class in mainstream schools dedicated to children with special needs include learning disabilities, communication disorders, emotional and behavioural disorders, physical disabilities,

and developmental disabilities (Fong, 2013). In Malaysia, there are currently 1300 mainstream schools with SEIP for primary schools (Fong, 2013).

The Development Group and Review Committee under MOH recognise the lack of resources for formal parent training. According to Amar-Singh (2013), there is a serious lack of trained professionals to carry out the effective early intervention childhood programme for problematic and disabilities children and their affected families. Lack of information is one of the reasons that limit the parents' involvement in dealing with the educating children with learning or other disabilities (Siti Zaharah, 2004). Children with ADHD might not respond as well as other children do the usual parenting practices, thus, experts recommend additional parent education. This approach has been successful in teaching parents how to help their children become better organised, develop problem-solving skills, and cope with their child's ADHD symptoms. Parent education can be conducted in groups or with individual families training and basically is offered by therapists or in special classes. In this case, the most recommended parent education is parent training and behavioural interventions (AAP, 2011). The Agency for Health Care Research and Quality (2010) conducted a review in all existing studies on treatment options for preschool children. The review found enough evidence to recommend parent behavioural interventions also known as behavioural parent training is a good treatment option for preschool children with disruptive behaviour in general and as helpful for those with ADHD.

In relation to this, MOH and MOE recognise that early detection and intervention programme is critical in Malaysia. This is attributed to the absence of a well-concerted multidisciplinary team approach in identification and intervention process and in addressing the needs of child and families (Special Education

Regulation, 2011). Consistent with the policy treatment for children with ADHD as stated by Education (Special Education) Regulations (2013), thus, given the right services, support and interventions, these children could maximise their talents and learning potentials to enable them to carry on with their life after they graduated from the educational system.

5.4.3 Implications of Abbreviated Intensive PCIT for Counselling Practices

Prior to receive Abbreviated Intensive PCIT, parents who have ADHD children with high rates of noncompliance behaviour improved rapidly and substantially during the first three sessions of the intervention. A quadratic growth pattern accounted for 70% of observed variance and virtually all change occurred during the first three of B-IT sessions. On average, the changes in the patterns of interaction also remained relatively stable for the remainder of treatment while parents continued to practice positive parental responses (parent's verbalisation) as well as began practicing effective discipline techniques. This suggests that use of immediate parent feedback through coaching, explicit directions to parents in how to respond to child behaviour, and customisation of the application of CDI and PDI skills to the problems that arise in session are important components to effective parenting programmes with parents. Moreover, there were many benefits to Abbreviated Intensive PCIT such as it is a brief, short-term family counselling procedure that teaches effective parenting skills and helps parents interact better with their children on a daily basis. Fundamentally, PCIT's two-tailed approach benefits both parents and children by reducing the internalisation of problems. Additionally, PCIT empowers parents through teaching positive interactive techniques that build parent-child relationship. PCIT fosters

creativity and increases child self-esteem, decreases noncompliance behaviours, and increases the quality of parent-provided positive regard through developmentally appropriate play.

In this study, all the PCIT intervention sessions focused on individual and family counselling basis which were conducting at home. Based on Dyad 6 achievement, this study found the three essential elements in the intervention of PCIT that may help the parent to master the CDI and PDI skills; (i) increased positive parent–child interaction and emotional communication skills, (ii) appropriate and consistent discipline methods, and (iii) direct scaffolding for parent training in the interventions. Thus, once the parent of Dyad 6 has mastered these skills in the final session with the child and therapist, the parent is able to transfer the skills to any location or setting to maintain positive interactions, emotional communication and disciplinary consistency with the child. These three elements should be emphasised by the researcher in ensuring that the PCIT should be in line with these elements in order to help parents to master the parenting skills of CDI and PDI appropriately.

In addition, 30-minute of counselling sessions at the end of each intervention session also found useful in dealing with relationship problems within the family and helping in reduce the noncompliance behaviour symptoms. The researcher also found that during counselling sessions, the family's strengths were used to help them handle their problems. For the best results, in this study, researcher asked the parents to work together with the researcher to achieve the main goals of the intervention. Moreover, this counselling attachment to the intervention has been found successfully to deal with child's behaviour and learning problems and also with parenting stress and negative attitudes toward their child. In this study, however, researcher found that, the

combination of counselling and psychotherapy (Abbreviated Intensive PCIT) was in the best position to help the parents to cope with ADHD children. This study supported the research findings in counselling that action-oriented approaches are vital such as play therapy (Portrie-Bethke et al. 2009; Schottelkorb & Ray, 2009) and behavioural therapy (Hoffman, 2009; Northey et al., 2003) may be effective when working with young children coping with ADHD symptoms.

Since the researcher found in this study, that counselling session (talking therapy) help the child and parents to talk about their problems, the information provide is useful for researcher to get involve and understand their needs. Therefore, the combination of counselling and PCIT intervention have proven its effectiveness with these six families and found a significant decrease in disruptive child behaviours as well as a decrease in inappropriate parent verbalisation over the 7-session. On average, the researcher also found that intervention effects remained in place for 1-month after the intervention terminated.

