The Hong Kong Jockey Club Community Project Grant: Parent-Child Interaction Therapy (PCIT) Service - An Effectiveness Study for Service 2015 to 2018

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Preface

With a constant concern on improving the parent-child relationship and alleviating the child abuse problem of Hong Kong, Tung Wah Group of Hospitals (TWGHs) started to pioneer Parent-Child Interaction Therapy (PCIT) service in Hong Kong in 2004, implementing in districts including Tin Shui Wai, Tuen Mun and Mongkok, where the child abuse rates were high. In line with The Hong Kong Jockey Club Charities Trust's (The Trust) commitment in nurturing strong and resilient families and promoting family well-being, the Trust has supported TWGHs to implement the PCIT service since 2008 and extended the service to nine service points over the territories. Over the past decade, more than 2,000 high risk families benefited from PCIT.

PCIT is a behavioral family-centered treatment approach proven effective for abused, at-risk and disruptive children ages 2 to 7 and their parents in increasing positive parent-child interactions and reducing children's disruptive problems. To understand the effectiveness and efficacy of PCIT service in Hong Kong, TWGHs has collaborated with Professor Cynthia Leung of the Hong Kong Polytechnic University and Dr. Sandra Tsang of The University of Hong Kong to conduct three PCIT studies from 2007 to 2015. The studies "The Outcome and Process Evaluation of the Parent-Child Interaction Therapy in Treating Families with Children with Behavior Problems in Hong Kong" and "Parent-Child Interaction Therapy Service in Hong Kong: An Efficacy and Effectiveness Study" conducted in 2007 and 2012 respectively confirmed that PCIT effectively reduced children's behavior problems, parenting stress and negative emotions, negative parenting practices and use of corporal punishment and increased parenting practices. A more specific study on the efficacy of PCIT on ADHD children conducted in 2015 further confirmed that PCIT was effective in reducing the children attention problems for those with ADHD features.

To further develop PCIT as a higher applicable and gender-sensitive parenting treatment, we conducted three studies between 2015 and 2018: (A) The effectiveness of PCIT service on 538 parent-child dyads who have completed the PCIT treatment in this period, (B) The Chinese fathers and mothers' differences in participating in PCIT, and (C) The effectiveness of PCIT on children aged 8 or above. The report is prepared to present the results of these studies.

Acknowledgement

We would like to take this opportunity to acknowledge parties and individuals who have contributed and assisted in The Hong Kong Jockey Club Community Project Grant: Parent-Child Interaction Therapy (PCIT) service and made this report possible.

First, we would like to express our sincere gratitude to The Hong Kong Jockey Club Charities Trust for the continuous support and generous donation for the PCIT service. We also thank the contributions of our research consultants Professor Cynthia Leung of the Hong Kong Polytechnic University and Dr. Sandra Tsang from the University of Hong Kong. Their all-along support to the service and their expertise are incomparably important to our PCIT service team. We are indeed fortunate to have PCIT founder Professor Sheila Eyberg of the University of Florida, and our PCIT Master Trainers Professor Cheryl McNeil of the West Virginia University and Professor Robin Gurwitch of the Duke University as our overseas consultants. The team benefits a lot from their expertise, experience and wisdom in practicing PCIT. We also have to thank thousands of parents and children for allowing us to walk with them and to learn about the way to adopt PCIT in various types of children and families.

Finally, the service would never have been recognized by the public and professionals without the efforts from all members of the PCIT service team. They have strived to provide the best service to the at-risk families and devoted many years to localize the treatment, which made a lot of differences to many families they served. They are credited for the success of the service.

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Table of Content

Parent-Child Interaction Therapy (PCIT) Service in Hong Kong:
An Effectiveness Study for Service 2015 to 2018

Executive Summary

October 2018

Introduction: This study mainly examined the effectiveness of Parent-Child Interaction Therapy (PCIT) Service of Tung Wah Group of Hospitals (TWGHs) from April 2015 to March 2018, the effectiveness of PCIT on children aged 8 or above, and the differences between Chinese fathers and mothers in participating in PCIT. Originally, the program targeted parent-child dyads with children aged 2 to 7 with behavior problems. The parents were those who used corporal punishment, were at-risk of child abuse, or experienced high parental stress. In this service project, apart from the usual children target group, we had also included 34 children aged 8 and 9 and used the adapted protocol for older children

Methods: This study was a program effectiveness study involving 538 cases (485 target children and 538 caregivers) served in the project. The mean age of the target children was 5.02 with more boys (70.1%) than girls (29.9%). The majority of these participants (63%) were self-referred. Both quantitative and qualitative data were collected.

Results: The effectiveness study lasted for three years. 382 of the 538 cases in the project completed PCIT treatment successfully. The overall success rate was 71%. Dependent t test was used to analyse the pre-intervention and post-intervention measures of all the 382 successful cases and the three sub-groups among these cases: the established/high risk child abuse subgroup (n = 31), the special educational needs (SEN) subgroup (n = 157), and the target children aged 8 years or above subgroup (n = 27). The results indicated that child behavior problems, parenting stress and the use of corporal punishment were consistently lower at post-intervention in comparison with pre-intervention for all the successful cases in the three sub-groups. There were also significant decreases in inappropriate child management strategies and significant increases in positive parenting practices.

Among the 382 successful cases, 374 participants who were the target child's biological or adopted fathers or mothers were categorized into 4 groups: mother only, father only, couple-mother, and couple-father for studying the differences between Chinese father and mothers in participating in PCIT. The results indicated that there was no significant difference among the 4 groups in post-intervention scores.

Qualitative results collected from the participants' focus groups and the therapists' reflection reports were consistent with the quantitative data. The parents appreciated the immediate direct coaching, the principle of "relationship before discipline", the systematic evaluation by the therapists, comprehensive service contents and the expertise of therapists. The therapists attributed the success to the direct observation and tailor-made feedback in on-the-spot coaching, intensive and regular interview arrangement, the two-section design of the treatment and the parents' effort in applying learnt skills at home.

For extending the service to older children, the therapist recognized that PCIT could also benefit this target group with adjustment of the protocol according to the children's developmental contexts and needs.

Some practice wisdom in engaging fathers to improve their parenting and involving fathers in the program was also collected from the parents. However, both parents and therapists did not find it necessary to make PCIT service differential to cater for the possible different needs of father and mothers.

Discussion: The results confirmed that PCIT was effective in reducing the children's behavior problems, parenting stress and negative emotions, negative parenting practices, the use of corporal punishment, and increased positive parenting practices. PCIT was also found to be a promising intervention strategy for established/high risk child abuse cases, children with special educational needs, as well as children aged 8 or above. Investigating the correlation between living environment, treatment homework completion and treatment impact, and content analysis of parent-child dialogues could be considered in future studies.

Chapter 1: Background and Objectives

Introduction and Background

1.1 Supported by The Hong Kong Jockey Club Charities Trust, Tung Wah Group of Hospitals (TWGHs) offered The Hong Kong Jockey Club Community Grant: Parent-Child Interaction Therapy (PCIT) services through nine centres to a total of 604 parent-child dyads from April 2015 to March 2018. This non-technical report is prepared to present the evaluation results of this 3-year service project.

1.2 PCIT is an empirically supported and clinically grounded treatment approach for young children, aged 2 to 7 with disruptive and oppositional behaviors, and their parents (Brinkmeyer & Eyberg, 2003; Herschell, Calzada, Eyberg, & McNeil, 2002). It was developed by Dr. Sheila Eyberg of The University of Florida, the United States and was adapted by TWGHs for the Chinese families in Hong Kong (Leung, Tsang, Heung & Yiu, 2009). Local PCIT effectiveness and efficacy studies were completed in 2007 and 2012 respectively. A specific efficacy study on children with ADHD was also completed in 2015.

1.3 To further develop PCIT to be a higher-applicable and gender-sensitive parenting treatment, TWGHs in collaboration with Professor Cynthia Leung of The Hong Kong Polytechnic University and Dr. Sandra Tsang of The University of Hong Kong, conducted the studies on (A) The effectiveness on PCIT service from 2015 to 2018, (B) The Chinese fathers and mothers' differences in participating in PCIT, and (C) The effectiveness of PCIT on children aged 8 or above.

1.4 There were 538 closed cases out of the 604 cases served in the period involved in the analysis of the program effectiveness in the project. Both quantitative and qualitative data were collected in the effectiveness study.

Participants and PCIT Therapists

1.5 The participants were parent-child dyads (and in a few cases, the main caregivers who were children grandparents or other relatives) served in the PCIT project in the evaluation study from April 2015 to March 2018. The participants were parents (or main caregivers) who expressed concerns about the children's behavior and parent-child relationship. Most of the participants (63.0%) were self-referred while the others were referred by Integrated Family Services Centres, Family & Child Protective Service Units of the Social Welfare Department (SWD), other non-governmental organizations (NGOs), Child Assessment Centres, medical units, schools or preschools, and other service units of TWGHs. All the participating parent-child dyads were assessed by the PCIT therapists to have met the inclusion criteria (children aged 2 to 7 exhibiting externalizing behavior problems in the clinical range as measured by the Eyberg Child Behavior Inventory [ECBI]; parents admitted to using corporal punishment or experiencing high parental stress) before receiving the service.

1.6 All PCIT therapists working in TWGHs have received qualification training from the PCIT program in the United States (US), or from Hong Kong PCIT trainers certified by the PCIT International.

The PCIT Treatment

1.7 The PCIT treatment program was delivered in selected social service centres and nursery schools of TWGHs to ensure accessible service coverage all over Hong Kong. There were two major components in the program: Child-Directed Interaction (CDI) sessions on parent-child relationship enhancement, and Parent-Directed Interaction (PDI) sessions on strategies to improve child compliance (Eyberg, 2011), together with pre-assessment, mid-term, post-assessment, and follow-up-assessment. The treatment progress was guided by the regular coding of observations of parent-child interaction using the Dyadic Parent-Child Interaction Coding System – 4th Editions (DPICS-IV; Eyberg, Nelson, Ginn, Bhuiyan, & Boggs, 2014). Treatment was conducted once a week and each session lasted for approximately one hour. In each week, parents were given "homework sheets" to record their daily practice of the skills at home with their children. Each treatment session started with a 10-minute check-in to review the homework and the current family situation, followed by a five-minute observation by the therapist to assess the parent's mastery of the skills. The therapist then coached the parents on the relevant skills and gave them feedback. The number of treatment sessions offered depended on the parent's mastery of the skills. Once parents met the mastery criteria of the CDI phase, they would proceed to the PDI phase on strategies to improve child compliance. The treatment was performance-based, and ended when the parent had mastered the required skills of the treatment phases. The treatment was conducted in Cantonese. Further service details could be found on the following website: http://pcit.tungwahcsd.org/.

1.8 A slightly adjusted protocol was used for cases with children aged 8 or above in

this project. There was no modification made to the CDI and PDI mastery criteria. However, since older children have enough sophistication to understand parents' messages, parents were encouraged to use shorter but more genuine praises, summarized reflections and complex description statements. More age-appropriate toys or activities which could encourage parent-child interaction, such as art materials, board games and indoor ball games, were included in the session for the children's selection. In PDI, standard procedures were followed except that removal of privilege was used instead of time-out chair or room for highly aggressive older children. In order to engage older children, therapist would arrange individual sessions with children when necessary.

Chapter 2: Quantitative Study

A. Quantitative Study Methodology

Participants

2.1 During April 2015 to March 2018, a total of 485 target children and 538 caregivers were being served and were closed by May 2018. There were 157 caregivers with target children with special education needs (SEN) such as Language Delay, Attention Deficit Hyperactivity Disorders and Autistic Spectrum Disorder. There were 16 established child abuse cases and 15 cases at risk of child abuse. The majority of the closed cases (n = 339, 63.0%) were self-referrals. The referral details are presented in Table 2.1. The demographic and family background characteristics of the target children are shown in Table 2.2.

2.2 Among the 538 caregiver cases, 382 cases had completed PCIT treatment successfully (post-intervention ECBI-intensity scores below the clinical range, achieved CDI mastery, or achieved both CDI and PDI mastery). The overall success rate of PCIT treatment is 71.0%. Among the successful cases, there were 314 who could achieve CDI and PDI mastery, and 68 who could achieve CDI mastery only.

2.3 A total of 156 cases dropped out from the service. The details are shown in Table 2.3. There were more participants with monthly income ≤ $19,999 among the drop-out cases (p = .007). There were more participants on Comprehensive Social Security Assistance (CSSA) among the drop-out cases, compared with the successful cases (p < .001). There were more participants who were married or in a de-facto relationship among the successful cases, compared with the drop-out ones (p = .005). There were more single parents among the drop-out cases than the successful cases (p = .036). There were more target children attending primary schools among the drop-out cases (p = .010). The age of the target child (p = .013) of the drop-out cases were older than those of the successful cases. The pre-intervention ECBI-intensity scores (p < .001), ECBI-problem scores (p < .001), PSI total scores (p < .001) and DASS total scores (p < .001) of the drop-out cases were higher than those of the successful cases.

Table 2.1: Source of Referrals (n =538)

Source	Number	Percentage
Social Welfare Department (SWD)	122	22.7%

Other government departments	1	0.2%
Non-governmental organizations (NGOs)	26	4.8%
Medical settings	24	4.5%
Schools	17	3.2%
Other units of TWGHs	7	1.3%
Family members/relatives	1	0.2%
Identified by worker	1	0.2%
Self-referral	339	63.0%

Table 2.2: Demographic Characteristics of All Participants (*n*= 485)

Socio-demographic Characteristics	Number	Percentage
Sex of target child - male	340	70.1%
Sex of target child - female	145	29.9%
Education level of target child - no education	29	6.0%
Education level of target child - kindergarten	337	69.5%
Education level of target child - primary	119	24.5%
Relationship of participant with child - mother	378	77.9%
Relationship of participant with child - father	37	7.6%
Relationship of participant with child - adopted mother	1	0.2%
Relationship of participant with child - relatives	16	3.3%
Relationship of participant with child - both parents including 1 step father	53	10.9%
Family type - nuclear	341	70.3%
Family type - extended	41	8.5%
Family type - single parent	72	14.8%
Family type - grandparents and mother/father and children	24	4.9%
Family type - grandparents and grandchildren only	3	0.6%
Family type - others	4	0.8%
Marital status - married/de facto/re-married	372	76.7%
Marital status - single/separated/divorced/widowed	113	23.3%
Participant in employment[a]	198	36.8%
Participant not in employment[a]	340	63.2%
Father's education[b] - 9 years or less	19	21.1%%
Mother's education[c] - 9 years or less	122	28.3%
Family monthly income - HK$19,999 or below	293	60.4%
Family monthly income - HK$20,000 or above	192	39.6%
Social security status - yes	112	23.1%
Social security status - no	373	76.9%
	Mean	*SD*
Age of target child (years)	5.02	1.61
Age of participant (years)	39.98	6.90

[a] *n* =538
[b] *n* = 90
[c] *n* = 431

Table 2.3: Socio-demographic Characteristics and Pre-intervention Scores of Successful Cases and Drop-out Cases

	Successful cases (*n* = 382)		Drop-out cases (*n* = 156)	
Socio-demographic Characteristics	Number	Percentage	Number	Percentage
Sex of target child - male	262	68.6%	114	73.1%
Sex of target child - female	120	31.4%	42	26.9%
Education level of target child - no education	21	5.5%	10	6.4%
Education level of target child - kindergarten	276	72.3%	99	63.5%
Education level of target child - primary	85	22.3%	47	30.1%
Relationship of participant with child - mother	305	79.8%	126	80.8%
Relationship of participant with child - father	67	17.5%	22	14.1%
Relationship of participant with child - relative (female)	7	1.8%	6	3.8%
Relationship of participant with child - relative (male)	1	0.3%	2	1.3%
Relationship of participant with child - step parent	1	0.3%	0	0.0%
Relationship of participant with child - adopted parent	1	0.3%	0	0.0%
Family type - nuclear	287	75.1%	102	65.4%
Family type - extended	32	8.4%	11	7.1%
Family type - single parent	43	11.3%	31	19.9%

Family type - grandparents with father/mother and children	17	4.5%	8	5.1%
Family type - grandparents and grandchildren only	2	0.5%	1	0.6%
Family type - others	1	0.3%	3	1.9%
Marital status - married/ de facto	313	81.9%	111	71.2%
Marital status - single/ separated/ divorced/widowed	69	18.1%	45	28.8%
Employment status of participant - in employment	154	40.3%	44	28.2%
Employment status of participant[a] - not in employment	228	59.7%	112	71.8%
Education level of participant[a]-- more than 9 years	277	72.5%	107	68.6%
Education level of participant - 9 years or less	105	27.5%	49	31.4%
Family monthly income HK$19,999 or below	206	53.9%	104	66.7%
Family monthly income HK$20,000 or above	176	46.1%	52	33.3%
Social security status - yes	66	17.3%	52	33.3%
Social security status - no	316	82.7%	104	66.7%
	Mean	*SD*	Mean	*SD*
Age of target child (years)	4.87	1.54	5.26	1.77
Age of participant (years)	40.05	6.73	40.35	7.19
Pre-intervention ECBI-Intensity	156.70	23.43	169.54	24.53
Pre-intervention ECBI-Problem	17.57	7.68	21.01	8.05
Pre-intervention PSI-total	116.10	18.63	125.65	17.71
Pre-intervention DASS-total	19.89	13.19	25.49	13.77
Pre-intervention corporal punishment	1.10	1.54	1.21	1.78
Pre-intervention Labeled Praise	0.33	1.06	0.28	0.86
Pre-intervention Behavioral Description	0.93	2.04	0.67	1.46
Pre-intervention Reflective Statement	2.49	3.05	2.13	2.80
Pre-intervention Command/Question/Negative Talk	12.91	10.03	11.18	9.00

Measures

2.4 All the participants of the project were requested to complete a set of questionnaires before (pre-intervention), mid-term, immediately after the program (post-intervention) and three months after intervention (follow-up). The Dyadic Parent-Child Interaction Coding System (4th Edition; DPICS-IV) is also used to assess the quality of parent-child interaction at the four assessment points.

- Socio-demographic Information - The information included the child's age, sex, schooling, the participant's age, sex, educational attainment, occupation, marital status, family type, household income and CSSA status.
- Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) - The ECBI contains 36 items on disruptive behavior (e.g. noncompliance and temper tantrums), and yields an Intensity Scale and a Problem Scale. The Intensity Scale measures the frequency of various behaviors on a 7-point scale, and the Problem Scale measures whether some specific behaviors are considered by parents to be problematic (yes = 1, no = 0). Higher scores indicate a higher frequency of disruptive behavior and parental concern. The Chinese version of the ECBI has been validated with good reliability (.94 and .93) for both scales (Leung, Chan, Pang, & Cheng, 2003). The clinical cut-off of ECBI-intensity is 131 and that of ECBI-problem is 15.
- Parenting Stress Index (Short Form) (PSI; Abidin, 1990) - This scale consists of 36 questions that measure three factors of parenting stress: parental distress (PD), which measures the impaired sense of parental competence and depression; parent-child dysfunctional interaction (PCDI), which measures dissatisfaction with the parent-child interaction; and difficult child (DC), which measures the behavioral characteristics of the child. A total score can be calculated, with a higher score representing a higher level of parenting stress. The Chinese version of this scale has been examined in Hong Kong and shown to have an overall reliability of .89 (Lam, 1999). However, Hong Kong norms for the PSI have not been established.
- Depression, Anxiety and Stress Scale (DASS; Lovibond & Lovibond, 1995) - This is a self-report instrument with 42 items measuring the negative emotions of depression, anxiety and stress. For the purposes of this study, the short form of the DASS was used (DASS-21). The scale has been validated with Hong Kong Chinese participants aged 18 or older and is the only measure reflecting negative

emotions among Chinese (Taouk, Lovibond, & Laube, 2001). Each of the three subscales (depression, anxiety, stress) of the DASS-21 contains seven items. Participants indicate on a 4-point Likert scale how much each statement applies to them over the past week. Response categories comprise: did not apply to me at all=0, applied to me to some degree, or some of the time=1, applied to me to a considerable degree, or a good part of the time=2, and applied to me very much, or most of the time=3, respectively.

- Dyadic Parent-Child Interaction Coding System (4th Edition) (DPICS-IV; Eyberg, Nelson, Ginn, Bhuiyan, & Boggs, 2014) - The intervention group participants were assessed by PCIT therapists using the DPICS-IV on four occasions: before (pre-intervention), mid-term, immediately after the completion of the PCIT program (post-intervention), and three months after intervention (follow-up). The DPICS-IV is used to assess the quality of parent-child interactions through observations of parent-child dyads in a clinical setting. The DPICS-IV parent categories coded for this study include Behavioral Description (BD), Reflective Statement (RF), Labeled Praise (LP), and Command/Question/Negative Talk (C/Q/NTA). The Chinese version of the DPICS-IV parent categories were translated by PCIT therapists and reviewed by their project supervisor. To reach the CDI mastery skill level, the parent has to demonstrate the following skill level during the 5-minute observation: 10 Behavioral Descriptions, 10 Reflective Statements, 10 Labeled Praises and less than 3 Commands/Questions/Negative Talk.
- Frequency of Corporal Punishment - The frequency of use of corporal punishment during the past seven days was also recorded at the four assessment points.
- Therapy Attitude Inventory (TAI; Hembree-Kigin, & McNeil, 1995) - At post-intervention, all participants were requested to fill in the Therapy Attitude Inventory (TAI) for measuring satisfaction towards the service. This is a 10-item questionnaire on client satisfaction with the PCIT. Participants rated their satisfaction on a 5-point scale from 1, indicating low satisfaction, to 5, indicating high satisfaction.

Procedures

2.5 The participants were requested to provide their socio-demographic data before intervention, and to complete a set of questionnaires before (pre-intervention), mid-term, immediately after program (post-intervention), and three months after intervention (follow-up). They were assessed by DPICS-IV by the therapists at the same sessions when they completed the questionnaires.

2.6 The treatment was performance-based and normally ended when the participants had mastered the required skills of the two treatment phases ("relationship enhancement" and "strategies to improve child compliance"), and the child's behavior was below clinical range as defined by ECBI-intensity scores. However, for some cases demonstrating skill mastery of the CDI phase (relationship enhancement) with children's behavior intensity scores dropping below the clinical range of ECBI, the cases would also be terminated upon the participants' request.

B. Quantitative Study Results

Comparison of child behavior problems and parenting stress and use of corporal punishment between pre-intervention and post-intervention among cases who have successfully completed PCIT program (Table 2.4)

2.7 A total of 382 parent participants successfully completed the program. Dependent t test results indicated that their ECBI-intensity and ECBI-problem scores, PSI-total scores, DASS-21 scores as well as use of corporal punishment, were consistently lower at post-intervention in comparison with the pre-intervention scores (p <.001).

Table 2.4: Comparison Between Pre-Intervention and Post-Intervention Scores Among Successful Participants (n=382)

	Pre			Post		
Measures	Mean	SD	Reliability	Mean	SD	Reliability
ECBI-Intensity	156.70	23.43	.86	107.55	18.20	.86
ECBI-Problem	17.57	7.68	.89	6.64	6.03	.88
PSI-total	116.10	18.63	.92	96.07	17.56	.93
DASS-21	19.89	13.19	.95	11.59	9.93	.94
Corporal punishment	1.10	1.54	NA	0.11	0.52	NA

Changes in Dyadic Parent-Child Interaction (DPICS) measures between pre-intervention and post-intervention (Table 2.5)

2.8 Dependent t test results indicated that the post-intervention scores on Labeled

Praise, Behavioral Description and Reflective Statement were significantly higher than the pre-intervention scores (p <.001). The post-intervention scores of Command/ Question/Negative Talk were also significantly lower than the pre-intervention scores (p<.001).

Table 2.5: Change in DPICS-IV Measures Among Successful Participants (n=382)

	Pre		Post	
DPICS	Mean	SD	Mean	SD
Labeled Praise	0.33	1.06	11.13	1.98
Behavioral Description	0.93	2.04	12.09	3.53
Reflective Statement	2.49	3.05	10.08	3.77
Command/Question/Negative Talk	12.91	10.03	0.52	0.87

Participant satisfaction

2.9 Participant satisfaction was measured using the TAI. The majority of the participants indicated high satisfaction with the program. For details, please refer to Table 2.6.

Table 2.6: TAI Scores (n = 380)

		Low satisfaction				High satisfaction
Items		1	2	3	4	5
1	Learning new and useful discipline techniques	0 (0.0%)	3 (0.8%)	71 (18.6%)	188 (49.2%)	118 (30.9%)
2	Learning new and useful techniques for teaching my child new skills	0 (0.0%)	3 (0.8%)	80 (20.9%)	186 (48.7%)	111 (29.1%)
3	Relationship between myself and my child	0 (0%)	1 (0.3%)	12 (3.1%)	202 (52.9%)	165 (43.2%)
4	My confidence in my ability to discipline my child	0 (0%)	4 (1.0%)	9 (2.4%)	255 (66.8%)	112 (29.3%)
5	Improvement of the major behavior problems that my child presented at home before the program	0 (0%)	6 (1.6%)	7 (1.8%)	184 (48.2%)	183 (47.9%)
6	Improvement of my child's compliance to my commands or requests	0 (0%)	2 (0.5%)	9 (2.4%)	223 (58.4%)	146 (38.2%)
7	The progress my child has made in his/her general behavior	0 (0%)	4 (1.0%)	12 (3.1%)	280 (73.3%)	84 (22.0%)
8	Degree to which the treatment program has helped with other general personal or family problems not directly related to the child	0 (0%)	0 (0%)	9 (2.4%)	184 (48.2%)	187 (49.0%)
9	Feelings towards the type of program that was used to help me improve my child's behaviors	0 (0%)	0 (0%)	26 (6.8%)	168 (44.0%)	186 (48.7%)
10	My general feeling about the program I participate in	0 (0%)	0 (0%)	4 (1.0%)	103 (27.0%)	273 (71.5%)

Effectiveness of PCIT by Caregiver Participant Status

2.10 This study adopted a quasi-experimental design. Written consent for participation in PCIT research was obtained from all the participants upon inviting them to complete the questionnaires. This study was approved by the Ethics Committee of The Hong Kong Polytechnic University.