5.5 Recommendations for Improvement of Mental Health Counselling

Mental health issues can have a profound impact on how people think, feel and behave which can range from the daily worries people all have from time to time, to serious long-term problems that require treatment to manage effectively. Mental health support covers a range of things designed to manage symptoms and improve quality of life. The most common types of treatments include, prescribed medication to control the symptoms but not a cure and talking therapies including psychotherapy, counselling, group psychotherapy, psychoanalysis and other forms of mental health counselling. Mental health counselling involves talking about the problems with a

trained counsellor or psychotherapist. Talking therapies can help clients to understand what may have caused their problems and how to manage them. Thus, based on the findings of this study, it is recommended that some improvements should be highlighted in the practices of mental health counselling in Malaysia.

First, mental health covers a wide spectrum of issues, some of which require specialised treatment. Instead of trained to listen with empathy or to deal with any negative thoughts and feelings the clients have, the roles of registered counsellors in Malaysia are needed in dealing with mental health issues and problems. In Malaysia, a child who diagnosed with mental health illness will be first recommended to get the medical treatment to reduce their symptoms of illnesses (See & Ng, 2010) without giving the priority to parents to undergo the psychosocial treatments before the medical treatment provided. 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). It seems that variety counselling services in Malaysia is still in its infancy stage (Ng & Steven, 2001; Zakaria & Asyraf, 2011) include the mental health counselling.

Second, in supporting the first recommendation, there is a directive from MOE clarified the roles of counsellors toward the psychosocial and mental-health-related issues. Most counselling practitioners in Malaysia are in the educational settings (Zakaria & Asyraf, 2011). It was approximately estimated about 826 from 4,000 (20.7%) school counsellors were registered with the MBC in year 2009 (Zakaria & Asyraf, 2011). This indicated that the task of counsellors is still concentrated in the field of education even though it begins to spread in the private sectors and other. More research is needed to help school counselling further define and refine its

purpose and directions, theory and practice, and training framework See and Ng (2010). The empirical findings then can help to improve the professionalism of school counselling. Therefore, the registered counsellors are recommended to improve the quality of their services and creating awareness for mental health services. Consistent with PERKAMA Code of Ethics (2008), counsellors need to be trained in using the assessment instruments and psychotherapy to identify, evaluate and to treat dysfunctions and disorders for purposes of providing appropriate mental health counselling.

Third, although it was recognised that one size does not fit all, PCIT has shown significant results with ethnic minorities and underserved populations in effectively increasing positive parenting behaviours and decreasing behavioural problems in children. The findings of this study support the notion that PCIT is culturally effective and produces robust modifications among diverse groups (Bagner & Eyberg, 2007; Matos, et al. 2006; McCabe & Yeh, 2009). Therefore, some of the parents' recommendations and concerns include the Islamic parenting technique in the treatment approach, the use of toys that represent Malaysian and Muslim people. The manual and hand-outs were translated into Malay language with a few modifications using back-to-back translation procedure and revised and preliminarily adapted following a framework of cultural sensitivity of interventions (Bernal et al., 1995). Some examples given in the original manual were modified to make them more attuned to the daily experiences of Malaysian children. Therefore, with some modifications and recommendation given by parents, this PCIT intervention can be used effectively in coping with children with disruptive behaviours and not limited to ADHD only.

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5.7 Conclusion

This study makes an important contribution to evidence-based parent education and demonstrates the potential of incorporating research into normal service delivery. However, more rigorous research is still needed to demonstrate the usefulness of PCIT across different settings (school) and different family backgrounds (in terms of socioeconomic status and psychological environment) to convince service providers and policy makers that this intensive case-by-case service is cost-efficient in promoting family solidarity and positive parent–child relationships, and in reducing disruptive child behaviours. Furthermore, the findings of the study can provide valuable information and guideline for school counsellors, teachers, parents and community about early symptoms of ADHD in children and relevant intervention used to treat affected children. The teachers and school counsellors are resources for initial identification, screening and assessment for ADHD symptoms, they must have good working knowledge of typical symptoms and well-trained in conducting early

interventions for ADHD problems either psychological or behavioural issues. Thus, the findings of this study can be a resource for screening, assessing and treating ADHD behavioural symptoms in young children. By understanding this, there is an opportunity for researcher to tailor the parents' needs in coping with their child's behaviour problems based on Malaysian culture.

Overall, the findings of this study demonstrate the potential of Abbreviated Intensive PCIT as an early intervention to improve the behavioural functional outcomes of preschool children with ADHD. The study suggested that the treatment strengthened parent-child attachments, increased positive interactions between parents and their children, and equipped parents with evidence-based disciplinary practices to improve children's compliance behaviours. These potential outcomes of the study have important implications for children's long-term outcomes, as stable parent-child attachments promote children's social, behavioural, and emotional development.