2.11 Among the 538 caregivers, there were 16 who were relatives of the target child and they were excluded from this analysis. Among the remaining 522 participants, there were 374 successful cases including 267 mothers and 1 adopted mother, 30 fathers, and 38 couples, with 1 step father. Among the couple group, there were 33 couples who have successfully completed treatment. For the other 10 participants, they themselves have successfully completed treatment but not their spouses. The following analysis is based on 374 successful cases only.

2.12 In the following analysis, the participants were categorized into 4 groups, mother only, father only, couple-mother, and couple-father. There were significant differences between these 4 groups in terms of family income (p = .003), marital status (p = .004), pre-intervention PSI scores (p < .001), DASS-21 scores (p = .003), ECBI-Intensity (p = .001), and ECBI-Problem scores (p = .001), pre-intervention use of corporal punishment (p = .002), and age of participants (p < .001). There were more married participants in the two couple groups and there were more families with income ≥ HK$20,000 in the two couple groups. Post hoc test (scheffe) indicated that the age of the father only group was higher than all other groups. Post hoc tests

(scheffe) also indicated that the pre-intervention PSI, DASS and ECBI-Problem scores of the mother only group were higher than the father only group. Post hoc tests (scheffe) further indicated that the pre-intervention ECBI-Intensity scores and pre-intervention use of corporal punishment of the mother only group were higher than the father only group and the couple-father group. The details are in Table 2.7. These variables would be treated as covariates in analyses.

2.13 Univariate analysis of covariance (ANCOVA) was used to examine the differences in post-intervention scores among the 4 groups, with the above-named variables as covariates. The independent variable was group status and the dependent variables were the post-intervention scores. The results indicated that there was no significant difference among the 4 groups in post-intervention scores. The details are in Table 2.8.

Table 2.7: Demographic Characteristics of Successful Case Participants

Demographic characteristics	Mother only (n = 268)	Father only (n = 30)	Couple - mother (n = 38)	Couple - father (n = 38)
Sex of target child - male	179 (66.8%)	26 (86.7%)	23 (60.5%)	27 (71.1%)
Sex of target child - female	89 (33.2%)	4 (13.3%)	15 (39.5%)	11 (28.9%)
Education level of target child - no education	18 (6.7%)	0 (0%)	2 (5.3%)	1 (2.6%)
Education level of target child - kindergarten	192 (71.6%)	22 (73.3%)	27 (71.1%)	27 (71.1%)
Education level of target child - primary	58 (21.6%)	8 (26.7%)	9 (23.7%)	10 (26.3%)
Family type - nuclear	191 (71.3%)	26 (86.7%)	32 (84.2%)	35 (92.1%)
Family type - extended	23 (8.6%)	2 (6.7%)	4 (10.5%)	1 (2.6%)
Family type - single parent	39 (14.6%)	0 (0%)	2 (5.3%)	1 (2.6%)
Family type - grandparents and mother/father and children	13 (4.9%)	2 (6.7%)	0 (0%)	1 (2.6%)
Family type - grandparents and grandchildren only	1 (0.4%)	0 (0%)	0 (0%)	0 (0%)
Family type - others	1 (0.4%)	0 (0%)	0 (0%)	0 (0%)
Marital status - married/de facto/re-married	210 (78.4%)	26 (86.7%)	36 (94.7%)	37 (97.4%)
Marital status - single/separated/divorced/widowed	58 (21.6%)	4 (13.3%)	2 (5.3%)	1 (2.6%)
Participant in employment	79 (29.5%)	20 (66.7%)	24 (63.2%)	29 (76.3%)
Participant not in employment	189 (70.5%)	10 (33.3%)	14 (36.8%)	9 (23.7%)
Father's education - 9 years or less		8 (26.7%)		6 (15.8%)
Mother's education - 9 years or less	84 (31.5%)		1 (2.6%)	
Family monthly income - HK$19,999 or below	159 (59.3%)	15 (50.0%)	13 (34.2%)	14 (36.8%)
Family monthly income - HK$20,000 or above	109 (40.7%)	15 (50.0%)	25 (65.8%)	24 (63.2%)
Social security status - yes	54 (20.1%)	4 (13.3%)	3 (7.9%)	4 (10.5%)
Social security status - no	214 (79.9%)	26 (86.7%)	35 (92.1%)	34 (89.5%)

Table 2.8: Pre-intervention and Post-intervention Scores of Participants

Measures	Mother only (n = 268)	Father only (n = 30)	Couple - mother (n = 38)	Couple - father (n = 38)
Pre-intervention ECBI-Intensity	159.51 (22.85)	147.00 (18.84)	156.05 (23.64)	146.34 (26.75)
Post-intervention ECBI-Intensity	107.85 (18.53)	110.23 (15.22)	106.87 (17.97)	101.42 (18.37)
Pre-intervention ECBI-Problem	18.63 (7.34)	14.13 (7.50)	15.82 (7.19)	15.00 (9.23)
Post-intervention ECBI-Problem	6.49 (6.03)	7.27 (7.76)	6.39 (4.71)	5.89 (4.96)
Pre-intervention PSI-total	118.00 (17.93)	105.60 (18.81)	119.29 (17.93)	110.05 (18.82)
Post-intervention PSI-total	96.52 (18.25)	92.07 (15.06)	97.32 (15.76)	93.16 (16.85)
Pre-intervention DASS-21	20.99 (13.36)	13.20 (9.40)	22.08 (14.07)	16.21 (11.41)
Post-intervention DASS-21	12.31 (9.87)	7.53 (8.86)	11.87 (9.91)	8.47 (8.07)
Pre-intervention Corporal punishment	1.27 (1.66)	0.90 (1.19)	0.71 (1.01)	0.37 (0.85)
Post-intervention Corporal punishment	0.12 (0.43)	0.00 (0)	0.03 (0.16)	0.18 (1.14)
Pre-intervention Labeled Praise	0.39 (1.17)	0.17 (0.46)	0.24 (1.03)	0.13 (0.41)
Post-intervention Labeled Praise	11.13 (1.96)	10.43 (1.38)	11.58 (1.84)	11.32 (2.63)
Pre-intervention Behavioral Description	0.98 (2.11)	0.47 (0.78)	1.16 (2.64)	0.76 (1.64)
Post-intervention Behavioral Description	11.92 (3.51)	12.10 (3.01)	12.82 (4.27)	12.74 (3.58)
Pre-intervention Reflective Statement	2.38 (2.88)	2.47 (3.21)	3.79 (4.42)	2.16 (2.34)
Post-intervention Reflective Statement	9.81 (3.46)	10.67 (4.54)	11.45 (3.61)	10.53 (5.07)
Pre-intervention Command/Question/Negative Talk	12.46 (9.88)	11.23 (10.05)	14.61 (8.82)	15.82 (12.16)
Post-intervention Command/Question/Negative Talk	0.58 (0.92)	0.43 (0.68)	0.39 (0.68)	0.34 (0.71)

Effectiveness of PCIT with Child Abuse Cases

2.14 The sample included 16 established child abuse cases and 15 cases at risk of child abuse which were established in multi-disciplinary case conference (MDCC) on child abuse and were being followed up by Family and Child Protective Service Units (FCPSU) or Integrated Family Service Centres (IFSC). Among these 31 cases, 20 cases (64.5%) successfully completed the PCIT treatment program.

Comparison of child behavior problems and parenting stress and use of corporal punishment between pre-intervention and post-intervention among child abuse cases who have successfully completed PCIT program (Table 2.9)

2.15 Among the 20 successful cases in the child abuse group, dependent t test results indicated that their ECBI-Intensity (p <.001) and ECBI-Problem (p <.001), PSI total scores (p <.001), DASS-21 scores (p =.006) as well as the use of corporal punishment (p =.015), were consistently lower at post-intervention in comparison with the pre-intervention scores. In view of the small sample size, Wilcoxon Signed-Rank test was also used. The results were the same as the dependent t test results except for corporal punishment (p =.001), PSI total scores (p =.001), and DASS-21 scores (p =.001).

Table 2.9: Comparison Between Pre-intervention and Post-Intervention Scores Among Child-Abuse Cases (n = 20)

	Pre		Post	
Measures	Mean	SD	Mean	SD
ECBI-Intensity	160.70	26.90	110.65	22.53
ECBI-Problem	19.90	6.69	8.75	7.18
PSI-total	125.05	21.30	103.05	18.17
DASS-21	30.10	14.20	16.60	8.66
Corporal punishment	2.85	2.13	0.35	0.67

Changes in Dyadic Parent-Child Interaction (DPICS) measures between pre-intervention and post-intervention (Table 2.10)

2.16 Among the 20 successful cases in the child abuse group, dependent t test results indicated that the post-intervention scores on Labeled Praise, Behavioral Description and Reflective Statement were significantly higher than the pre-intervention scores (p <.001). The post-intervention scores of Command/Question/Negative Talk were

also significantly lower than the pre-intervention scores (p <.001). In view of the small sample size, Wilcoxon Signed-Rank test was also used. The results were the same as the dependent t test results.

Table 2.10: Change in DPICS-IV Measures Among Participants (n=20)

	Pre		Post	
DPICS	Mean	SD	Mean	SD
Labeled Praise	0.10	0.31	11.10	1.71
Behavioral Description	0.85	1.04	11.15	1.35
Reflective Statement	2.55	2.44	10.75	3.57
Command/Question/Negative Talk	12.25	6.94	0.35	0.59

Effectiveness of PCIT on Children with Special Educational Needs (SEN)

2.17 There were 157 children with confirmed diagnosis for special educational needs. Among them, 108 (68.8%) cases successfully finished PCIT program with complete data.

Comparison of child behavior problems and parenting stress and use of corporal punishment between pre-intervention and post-intervention among participants with children with SEN who have successfully completed the PCIT program (Table 2.11)

2.18 Among the 108 successful cases in the SEN group, dependent t test results indicated that the ECBI-intensity and ECBI-problem scores, PSI-total scores, DASS-21 scores as well as use of corporal punishment, were consistently lower at post-intervention in comparison with the pre-intervention scores (p <.001).

Table 2.11: Comparison Between Pre-Intervention and Post-Intervention Scores Among Participants with Children with Special Educational Needs (SEN) (n = 108)

	Pre		Post	
Measures	Mean	*SD*	Mean	*SD*
ECBI-intensity	160.55	22.07	108.42	19.34
ECBI-problem	18.94	7.28	6.49	5.79
PSI-total	119.73	18.80	96.51	16.95
DASS-21	19.56	13.86	11.31	9.92
Corporal punishment	1.22	1.59	0.10	0.70

Changes in Dyadic Parent-Child Interaction (DPICS) measures between pre-intervention and post-intervention (Table 2.12)

2.19 Among the 108 successful cases in the SEN group, dependent t test results indicated that the post-intervention scores on Labeled Praise, Behavioral Description and Reflective Statement were significantly higher than the pre-intervention scores (p <.001). The post-intervention scores of Command/Question/Negative Talk were also significantly lower than the pre-intervention scores (p <.001).

Table 2.12: Changes in DPICS-IV Measures (n = 108)

	Pre		Post	
DPICS	Mean	*SD*	Mean	*SD*
Labeled Praise	0.27	0.84	10.71	1.85
Behavioral Description	0.69	1.33	12.15	4.23
Reflective Statement	2.43	2.80	9.56	3.56
Command/Question/Negative Talk	12.43	8.25	0.63	0.92

Effectiveness of PCIT with Target Children Aged 8 Years or Above Cases

2.20 There were 27 target children aged 8 years or above at the time of pre-assessment. Among these 27 cases, 18 (66.7%) successfully completed the PCIT treatment program.

Comparison of child behavior problems and parenting stress and use of corporal punishment between pre-intervention and post-intervention among target children aged 8 years or above who have successfully completed PCIT program (Table 2.13)

2.21 Among the 18 successful cases where the target children were aged 8 years or above, dependent t test results indicated that the ECBI-intensity (p <.001) and ECBI-problem scores (p <.001), PSI total scores (p <.001), DASS-21 scores (p =.001) and use of corporal punishment (p =.007) were consistently lower at post-intervention in comparison with the pre-intervention scores. In view of the small sample size, Wilcoxon Signed-Rank test was also used. The results were the same as the dependent t test results except for corporal punishment (p =.011) and DASS-21 scores (p =.002).

Table 2.13: Comparison Between Pre-Intervention and Post-Intervention Scores Among Target Children Aged 7 Years or Above Cases (n = 18)

	Pre		Post	
Measures	Mean	SD	Mean	SD
ECBI-intensity	165.61	24.22	103.44	13.06
ECBI-problem	18.50	6.31	4.50	4.31
PSI-total	124.50	16.18	94.44	14.50
DASS-21	17.28	11.58	9.67	9.57
Corporal punishment	0.94	1.11	0.11	0.32

Changes in Dyadic Parent-Child interaction (DPICS) measures between pre-intervention and post-intervention (Table 2.14)

2.22 Among the 18 successful cases in the target children aged 8 years or above group, dependent t test results indicated that the post-intervention scores on Labeled Praise, Behavioral Description and Reflective Statement were significantly higher than the pre-intervention scores (p <.001). The post-intervention scores of Command/ Question/Negative Talk were also significantly lower than the pre-intervention scores (p <.001). In view of the small sample size, Wilcoxon Signed-Rank test was also used.

The results were the same as the dependent t test results.

Table 2.14: Change in DPICS-IV Measures Among Participants (*n*=18)

	Pre		Post	
DPICS	Mean	SD	Mean	SD
Labeled Praise	0.22	0.43	11.78	3.00
Behavioral Description	0.17	0.38	12.06	1.98
Reflective Statement	1.06	1.96	11.22	5.26
Command/Question/Negative Talk	9.39	5.73	0.50	1.10

C. **Conclusion on Quantitative Study**

2.23 In the overall service effectiveness study using the 538 cases closed in the present PCIT project, 71.0% of the parent-child dyads had completed the treatment with satisfactory outcome. The findings indicated that PCIT had significantly

a. reduced child behavior problems,
b. reduced parenting stress and negative emotions,
c. reduced negative parenting practices,
d. increased positive parenting skills, and
e. reduced the use of corporal punishment.

2.24 The overall participant satisfaction was very positive, as consistently indicated by the TAI findings. PCIT has been found to be an efficacious treatment for Chinese parents with parenting stress and children with behavioral problems locally in Hong Kong.

2.25 PCIT was also found to be effective with established child abuse and high risk cases. Despite the small sample, the results suggested that PCIT could be a promising intervention strategy for these cases. Moreover, PCIT was effective with children with SEN. The results suggested that PCIT has been a useful strategy for supporting parents with young children with SEN.

2.26 There were some differences between the successful and drop out cases. There were more participants with monthly income ≤ $19,999 among the drop-out cases. There were more participants on CSSA among the drop-out cases. There were more participants who were married or in a de-facto relationship among the successful cases, compared with the drop-out ones. There were more single parents among the drop-out cases than the successful cases. There were more target children attending primary schools among the drop-out cases and the age of the target child of the drop-out cases were older than those of the successful cases. The pre-intervention ECBI-intensity scores, ECBI-problem scores, PSI total scores and DASS total scores of the drop-out cases were higher than those of the successful cases. The effectiveness of PCIT should be interpreted taking these into consideration.

2.27 Based on the positive result of the present overall service effectiveness study, it is recommended that PCIT service should be extended to more families as an early intervention against child abuse, and as a timely support for families with children with SEN challenges and aged 8 years or above.

Chapter 3: Qualitative Study

A. Qualitative Study's background, objectives and informants' profile

Objectives of the focus groups

3.1 To supplement the findings from the quantitative data to more adequately address the research objectives, two waves of qualitative studies were conducted. The first included 5 focus group discussions involving 24 parents who completed PCIT between 2015 and 2018. They were selected through purposive sampling to address the gender-specific research questions, and all volunteered to participate upon invitation. Some were single parents, some had history of child abuse, and some had mental health challenges. The focus groups were conducted from January to May 2018 according to the focus group guide in Appendix 1. The discussions were audio-taped and transcribed for content analysis. Details of the focus arrangements are listed in the table below. The second wave involved collection of reflection reports from PCIT therapists in the project. A total of eight therapists entered their views into a template developed by Dr. Sandra Tsang and the team leader Ms. Gene Ng. The therapists ranged from 1 to 10 years in their experience in working on the TWGHs PCIT team. Content analysis on the eight reports was conducted with names of the therapists presented as A to H.

Focus group details

FG	Nature	Mothers	Fathers	Facilitators
1	Fathers	-	3	Consultant Dr. Sandra Tsang
2	Couple	4	4	
3	Mothers	3	-	PCIT therapists not working with any of the parents in that focus group
4	Mothers	2	-	
5	Mothers	8	-	
	Total	17	7	

3.2 A total of 17 mothers and 7 fathers contributed their views in 5 focus groups conducted from January to May 2018. There were 16 participants having intact marriage. Quite a few had history of long term physical or mental health issues. Some had history of beating up children even if not known as abuse cases. One single father had long term illness and had to reclaim the son's custody because the son was traumatized after sexual harassment by mother's boyfriend. Quite a few reported their children were challenged by some sort of Special educational need problems, like ADHD and ASD.

3.3 Very encouraging comments were collected from the parents who completed PCIT intervention with their target children and also from the Therapists. A few even volunteered to appear in PCIT promotional materials, including videos. They also made very constructive suggestions on how PCIT can be improved and promoted. Their views are presented in the following sections, with parents' views followed by Therapists' views as supplements.

B. Qualitative Study Results

Impact of PCIT: On Children, Parents, Families, Challenges Communities and Hong Kong

PCIT impact on Children Participants

3.4 Parents' views: All parents reported their **c**hildren improved in emotion, behavior and compliance through PCIT. This is expected as PCIT has clear procedures to monitor case progress to achieve targeted outcomes. Noting how parents articulate the improvements shows the parents have developed more keen observations on their children and can see their performance from multiple dimensions.

a. Children's emotion improved

External reasons might induce emotional instability in the child. The training helped the child to better manage his emotions. (This included the views of father 1B, when his son studying in K2 suffered sexual harassment by the boyfriend of his divorced wife)

小朋友因各種外在原因而導致情緒不穩定，經過訓練後情緒得到改善 (1B, 2, 4, 3B&C)

b. Children's behavior improved

The child might be more active with inadequate attention. The training helped the child to follow rules and achieve goals; and used gentle statements.

小朋友較活躍，缺乏專注力，經過訓練後學懂遵守規矩和達成目標；以較溫和的說話來回應父母的要求或問題 (1A, 3C)。

c. Children's compliance improved

The child could not control emotions and often lost temper and even attacked others. After the service, the child could gradually learn to calmly manage one's emotions and follow rules.
小朋友因未能控制情緒而經常發脾氣甚至襲擊別人。接受服務後，小朋友漸漸能學習冷靜地處理自己的情緒和遵守規則 (3B)。

The child lacked concepts of time management, sense of responsibility and proper executive functioning. There was steady improvement after the therapy.
小朋友缺乏時間觀念、責任感和執行力，經過治療後逐步得到改善 (3B)。

The child feared or rejected strangers before. After training, the child learnt to use more positive attitudes to face strangers.
小朋友懼怕或排斥陌生人，經過訓練後懂得以較正面的態度面對陌生人 (5)。

d. Children have more options other than taking medication

The children became more manageable and need not take medicine to control their ADHD-like condition.
都唔需要一定急住食藥…….就真係好過真係要食藥 (4B)。

3.5 Therapists' views: All Therapists found PCIT useful. So they continued as PCIT therapists, and shared their views in this study to help further advance PCIT.

a. PCIT is not only a useful and effective program. It is a comprehensive counseling program. Through CDI and PDI, it can offer immediate guidance on parenting skills to families in need.
我認爲 PCIT 是一套完善的輔導方法，能夠爲有需要的家庭提供即時指導及協助，而 CDI 及 PDI 的教學及示範都能夠有效協助家長掌握當中的技巧 (C,E,G)。

b. PCIT helped parents to effectively manage their children's behavior.
PCIT 能有效協助家長管教兒童 (All and C)。

c. PCIT can effectively intervene on problems, especially when child is young.
PCIT 是十分有效的介入方法，很多問題能從孩子小時得到改變(All and C)。

d. Some of the PCIT skills can be applied to daily family life and individual functioning.
在個人層面上亦有幫助，部份技巧用於日常生活中亦能提昇與人相處及家庭關係 (C,E,G)。

PCIT impact on Parent Participants

3.6 Parents' views: Parents responded more appropriately to children by praising more, offering more positive attention and replacing corporal punishment by reasoning. The parents also gained insights on how their reactions affected their children. When their interactions and their children problems improved, they had reduced stress and mental health problems.

a. ***Parents had better skills and attitude***

Praised more

The parent understood the importance of "praise", and on many occasions tried to use positive ways to talk to and encourage children.
家長明白讚賞的重要性，並盡量在各種小事上以正面的說話來鼓勵子女 (All, 1A, 1C)。

More attentive to children

The parents learnt to be more attentive to their children, instead of just physically accompanying the children.
家長懂得用心留意子女，而並非只在行動上陪伴子女 (3, 5) 。

Reasoned with children and reduced use of corporal punishment

The parent tried to use reasoning to manage the child and avoid using physical punishment.
家長嘗試以講道理的方式管教子女，而盡量避免體罰。(All)

Relaxed attitude

The parent learnt to use more relaxed attitude to manage children to avoid exerting too much pressure on the children.
家長學會用較輕鬆的態度管教子女，避免子女壓力過大 (1)。

b. ***Parents experienced reduced stress***

Parents gained insight that parental problems affect children

Mothers with emotional problems cannot teach children well.
媽媽有情緒其實教唔到細路 (5E)。

The parents learnt to forgive the children's over-reactions and avoid amplifying small problems into big issues. This greatly helped the parents to control their own emotions (especially from mother 3B who suffered from post-partum depression).
家長學懂原諒子女的過激行爲，避免把小事看得過於嚴重，對他們自身的情緒控制能力也有很大的幫助(3B, 5)。

The parents learnt to control their own temper, and used appropriate ways to ventilate their emotions. This set up very proper models for the children.
家長懂得控制自己的脾氣，以適當的方式(等佢冷靜喇，你又冷靜喇，你唔好嬲) 來宣洩情緒，給子女樹立了良好的榜樣 (3B, 5)。

Parents' mental health situation improved

Some parents were suffering from mental health problems. After the training, their mental condition also greatly improved.
有些家長原本患有精神疾病，經過訓練後，他們的精神狀況也得到很大的改善 (3B, 4)。

Depressed and abusive mother stopped child abuse.
其實我自己有抑鬱嘅……我自己有問題，對住佢兩個，佢咁嘅反應，我梗係癲，直頭有陣時打和鬧佢，我唔理隔離真係聽唔聽到，話知你真係報警，我唔介意架，但係嘅話真係打得好癲……真係打佢打得好犀利……依家無喇 (4B)。

Improvement in child reduced family social stigma

After achieving improvements in the children's behavior, the parents no longer need to put up with negative comments from others, and the parents' emotions also became more stable.
子女的行爲得到改善後，家長亦不須承受別人的閒言閒語，令他們的情緒也變得更穩定 (3,4,5)。

3.7 Therapists' views: The parents improved in emotions, relationship with kids and self-efficacy/competence in parenting.

a. Parents understood children's needs

Parents learnt children need parental positive attention.
家長了解兒童成長需要及被關注的需要，建立正面關係及管教技巧，促進家庭和諧 (C)。

b. PCIT supported parents' emotions and enhance their self-efficacy

PCIT enhanced parent-child relationship and competence and reduced stress.
服務能有效增進親子關係及提升家長處理子女行爲問題的能力。當親子關係得到改善，家長的壓力都得以舒緩 (D, E)。

PCIT 是一項有效支援家庭的治療，即或治療成效可能有差異，但密集的會面，已給予不少家長情緒上的支援，加強家長的能力感 (D)。

PCIT brought emotional support and sense of competence to the families.
我覺得 PCIT 對使用者家庭帶來情緒上支援，給予能力感 (D)。

c. Prevented continuation of childhood problems

PCIT prevented children carrying their emotional and behavior problems into adolescence, and also enhances parental mental health.
PCIT 可避免兒童行爲情緒問題持續甚至演化成青年問題，而家長的精神健康亦有效改善 (G)。

PCIT impact on Families

3.8 Parents' views: Couple achieved parenting consistency and their marital relationship improved

a. Couple consistency improved relationship and created time to rest

Couples who went through PCIT together could cooperate and reduce stress.
夫婦一齊做，互相明白能減壓 (2H)。

Child is better engaged to father after PCIT. Mother can be released to take time to relax.
PCIT 之後，爺爸爸多咗，媽媽可以喘下氣 (2G)。

Couple adjusted family roles, when introvert father who indulge in computer games went to work and learnt how to take care of son after work.
我自己本身係一個「宅男」黎，即係好鍾意玩電子遊戲機。但爲咗我個仔都唔玩囉，又要去返工，又要湊仔，又要學點湊仔 (1A)。

Consistency achieved in the parents' parenting style helped to improve couple and family relationship.

父母雙方的管教方式變得一致，對夫婦和整個家庭的關係也有一定的幫助(2, 4)。

b. Sibling relationship improved

Improvements in sibling relationship indirectly reduced parental work and emotional burdens, and family relationship became more intimate.
兄弟姊妹間嘅關係得到改善，間接減輕了父母嘅工作量和情緒負擔，令各家庭成員間嘅關係更密切 (4, 5)。

The parents can apply PCIT contents to manage other children, thus achieving fairness in parenting.
家長能運用 PCIT 嘅教學內容來管教其他子女，公平地對待所有子女(3, 5)。

Sibling relationship improved with less sibling rivalry. Elder brother sometimes helped younger brother with revision and schoolwork.
……而家同個細佬少咗打，不過都有打交……即係佢會幫到我囉，細佬默書考試，佢可以幫佢溫下書，好似個小老師咁樣幫佢 (4B)。

Learning PCIT strategies for the elder son benefitted parent's management of the 2.5-year-old younger son and enhanced his expressive competence.
我其實仲有個細仔，依家兩歲半，佢一直都好乖好聽話，但我參加依個服務，學識埋點樣同細仔溝通，所以細仔嘅表達能力係非常好(5B)。

The son used to beat up his elder sister and irritated his father. Now he learnt to play well with his elder sister.
佢情緒成日唔好，於是家姐成日被打，爸爸睇到又成日好嬲，自己又處理唔到。依家家姐同細佬玩得好好，佢嘅情緒好咗又識玩多咗唔同嘅野，依家家姐都肯同佢玩 (5F)。

c. Parent-child interaction improved

Parents adopted PCIT methods to teach their children, e.g. setting up rules instead just asserting parental authority. It caused improvements in their mutual interactions and reduced conflicts.
運用 PCIT 所教授嘅方法教育仔女，例如訂立規則，避免以權威來對待仔女。 雙方嘅行爲都得到改善，就減少咗與子女間嘅衝突 (1, 3, 5, 1C)。

Parents began to apply what they learnt in PCIT in their daily living, and made the children more clear about parental expectations.
開始能夠响日常生活中運用 PCIT 嘅教學內容，令子女更明白我地嘅要求(3, 5)。

The parents began to try to understand what their children wanted, and tackled the root issues of their behavior problems.
……嘗試了解子女的想法，從根源上解決子女的行爲問題……例如：孩子成績唔理想，我自己就算個心裡面幾唔開心都好，我問，即係我會做 research，我問吓啲家長幾多分，我個仔……其實已經排到嗰班尾十架喇，咁但係我都無所謂，我反而著重事後點去補救，唔識嘅要學返識。即係好在學校個啲卷會派返俾我地，知道佢地究竟係邊啲唔識，咁然之後我又亾吓佢，你做完呢度呢樣野，跟住爸爸就同你去玩吓遊戲 (1A,5)。

Both parties (parent and child) were more willing to communicate and get close to each other, thus improving the relationship.
雙方更願意溝通和親近對方，使關係得以改善 (2, 3, 4, 5)。

The parents and children both learnt to use gentle reminders to improve their communication skills.
大家同時學會互相提醒，以改善雙方嘅溝通技巧 (2, 3, 5)。

The children learnt to initiate concerns over their parents' needs and this helped to improve their relationship.
佢懂得主動關心我地嘅需要，改善雙方嘅關係 (4)。

The parent and child developed a bonding and shared their "heart" to each other.
我地兩個建立咗一個連結，跟住慢慢、慢慢好似你將個心俾我，我嘅心俾咗你 (4A)。

d. Family relationship improved

PCIT benefited the family as a whole.
PCIT 令全家有全面益處 (2E)。

Some parents were reluctant to accept the reality that their "children needed treatment". Such concepts changed gradually when they witnessed the improvements after treatment.
有些家長不願接受「子女需要接受治療」這個事實，看見治療的成效後，想法便逐漸改變 (1)。

Children's effective management of emotions helped to soften the atmosphere in the whole family.
子女懂得控制情緒，令整個家庭嘅氣氛也得以緩和 (3)。

Improved parent child communication helped to work out family routine: work hard in weekdays, play hard over weekend
依家我知道(佢)有壓力，我唔想佢走返啲曳野出來，所以盡量限制星期一至五就辛苦，佢明白，星期六、日呢，佢就自由嘅，打波呀、游水呀、玩呀，呢兩日你係自由嘅，就唔需要話再話溫功課呀，死讀書嗰啲，但一至五你係會做一樣野，大家溝通咗啦，就無咁多拗撬 (1B)。

Child could remind mother to speak in more gentle ways and they could have fun with each other.
佢依家會話：「媽咪，你講嘢可以再溫柔啲」，咁我就好似姑娘咁樣再溫柔啲囉，大家多咗講笑 (5C)。

3.9 Therapists' views: Family relationship improved after PCIT.

a. PCIT provided support and help to the whole family

PCIT is a therapy that can effectively support families.
我認爲 PCIT 係一項有效支援家庭的治療 (C, D)。

b. PCIT brought support and help to family users

PCIT mobilized family system to be more positive and organized.
能爲使用者家庭得到支援和幫助，讓整個家庭的系統、互動模式有著重要的改變和正面的推動，重整整個家庭 (A, H)。

PCIT impact on Challenged Families

3.10 Parents' views: Some parents sought trainings for continuous development, and became more altruistic.

a. Parents sought training for continuous development

Father actively took courses after resolving son's trauma
參加輔導後小朋友就穩定返，咁呢就我就放下心頭大石啦。咁就跟住周圍去學野喇……上中學反叛期你都預測到嘅。咪要去學野囉 (1B)。

b. Parents became more altruistic and served as volunteers

Single father served as school volunteer to benefit other students
我喺學校做義工，由佢一年班做到四年班，又做埋家教會，嚟好多嘢
我就明白，咁又幫到人又幫到自己……因爲好多細路仔，喺午飯嘅時候我派飯，你真係愛佢，佢知。你關心佢，佢亦都知。咁好多小朋友就有啲家長無上過 course，淨係知道 A 班嘅同學和 B 班嘅同學好曳，其實佢唔係曳，佢係自己保護自己，同埋佢曳，佢嘅目的係想你注意佢、關心佢 (1B)。

Single father urges other parents to learn parenting skills
我都有同啲家長分享……提佢地唔好成日話佢曳，咁或者要放低自己，去敲門，搵人幫吓你 (1B)。

3.11 Therapists' views: PCIT brought hope and empowered families.

a. Brought hope

PCIT brought hope and support and made families more positive.
爲家庭帶來希望，提供足夠的支援，以協助處理孩子的行爲問題，改善家庭的正向氣氛 (A, H) 。

b. Empowered parents and children

Empowered the parents and children by letting them learn about their personal strengths and value.
爲家長及兒童充權，讓其了解自己的個人優勢、長處及價值感 (C) 。

c. Prevented child abuse

Service enhanced family harmony and prevented child abuse
服務能令使用者家庭和諧，防止家長虐兒 (B)。

PCIT impact on Challenged Communities

3.12 Only Therapists responded on this.

PCIT is a Non-expensive effective help for challenged communities.
The service can help families with different structures and background. It can help parents with financial pressure to better manage their children as its fees exemption policy allows financially challenged families to enjoy non-expensive and effective service.

此服務能爲弱勢社群及社會帶來正面的作用，此服務能幫助不同特色的家

庭組合，不論他們的經濟收入如何，也同等有機會接受本服務。

面對現時有經濟壓力的家庭，此資助服務能照顧他們的管教需要。

對弱勢社群而言，因服務可豁免有經濟困難之家庭的收費，因此他們亦得到同等機會以改善孩子及管教問題。

爲弱勢社群帶來不昂貴的有效治療 (A, B, D, F, G, H)。

PCIT impact on the Agency

3.13 Only Therapists responded on this.

a. PCIT builds up the professional image of the agency
Its innovative and unique professional therapeutic model is well-supported by team members and local and overseas consultants.

爲機構打造專業形象 (C)。

此服務能令機構有一個最創新和獨有的服務，而此服務有不同團隊和顧問的支援及幫助，從而令同工專業地提供有效的治療模式 (A)。

It is supported by training from overseas experts
爲機構帶來創新、獨特及具實證研究的治療，亦有外國培訓師合作參與培訓，擴闊了機構的國際視野 (H)。

It made people learn that our agency is committed to prevent parental child abuse, and allow financially challenges families to obtain quality services.
令人認識機構致力防止家長虐兒、令弱勢社群不受經濟能力限制而獲得服務 (B)。

PCIT is an excellent partner with other agencies to support families.
對其他機構而言，PCIT 也成爲很好的合作伙伴，與其他機構一同分工合作，有效協助家庭 (D)。

PCIT impact on HK Society

3.14 Only Therapists responded on this.

a. This service brings positive function and professional help to challenged communities.
此服務能爲弱勢社群及社會帶來正面的作用，此服務能幫助不同特色的家庭組合，不論他們的經濟收入如何，也同等有機會接受本服務 (A)。

b. Harmonious families create stable society.
和諧家庭能帶來社會穩定 (C)。

c. PCIT support to parents with mental health problems not only helped the families but also benefits all Hong Kong.
在前線個案中我幫助了很多患抑鬱症的家長，完成 PCIT 後再無須服食精神科藥物，整個家庭關係及生活質素亦有很大改善。因此，服務正改變著很多家庭和社會，如能廣泛推廣，將是造福整個香港 (G)。

d. The fight corporal punishment message brings positive atmosphere to society.
爲社會帶來正向氣氛，向外推廣零體罰的管教訊息 (H)。

e. PCIT previous efforts in service dissemination reminds parents of better child management and the importance of play for children.
PCIT 在香港社會推行多年，透過過去的研究發佈、講座或傳媒訪問，讓社會察覺家長管教的困難和遊戲的重要 (D)。

f. PCIT is a service worthy for promotion in Hong Kong.
我認爲 PCIT 是在香港值得推行的服務 (D)。

Services Elements Contributing to PCIT Positive Impacts

PCIT content and design

3.15 Parents' views: The parents found PCIT content to be comprehensive, with clear principles, and systematically presented.

a. Comprehensive Content
Comprehensiveness of the therapy helped not only to improve children's behavior problem, but also changed parents' parenting attitude and style.
全面的治療，除了改善小朋友的行爲問題外，同時改變家長的管教態度與方式 (2)。

b. Content included establishing family rules
Establishing family rules helped the children understand when they have to follow rules.

建立家規，令子女明白在那些時候該遵守規矩 (5)。

c. Useful Principle of "Relation before discipline"

While other programs taught parents how to manage children, this program started with praise and understanding the child. The process was smoothened and more effective and punishment strategies were less necessary.
我見到出面個啲課程教你點樣教小朋友，其實一路都係叫你遷就佢，讚佢，呢度就唔同嘅，呢度就即係一路陪住佢玩啦，同埋用嗰啲讚賞字眼，佢真係好受落囉，因爲出面嗰啲唔會咁樣教你……後期又有後果呀，即係要佢坐暫停櫈……你同佢講你係咪想坐暫停櫈，佢話唔好唔好，即刻態度會轉返好，咁所以我就覺得係好好 (4B)。

d. Systematic evaluation

The evaluation process was important as the parent was able to report their problems to get opinion from the Therapist.
個檢討嘅過程我覺得好重要，因爲就係檢討嘅過程裏面講返比姑娘聽我遇到嘅問題，姑娘會話返比我聽可以點做 (5E)。

The review helped parents conduct self-evaluation so that they can better apply what they have learnt.
回顧，幫助家長進行自我檢討，以致能更好地運用所學的知識 (3, 5)。

e. Appropriate sessional designs and goals to fit case progress

Session One: It was good in Session One to see only parents, without their children around. The parents could ventilate their frustrations, and calm down to learn.
第一堂不用見小朋友，只見父母。導師明白，淋熄啲火 (2E)。

Sessions Five and Six: The parents were encouraged to appreciate merits in their children. The Therapists guided the parents to identify positive support points.
第五或六堂，姑娘請父母講孩子的優點，offer 正面 support 位 (2E, H)。

f. Therapists' useful immediate coaching to phrase their responses

最好係即時可以教我地點講，點回應佢 (3A)。

g. Immediate prompting

Immediate prompting can solve problems immediately, and the effect is better than evaluation afterwards.
即時提示，即時地解決問題，效果比事後檢討更佳 (2, 3)。

h. Tailored individual teaching

The intervention is based on the characteristics of each parent and child. It can well-fit the needs of different families.
因材施教，根據每一位家長和子女的性格設計教學內容，能切合不同家庭的需要 (5H)。

i. One-way mirror

Since the children could not see the interactions between the parent and the Therapist, this indirectly created a chance for the parents to praise the children. (a real practice under therapist's guidance)
單面反光玻璃，因子女看不見父母與治療師的互動，而間接爲父母提供一個讚賞子女的機會。(3G)

3.16 Therapists' views: The Therapists could more specifically point out therapeutic components in PCIT that achieved the effective results.

a. The two-section CDI and PDI design

Child-Directed Interaction helped improve parent-child relationship and paved way to improve behavior management
分兩個部份/階段的設計：第一階段兒童帶領技巧，第二階段家長帶領技巧。CDI (PRIDE skills)及 PDI 兩個階段中的元素也能協助遇管教困難的家庭。CDI 部份有助家長與孩子建立親子關係，減低管教的無助感 (A,C,F)。

b. Weekly intensive coaching and meetings with parents

The format and intensity provided effective support and help to the parents through a good relationship with the Therapist
每星期一次面見。
每星期密集式現場指導及與家長面談。
密集的會面使治療師和家庭更容易建立治療關係，讓家長感到支持。同時因爲頻密的見面，這更有效幫助家長堅持使用新技巧，從而有效改善管教模式 (A, D, H)。

c. Systematic monitoring and feedback

Clear records provided convincing evidence for the therapists to show parents the process and cause and effects of parent-child interactions and let parents

appreciate their improvement during their PCIT learning.
依照家長的技巧達成度及孩子 ECBI 的分數檢視進度。
PCIT 有細緻的評估是有效制定輔導目標的一環，因能讓普遍家長所述的管教困難，具體地透過 PCIT 解讀系統及其他問卷清晰地呈現其親子互相、父母管教、兒童行爲、家長情緒等因素如何構成問題 (A, G)。

Systematic goal-setting for each session.
有系統地制定每節治療目標 (A)。

Play is a wise and attractive means to work with children and parents.
運用遊戲是很聰明的方法，因能吸引孩子，亦方便在家長作延申練習(G)。

Therapists' immediate, direct and tailor-made instructions for improvement helped parents to master exact skills.
工作員即場直接指導家長透過親子遊戲掌握有效親子技巧。
即時指導可以讓家長把理論實踐在現實當中,讓他們感到更踏實,。治療師亦能更適切按各孩子家長的氣質、狀況而加以指導。
治療師可爲家長即時指導管教技巧，如遇到兒童的行爲問題便可即時處理。
PCIT 即場指導的模式，能協助家長應用所學的技巧在自己的家庭上。
治療師即時指導家長處理孩子行爲問題，家長能夠將所學的知識，即時轉化爲實際行動。同時，治療師可即時因應孩子的情況度身訂造合適的目標 (B, D, E, G, H)。

One-way mirror allowed direct communication between Therapists and parents.
以單面反光鏡及耳機讓治療師與家長即時溝通，可讓他們有更清晰的管教手法及具體訓練 (F)。

Daily homework offering specific parent-child play time is very useful to stabilize parental mood and skills.
功課亦爲重要一環，家長按要求每日進行「特別遊戲時間」，兒童在情緒及爲方面也趨向較穩定，直接減輕家長管教兒童之壓力 (C)。

Therapists' Attitude and Skills

3.17 Parents' views: Most parents were very appreciative of the high quality professional attitude and services of the PCIT Therapists.

a. Therapists were trusted and respected by parents
Therapists engaged to parents as a resource person.
姑娘係一個可以問嘅人 (2H)。

b. Therapists as good role models
Modeling from the therapists: Their demonstrations served as good role models for the parents and helped the parents to understand how to face their children's behavioral problems.
治療師嘅身教，成爲家長嘅良好榜樣，並讓家長了解該如何面對子女嘅行爲問題 (5D)。

c. Therapist modeled gentler and more effective communications
Child assured mother gentler communications like that of the Therapists are more effective and fun.
佢依家會話：「媽咪，你講嘢可以再溫柔啲」，咁我就好似姑娘咁樣再溫柔啲囉，大家多咗講笑 (5C)。

d. Tailored, flexible and effective skills
The therapists can responsively and flexibly use different management approaches under different circumstances.
導師能靈活、彈性地在不同的情況下運用不同的管教方法 (2)。

e. Rehearsed skills before application
Rehearse before implementing consequences like Time Out.
施行懲罰前先預習，讓孩子完全明白爲何被罰 (1B)。

3.18 Therapists' views: The Therapists added the enhancing instructions from the Therapists helped the parents to improve.

a. Encouraging and positive instructions from Therapists helped the parents to make progress
治療師富鼓勵的指導亦是關鍵，PCIT 培訓中指導技巧乃經過研究而修訂，因此治療師會用有效指導家長的說話，而非句句說家長說錯 (G)。

Parents' Efforts

3.19 Parents' views: The parents offered very specific examples on how they could make

specific efforts through the PCIT intervention to improve their parenting attitude and skills.

a. Parents learnt to view and respond from child's needs

Followed therapist's instructions, learnt child's needs and completed homework with heart to accompany child with genuineness.
理解孩子需要，用心做家長家課：冷靜後，嘗試從孩子角度考慮孩子需要，覺得孩子需要人陪伴，我真係想照住姑娘教我地咁樣，真係攞個心來陪佢玩 (3B)。

b. Parents learnt and applied useful skills

Parents mastered some skills and could turn parenting from reactive to active: Time out room/chair could immediately improve or control children' emotions. They could flexibly apply different skills when child grows and faces new issues, e.g. setting priorities.
家長有招數，從被動到主動：暫停房/暫停椅，即時地改善和控制小朋友的情緒，按孩子成長的情況靈活變通……即係唔係話淨係 A B C 咁做，而係話你將佢諗下邊樣要緊(嚴厲)啲，邊樣要無咁緊……有提煉下，然後就邊樣要「推推」佢啦，邊啲就自己搞……即係與時並進，睇下點樣拆呢個「彈」啦 (All, 1A)。

c. Parents learnt to use clear and effective instructions

Clear instructions helped the children understand parental expectations on self.
清晰的指令讓小朋友明白父母對自己的要求 (1, 5)。

d. Parents noted, practiced and shared Therapists' teachings

Mother jotted down and posted notes on cabinet at home. Father also noted and followed.
我都係跟姑娘講嘅說話，同埋我將佢教我啲說話寫低，貼响個櫃上面，得閒望一望，跟住玩時諗一諗呢句說話……唔啱咪收埋口先，冷靜啲先，跟住望一望嗰啲字再講過。爸爸都好識做，佢會望一望上面嘅字再同佢講嘢 (4A)。

e. Parents kept up with homework practice

Mother practiced homework, and interested the father, and so the couples took turns to do homework, effecting in great improvements.
做功課唔困難，好好玩呀，同埋呢我覺得呢個真係要堅持，你一定要做落去，之後嗰啲效果就會好明顯，爸爸都係一樣……小朋友真係你同你傾呢啲，佢轉變好大(4A)。

f. Parents learnt when to let child choose, and when not

Mother used to respect child and let him choose but this often could not tackle the problems. The Therapist taught mother that sometime the child is too young to make reasonable choices and so mother had to learn when to let child choose and when not.
我嘅情況就係好唔好比佢揀，我自己係以佢爲先嘅，咁但係永遠好似解決唔到問題。到姑娘嗰度姑娘就話你唔可以比佢揀呀，佢咁細個未必識揀，要直接話比佢聽，同埋指示要簡單唔好咁長 (5G)。

g. Effective use of play and praise

Parents learnt to play with child and use praise.
譬如佢地玩嘅時候我地又唔識得同佢地玩呀、讚呀……依家識嘞 (5C)。

h. Parent taught to be more patient and give child buffer time

Instead of hurrying the child, the Therapist taught the parents to give mental preparation for the child. This helped to make child respond cooperatively.
姑娘會教我唔好成日催佢去做一樣嘢，可能試下譬如依家 10 點鐘要出門口，咁就之前提佢兩三次，唔好不停催佢，咁佢又識得睇時間，佢望住個時間走得，就快手快腳做埋 d 哩出門口 (5B) 。

i. Parents listened instead of only asserting authority

Parent shifted from asserting authority to listening to child too.
以前就成日咁講我係媽咪你係仔，太過權威，依家就多咗响佢俾唔係好過份嘅意見時我就聽下佢 (5C)。

Hard to Achieve Improvements in the Participants

3.20 Only Parents responded to this section. They remarked that it was difficult to change if the problem was too hard core, too many children involved, when child and family transit to new phases of development, or when work and family life clashes.

a. Hard to change established habits

At the beginning phase of the intervention, many parents were not used to expressing verbal appreciations and affirmations to their children.
在治療的初期，很多父母難以習慣响口頭上對子女表達讚賞與肯定(1, 5)。

b. Hard to apply when caught by surprise

Some parents can understand the methods taught but in actual implementation

under sudden circumstances, they might still find it hard to use the right methods right away.
有些父母雖然明白治療師所教授嘅方法，但响面對突發情況時亦會有不知所措嘅感覺(1, 2, 5)。

c. Families with more than one child might have more issues in benefitting from PCIT

Families with more than one child and focusing on only one child for treatment might not achieve optimal treatment effect.
有多於一個孩子嘅家庭，若只有一名子女接受治療，便難以達到較顯著效果 (3)。

d. New challenges in new developmental phases, e.g. P1

上完你地嗰個 course 架，但係一去到小學又有另外一個問題 (1A)。

e. Work time clashes with PCIT training

Some parents cannot squeeze time from their work to attend the training.
有些父母自身嘅工作難以與治療嘅時間配合 (3)。

Parents might not achieve right balance between time management and seeking close interactions with their children.
家長難以在時間分配和親近子女這兩方面取得平衡 (4) 。

PCIT Suitability for Older Children, e.g. those aged 8-9

PCIT effectiveness on older children

3.21 Parents' views: Most parents acknowledged older children also could benefit from PCIT.

a. PCIT effectiveness on children aged 8-9

There is a need to extend services to older children (All, 2A)。
Need to enrich PCIT to serve children of different ages.
要按孩子年齡令(治療)更豐富 (2A)。

3.22 Therapists' views: The Therapists could identify specific components in PCIT that can benefit children aged 8 to 9.

a. Work on improving parent-child relationship

Parent-child relationship was often omitted after the child entered primary school. CDI can achieve this goal.
使用 PCIT 於 8 至 9 歲的兒童上，我認爲增進親子關係有成效……
我認爲大部份都是大成效的，因爲建立關係尤其對 8-9 歲孩子重要，但往往家長已在孩子升小後忽略此事，PCIT 正好幫助他們重建良好關係。改善親子關係及讓家長明白孩子的發展需要 (B, D, G,H)。

b. Use CDI

我認爲對於 8 至 9 歲的兒童，他們在 PCIT 的 CDI 階段時家長能與兒童有遊戲時間，專注兒童的好表現及表達欣賞，使家長和兒童重建互信的關係，在改善親子關係上最爲有效。CDI 技巧鼓勵家長多陪伴子女，我相信家長學習技巧後可有效地運用在子女身上。針對年紀較大的兒童，CDI 部份仍有相當效用，讓親子關係得以加強 (E, F)。

c. Use concrete praise

This enhances parent-child relationship and helps children develop positive self-image.
「具體讚賞」能協助年齡較大的兒童與家長建立關係，同時亦能協助他們建立正面的自我形象 (C)。

d. Enrich behavior management strategies

Including strategies that works better for older children, e.g. removing privileges, fore-warning, reinforcement schemes.
需加入其他管教策略，如：取去特權、預告及獎勵計劃等 (B)。

e. Time-out seat and time-out room might be too mild for such children

暫停椅和暫停房的手法對兒童未必有明顯效用，孩子可能較不在乎，甚至會自行爬出暫停房。如孩子有較多攻擊性行爲是較困難使用 PDI 的暫停技巧，這些孩子在 PDI 對家長有更多攻擊行爲，因此只能用取去特權去幫助部份孩子。但面對無欲無求、物質過剩的孩子，取去特權亦未能有把握取得孩子的合作。另外對不專注的孩子，暫停對他們的作用亦較弱 (F, G)。

f. Enrich praise skills and content (adapted CDI skills)

讚賞的內容須更爲豐富、具體及提高層次，讓兒童明確了解自己於行爲或態度上的優點 (C)。

g. More spacious facilities for enriched activities for older children

Including use of IT like photography, video shooting, virtual reality. (adapted parent-child game)

一方面要有更大的房間，另一方面要有更多適合 8 至 9 歲的玩意。 在學校已有要求他們坐定定，所以他們較喜歡在遊戲室有較大幅度的活動。若在玩意上停留傳統玩具，感覺上較難吸引兒童參與，可考慮運用電子器材做 project，如拍照片、短片製作、VR (D)。

h. Use age-appropriate activities (adapted game)

Including more reality-based discussion, games that suit their age e.g. board games.

如兒童是 8-9 歲，我相信他們未必喜歡玩玩具，可能要引入生活化的情景來教授家長運用 CDI 及 PDI 技巧。在選取玩具上，8-9 歲孩子仍喜歡玩的，但要按其能力安排合適遊戲，例如簡單的桌面遊戲、棋子等，治療師需要很花心力去找尋合適的玩具以投孩子所好 (E, G)。

i. Address age-relevant study issues (adapted PDI content)

Children 8 to 9 might need more academic support.

8 至 9 歲的兒童的功課比較多，需要更多的學術支援 (H)。

PCIT for Children with Special Educational Needs (SEN)

PCIT impact on Children with SEN

3.23 Parents' Views: They were positive on PCIT's usefulness on children with SEN, like children with ASD.

a. Helpful for children with ASD

PCIT stabilized results and conduct

ASD son in K2 has satisfactory results and conduct in school.

自閉症傾向嘅仔响班中成績及操行都 OK. (2H)。

PCIT stabilized temper

ASD daughter in K2 used to lose temper. She could now do homework on her own and achieve satisfactory results and conduct in school. She was now a model student in school.

在中班有自閉症傾向嘅女以前易發脾氣。現在能自己做功課，成爲學校模範生 (2G)。

3.24 Therapists' views: The Therapists were confident that PCIT was beneficial when the SEN condition was not too serious, or more psycho-social instead of neurologically-based.

a. PCIT helpful to those children with milder SEN

Parents' mastery of positive parenting skills will smoothen many of the parent-child interactions.

PCIT 對有輕微特殊需要的兒童皆有幫助，因家長已學習到用正面的方式與兒童相處，同時亦在過程中了解到其限制及被關注的需要，兒童在被了解及明白的情況下，情緒及行爲皆會較穩定，家長亦較容易處理其問題(C)。

PCIT helpful to all children in improving parent-child relations

在建立正面親子關係此目標上，我認爲 PCIT 對所有特殊需要的孩子亦有效 (G)。

b. Helpful to children who are of High Functioning ASD

PDI guides them to appraise consequences and enhances their sense of security.

針對高功能的自閉症兒童亦有效果，因他們在 PDI 階段對可預計和一致的後果有較大安全感，認爲將要接受的後果是自己可以預算到的 (F)。

c. Helpful to those with ASD, ADHD, oppositional defiance and speech delay

Improved family relationship and parenting skills for ASD, ADHD, ODD children.

自閉症徵狀、專注力不足及過度活躍症的兒童也合適，因爲 PCIT 技巧能幫助家長與這些子女建立和諧家庭，並讓子女合作聽話。2-5 歲自閉症兒童、過度活躍症兒童也合適（因爲他們都需要良好親子關係、有效的指令及一致的後果。）(A, H) 。

Play and communication in PCIT was effective on ADHD children.

PCIT 有效於過度活躍或對立反抗症之兒童。我認爲運用在 ADHD 的兒童上是有效的，因爲他們都樂於跟家長溝通及喜歡玩耍，家長能夠在特別遊戲時間中建立親子關係及學習有效的管教技巧，從前線經驗在 ADHD 的兒童上有明顯幫助 (B, E)。

Children with speech delay can improve communication skills

言語遲緩的兒童在 PCIT 的成效尤見顯著。一方面可能因爲 CDI 技巧中的

反映和描述，也幫助這些兒童學習表達，從而改善情緒。另一方面,很多時這些兒童的行爲困難源於表達困難或辭不達意，在 coaching 的時候，當治療師向家長解釋兒童外顯的行爲困難所包含的意思時，家長對兒童會多一份理解和接納，從而減少不必要的衝突 (D)。

Children less able to benefit from PCIT

3.25 Only Therapists contributed their views to this section.

a. Children with ASD, low intelligence and ADD were less able to benefit

Such children had lower self-control and comprehension capacity. They might not fully understand treatment content or instruction from parents.
自閉症、智力較低、多於一項等特殊學習需要兒童的成效較低，因爲他們自控能力和理解能力較弱，未能明白治療內容或依照家長的指示。
智力遲緩的孩子可能不明白指示內容，甚至連暫停程序中的因果關係亦未充份掌握，故成效要視乎其嚴重程度，較嚴重的並不合適。 (A,G,H)。

PCIT not strong in improving social competence in ASD
我認爲對 ASD 兒童是成效較低，因爲 PCIT 不有利於改善社交能力。
PCIT 運用在 ASD 的兒童上成效較低，因爲這些兒童的溝通及社交能力有限，家長在遊戲過程中較難跟子女交流。部份 ASD 的固執思想及行爲、對改變的反抗及社交能力缺失以致他不能與人合作，雖然 PDI 暫停程序有時能增加他對成人的要求及變得較合作，但並沒有針對其缺失而改變其合作性 (B, E, G)。

PCIT not strong in helping children with typical ASD, emotional disturbance or oppositional defiant problems
PCIT 對於典型自閉症、情緒嚴重困擾或患有對抗性反叛症等等的兒童等則較難成功推行。他們對所用的技巧並未能給予恰當的反應/回應，故此對此類型兒童成效並不顯著 (C)。

b. PCIT cannot handle children with ASD with unconventional interests

Some standard PCIT strategies might be misunderstood or even provocative.
有些自閉譜系兒童在「互動」的喜好上與一般兒童較不同，他們有的不喜歡這種互動模式、不喜歡家長改變說話方式、或對於「讚賞」的理解會有落差。故此在經驗裡發現，有些 CDI 技巧在某些自閉譜系兒童身上不見效果，甚至觸發他們的負面情緒 (D)。

c. Children with ADD has problems with attention and execution, which are not just simple compliance issues

ADD 孩子的專注力困難與執行能力缺失有關，並非只是簡單的不合作行爲，因此行爲治療對其做事拖延、做事分心的困難成效不明顯，工作員需要加上額外的技巧去補足 (G)。

Making PCIT more Gender-Sensitive for Fathers and Mothers

Need for gender-sensitive PCIT practice

3.26 Parents' views: The parent participants generally did not take gender-sensitivity a serious issue in PCIT practice. There could be some possible reasons: a) PCIT is a case service. The parents focused on their own dyad and need not be bothered about other cases. There is no way to compare and tell any gender-differential practices by the Therapists. b) social services are over-served by women professionals and the parents expected so and gender-issues became nearly irrelevant. But some of the specific comments made by father and mother participants still provided some useful alerts for practice.

a. Presence of PCIT differential benefits on fathers and mothers not obvious. Gender difference not a critical issue.

Time is more important than gender. Fathers are more available over holidays, and mothers normally more flexible.
時間比性別更重要，爸爸多數响假日較爲方便，而母親就較爲彈性 (1B)。

b. Best strategies to engage fathers to improve parenting

Create Father-friendly session: convenient timing, less frequent. Add one or two sessions to invite fathers to join so that they can directly experience the intervention and its impact.
特別加設一、兩節課俾爸爸們參與，令佢地能夠親身體驗治療過程和成效。

佢嘅爸爸都响上面(中國)做嘢呀，肯定無呢個機會上呢啲課程 (3B) 。

一個月一次爸爸(參與)，有幾堂都好過無 (3A) 。

c. Identify best person to persuade father to join

Spouse might not be the most convincing sales.
即係睇另一半嘅性格，係需要要由第三者 (輔導員) 同佢講，定係由老婆

同佢講嘅類別 (3A) 。

d. Make father attendance compulsory for the first session

可能第一次見一定叫父母一齊來，咁就會，我覺得有個機會接觸爸爸，然後感化個爸爸繼續來 (3A) 。

e. Create coincidence for father to join and break ice

For example, mother absence from one session.
我嗰次係試咗一次唔得閒，我特登要爸爸去上咗一堂，佢馬上就改變咗……其實我同姑娘夾咗特登要爸爸去試下 (5F)。

f. Involve father in studying notes and completing homework

我次次都係攞返姑娘嗰啲工作紙，又或者係其他點樣講嗰啲說話，我都俾佢(丈夫)睇先。譬如第一部分完，我都話：「爸爸我地到咗第二部分喇，你睇下啦」，佢都係好正經咁睇，咁得閒都會試一試呢個方法 (4A) 。

g.Create Family-friendly functions

Arrange family functions over weekends so that the fathers can also participate.
在假日舉辦家庭活動，讓父親也能一同參與 (5)。

h. Show child improvements to impress father

其實有咗小朋友之後呢，真係好大唔同，之前我同爸爸係真係自由多啲，有時真係小朋友有啲難搞嘛。當第一階段完之後，爸爸嗱嗱聲再講：「去參加第二部分啦」，因爲我地兩個真係留意到啲效果，同埋係我返到屋企，有用到姑娘教嗰啲說話同小朋友講野，爸爸見到有用，佢都會跟住做……我見到佢都想同我一齊去改變，咁我覺得呢個對我地個家庭黎講，係一個推動，一齊去做好 (4A)。

3.27 Therapists' views: Most Therapists also did not find gender-sensitive practice a big issue, though it is generally a good practice to be more sensitive to the individual needs and styles of service users. They made some useful suggestions in the timings and channels of better engaging the fathers.

a. No difference in reaching fathers and mothers

根據工作員的經驗，接觸爸爸或媽媽的策略都是一樣的。(E)

b. Gender-sensitivity practice is useful

Mothers were more interested in child development and studying, and needed more empathy. **Fathers** needed more recognitions on their identities and recognitions of their contributions to the family. Fathers tended to under-acknowledge the seriousness of the problems.
在接觸爸爸/媽媽的策略上確實有分別，在接觸媽媽的方面中多會集中子女成長、學習的話題，這已經能夠讓媽媽投入參與服務及訓練。而爸爸方面須多加一點他們在家的身份認同及爲家庭付出之肯定，普遍來說，部份家庭在孩子出現後，爸爸的角色很容易被淡出，令其容易將管教子女的責任置身事外，若能在面談時加強爸爸在家的角色及能力感，相信對其參與服務及訓練的動力亦會增加 (C, D)。

c. Avoid pointing out mistakes of fathers.

Show them information on the results. More fact-based will be more convincing to fathers.
我通常會避免指出爸爸在練習時技巧的問題，反而較多用客觀的數字和現象來作出肯定 (D)。

d. Engage fathers at Intake

Therapist persuades fathers to join at intake session.
可邀請父母一同參與初步面談，由治療師游說爸爸參加 (G)。

e. Engage fathers through role models in promotional materials

Fathers should appear in promotional videos on fathers.
接觸爸爸，可靠服務宣傳短片，內含父親親述輔導的效益 (G)。

PCIT and Couples' Cooperation in Parenting

Merits in having couples attend PCIT together

3.28 Parents' views: The parent participants generally thought that having couples joining PCIT together should be even more beneficial.

a. Sharing facilitates cooperation

Shared experience and shared direction acquired in PCIT synchronized the marital relationship.
夫婦一齊同方向，關係有改善；夫婦一齊做好啲 (2A, C) 。

Couples who went through PCIT together could mutually cooperate and reduce stress.
夫婦一齊做，互相明白能減壓 (2H)。

3.29 Therapists' views: The Therapists also found joint participation by couples useful, but it could be more demanding on the time and energy of the Therapists, especially in handling likely differences between the couple.

a. Joint participation enhances parenting consistency and generates systemic improvement

父母一同前來接受服務，就能達致父母用一致的管教方法處理孩子問題，並建立良好的家庭互動……如另一半未能參與治療及作出改變，對方與孩子的互動仍然依舊或夫婦關係僵持，則未能有效推動整個家庭互動，很多的家庭系統亦未能有所改變 (A)。

b. Joint participating enhance effectiveness

夫婦參與服務的家庭比母親或父親更有成效 (B)。

c. Joint participating might require more time in session to mediate couple differences or even conflict, but often achieves proportional improvements

夫婦一同參與服務能在過程中互相認識、觀摩及了解，從而收窄彼此分歧及調整管教孩子的方式，孩子亦能容易明白父母的期望及作出適當的配合。在處理上有時要爲夫婦作出調解以達致雙方有共同及合理期望及做法，所花的時間亦比一般個案爲多，但所提供的服務內容及成效則大致相若 (C, D, E, F, G, H)。

Enhancing couple's cooperation in PCIT and parenting

3.30 Therapists' views: Only the Therapists offered their views in this section. Some specific strategies were suggested in engaging the couples and even in handling conflicts in the sessions.

a. Allow observation and occasional participation

Invite the non-participating parent to attend or observe some sessions, e.g. didactic sessions, skills training sessions.
如其中一方不接受服務，都建議參與家長鼓勵另一半出席一至兩節出席技巧教授的環節，並進行觀察……並教授相關技巧及背後的理論 (A, C, H)。

Arrange individual interview with that parent

相約該名家長作個別面談，以了解其想法、期望、面對的困難、學習 PCIT 上的疑問及提供在家配合之方式 (C, D, E, H)。

b. Refer for counseling if necessary

如有需要，就轉介至夫婦輔導治療 (C, D, F, H)。

c. Handling couple conflict in session

Impartiality of the therapist

Therapist needs balanced address of the needs and interests of both parties.
夫婦一同參與服務時，母親或父親或會有互相指責或批評對方，工作員需平衡雙方的利益，了解雙方的期望及需要，讓他們互相對尊重，互補不足，逐步達致一致管教 (B)。

Immediate mutual validation

Invite couple to validate the contributions of each other in that session.
爲了緩和爭競的氣氛，及改善夫婦彼此的關係，有時我會邀請他們就當天的表現，彼此肯定對方 (D)。

Identify couples not suitable for joint participations

關係惡劣的夫婦我認爲不合適一起接受 PCIT，分開見會減少處理二人衝突的需要 (G)。

Way Forward: Improving PCIT for Hong Kong

Suggestions for PCIT improvement and development in HK

3.31 Parents' views: The parent participants offered very concrete suggestions to improve PCIT, beginning from coining a sharper brand name for the service.

a. Sharpen program branding and promotion

Simplify the Chinese name of PCIT.
簡化中文名：親子遊戲治療 (1B)。

Avoid stigmatization.
避免標籤 (1B)。

b. Step up promotion

Promotion is not adequate.
其實真係宣傳唔夠 (3A)。

Make the PCIT website even more clear and user-friendly for those parents not so proficient with IT.
PCIT 的網頁在設計上應更清晰，讓那些對電腦操作不太熟練的家長也能輕鬆使用 (1, 2)。

c. Improve facilities and service availability

Improve centres
Some PCIT service centres need to step up its facilities.
個別服務中心的設施未盡完善 (2D)。

Enrich toys
A centre should have more toys and lower the height of the one-way mirror.
某中心欠一大箱玩具；單面鏡太高 (2D)。

Improve centre accessibility and setting.
改善地方 (2E, 2D, 2G, 2H)。

Improve service availability and scheduling
改善排期 (2E, 2D, 2G, 2H)。

Try to obtain more resources and manpower to shorten the waiting time for service.
嘗試爭取更多資源和人手，以縮短輪候的時間 (3A)。

d. Improve content

Enrich notes for parents: Glossary, case applications
Parents notes can be enriched with glossary list, and examples of applications.
家長筆記要有詞彙，有應用舉例 (2H)。

Develop some simple notes with illustrations on applications to help parents understand how to apply, e.g. praise and encourage children.
製作一些內容較淺白，又有應用例子的筆記，如：讓家長了解如何讚賞和鼓勵子女 (1A, 2)。

e. Improve some program arrangements

Joint or separate parent and child session as appropriate
Try to separate the children from the parents when coaching the parents so that the children do not get sensitive about their parents' parenting.
個別教導家長和子女時，盡量把他們分開，以免子女對父母將來的管教方式有所防範。

Sometimes seeing parents without children might be more effectiveness, especially when the child is too smart and sensitive.
導師最好分開見大人，因孩子太醒目 (2A)。

Sharing amongst PCIT dyads as appropriate
Occasional sharing between different PCIT dyads might create consensus and support. After session eight should be a good time because the participants have learnt somethings and seen some effects.
合組 sharing 有共鳴，有支持 (2E)。

Include siblings as appropriate
Involving siblings in PCIT skills practice might achieve even better effect.
邀請兄弟姊妹一同參與演練，效果可能更佳 (1:A,C)。

f. Strengthen follow-up services

Step-up follow-up services
加強跟進服務 (2E, 2D, 2G, 2H, 5A)。

Provide extended services to more serious cases.
要按需要加家長堂 (2A)。

Insert a parent gathering after session 8 for interim evaluation.
約在第八節課後舉辦家長聚會，作中途檢討 (2E)。

Arrange some follow-up services after completion of PCIT treatment.
後續服務，在課程完結後舉辦一些聚會 (1B, 5A)。

3.32 Therapists' views: The Therapists also shared very specific suggestions on how to further improve PCIT in Hong Kong, and many views concurred with that of the parent participants.

a. Sharpen program branding and promotion

Early promotion, consider PCIT for toddlers.
及早推廣：如在兒童入學前各家長也能初步對 PCIT 技巧有了解，相信可減輕家長管教之壓力。

香港教育逐漸重視及早介入和預防工作，近年美國 PCIT 學者均鑽研如何

向低於 2 歲嬰兒推行 PCIT，相信發展 PCIT-Toddler 會爲 PCIT 開展新一頁 (C, F)。

b. Improve service availability

在服務地點及人手方面是需要再增加的，以縮短輪候時間 (D)。

c. Improve content

Strengthen management of child emotions.
PCIT 以行爲治療手法的確能有效改善兒童的行爲表現，亦有助家長建立信心面對管教的挑戰。若此輔導手法能加以照顧兒童的情緒需要，可減低孩子的情緒波動 (F)。

Enhance local adaptation: need to strength management of issues arising from local education system, which exerts pressure on children and families.
然而由於 PCIT 是源自美國，故此一些因香港處境而引申的兒童困難是較難回應的，如家庭因功課而誘發的衝突，這就需要從治療師自身工作經驗及彼此交流中，再額外處理 (D)。

Adjust to cater for needs for children with diverse needs: e.g. ASD.
面對 ASD 的人口群眾越來越多，PCIT 以往表示當中技巧未能有效應用於此群眾上，我相信透過適應性調整 PCIT 當中的安排和治療技巧，便能同樣使自閉症兒童及其家庭均有幫助 (F)。

Enhance resources to respond to increasing case complexities:
Family cases are getting more complicated. Addressing only child issues is not enough. There are great need to handle parents' emotion and couple expectations. Service time is often extended accordingly.
大部份個案已不如以往般純管教問題，當中除涉及兒童的特殊需要外，家長在情緒需要上亦須給予大量關注，有時候訓練的時間大部份也會用於處理家長情緒或調整夫婦期望等，令整個訓練時間及節數皆不停延長。(C)

d. Improve some program arrangements

New service mode: e-learning could be considered.
改變服務方式：網上指導家長。(B)

e. Sustain and extend the service

Continue funding and extend PCIT service: hope there is continuous funding to support the extension of PCIT in Hong Kong.

希望 PCIT 能持續地、全面地推廣至全港、每個家庭，讓每位父母都學習有效的管教技巧。故此，希望有機構資助 PCIT 繼續持續及發展。

PCIT 應該持續並廣泛地推展至全港家庭及學校。

取得資金讓服務延續。

希望有基金或機構能繼續撥款支持這計劃，使現有的同工能維持優質的服務，服務能得以延續。

得到穩定的資助，繼續前線服務；培訓更多人，使用此模式協助更多家庭。
希望可以繼續有資助者贊助服務，讓服務可持續發展 (A, B, G, H)。

Make services available to more districts in Hong Kong.
擴展至其他區域。現階段 PCIT 只在部分區域提供服務，如此服務能擴展至其他區域 (如港島區) 或增加更多服務時段，相信能爲有需要家庭提供適時協助。在服務地點及人手方面是需要再增加的，以縮短輪候時間 (C)。

Develop new staff from other units.
培訓新同工；繼續有資源培訓其他單位同工學習此治療，讓更多家庭受惠。(A)

Strengthen existing staff: attend quality local and international training.
加強同工持續進修；讓同工出席不同國際性的 PCIT 研討會，交流彼此的心得及改善服務質素。(A)

Way Forward: Promoting PCIT to benefit more families in Hong Kong

Strategies to reach more families to benefit from PCIT

3.33 Parents' views: The parent participants were creative in suggesting ways to make PCIT better known to needed families in Hong Kong. Some (1A and 1B) even volunteered to appear in PCIT promotional materials to advocate for the service.

a. Reaching parents

Create need from parents

Make many more parents understand children's behavior and emotional problems require early intervention.

讓更多父母明白子女的行爲和情緒問題必須及早處理，搞啲講座。即係俾啲父母一齊參與 (1B)。

Witness by previous beneficiaries
Invite PCIT graduate parents to promote to parents in need.
邀請 PCIT 畢業的家長向有需要的家長介紹服務 (2)。

Vary service format to make it easy for parents to join
Consider changing service format, e.g. using PCIT coach, PCIT on skype, to reach more families in need.
可考慮改變服務的形式，如 PCIT 車、skype 視像服務等，以接觸更多有需要的家庭 (1B, 2)。

b. Reaching professionals
Promote the service to professionals, like social workers and medical professionals, so that they can recommend the services to parents in need.
向專業人事，如社工及醫護人員推廣服務，讓他們轉介給有需要的家長 (2, 3)。

c. Reaching the public

Extend promotion methods
Promotion strategies: television advertisements, promotional leaflets, posters, promotion videos, on-line case sharing
宣傳/推廣方式：
電視廣告、派發傳單、張貼海報、拍攝短片、在網上進行個案分享 (All)。

Capture best timing for promotion
Organize activities over holidays, like carnivals or promotion booths, to let parents learn about PCIT
在假日舉辦活動，如親子嘉年華或宣傳攤位，讓更多家長認識 (1, 3)。

Create PCIT resources
Establish PCIT resource hub for public reference to popularize PCIT.
讓 PCIT 更爲普及，例如建立資料庫供市民參考 (2)。

3.34 Therapists' views: The Therapists pointed out that introducing PCIT in the pre-service training of relevant professionals e.g. child-care teachers, can be useful.

a. Reaching parents
Promote in nurseries and kindergartens.
定期作宣傳、爲幼兒/幼稚園提供講座或工作坊、與各提供兒童及家長服務工作的機構多作服務介紹 (C)。

Word of mouth by mothers who used the service.
透過媽媽推介。媽媽在放學後，互相交流育兒心得。曾接受服務家庭的口碑 (H,F)。

b. Reaching professionals
Provide training to child care teachers.
我覺得可以透過爲幼師提供訓練，讓他們認識 PCIT，從而轉介一些較隱藏但有需要的家庭 (D, E)。

c. Reaching the public
Appear in public and social media.
接受電台或報章訪問、刊登廣告、網頁介紹、網上傳宣片(家長教育)、寄宣傳單張到學校、醫院及評估機構。接受電台訪問，刊登個案於報張上，網上宣傳 (A, B, H)。

Promote in Maternity and Child Health Centres.
我認爲 PCIT 可以在健康院及幼稚園多加宣傳，令到更多有需要的家長接觸到 PCIT 的服務 (A, B, H)。

Suggestions on Future PCIT Research

3.35 Only Therapists offered views on this section. Some suggested topics for future PCIT research included:

a. Connection between housing condition and treatment impact: some families do not have space for PDI
家庭居住環境與治療成效的關係，因部份家庭因環境關係未能在家執行 PDI 程序，須改變策略及方法以讓孩子服從，雖然仍能協助家長處理兒童行爲問題，但卻未能推行整全的 PCIT 訓練 (C)。

b. Connection between homework completion and treatment impact
家長進行遊戲家課的狀況與治療成效的關係 (D)。

c. Reasons for dropping out from service

未能完成治療家庭的可能因素 (D)。

d. Content analysis of parent-child dialogues
可以加入分析家長與孩子的對話內容研究 (H)。

e. PCIT effectiveness on siblings
對改善兄弟姊妹/祖父母/監護人/老師/關係的成效 (F)。

Staff Training Needs

3.36 The PCIT Therapists expressed needs for further professional enhancement in the following areas:

a. Training about SEN and ASD support
支援 SEN, 如：自閉譜系兒童的訓練 (A, B, D, E)。

b. Training about Counseling: About trauma for children and adult, Individual and couple counseling and Art therapy
創傷治療、藝術治療
有關兒童及成人的創傷輔導、個人及婚姻輔導、藝術治療 (A, H)。

c. Child development and local resources development
工作員亦必須了解兒童各方面之發展需要、學校及社會上配套以協助各家庭。另外，在家長層面上亦須提供情緒支援及社區資源建議 (C)。

C. Conclusion on Qualitative Study

3.37 The qualitative studies which collected views from 17 parents and 8 therapists provided rich information on how PCIT benefitted children, parents, families, challenged communities and Hong Kong. It also identified important therapeutic elements that effected the improvements. Aside from the recognitions, the informants also pointed out rooms for improvement of this generally welcome service, including improvements in services content, format, resources and promotional strategies. Directions for further extension of the service were also articulated e.g. sustain and extend the services to more districts in Hong Kong, extend the services to older children while attending to their developmental contexts and needs, stepping up staff training and research to provide more evidence on the program effectiveness. Some practice wisdom in engaging fathers to improve their parenting was also collected even though most parent participants did not find it very necessary to make PCIT services even more sensitive to the characteristics of fathers and mothers. There are more unique variations than gender-based differences, and whether the parent can make time for the service is most important if motivation and needs are the same.

Chapter 4 Conclusions, Limitations and Recommendations

Conclusions

This report presented the findings of three studies on PCIT service from 2015 to 2018.

The effectiveness on PCIT service from 2015 to 2018

4.1 The effectiveness study involving 538 parent-child dyads who completed the PCIT demonstrated that 71% of them had completed the treatment with satisfactory outcome. 99% parents who completed the program were highly satisfied with the treatment. PCIT had significantly reduced child behavior problems, parenting stress, negative parenting practices and increases positive parenting skills. The quantitative results were consistent with the qualitative findings collected in the focus groups of participated parents and the therapists' reflection reports.

The Chinese fathers and mothers' differences in participating in PCIT

4.2 For the comparison between Chinese fathers and mothers in participating in PCIT, 374 participants were involved. They were categorized into 4 groups: mother only, father only, couple-mother, and couple-father for analysis. The quantitative study results indicated that there was no significant difference among the 4 groups in post-intervention scores. This result indicated that PCIT seems to cast the same effectiveness for Chinese fathers and mothers, whether they joined alone or together with their spouses. The qualitative study result also showed that it might not be necessary to make significant adjustment in PCIT to cater for the possible different needs of the fathers and mothers, though it is worthy to recruit fathers in the treatment for facilitating couple cooperation in parenting which is considered a crucial factor in children development in the long run. These results echo those of a study (Bagner & Eyberg, 2003) which found that fathers' participation in PCIT treatment might not improve immediate treatment outcome, but it might help maintain the beneficial effects of PCIT after the treatment ended.

The effectiveness of PCIT on children aged 8 or above

4.3 Differential impact of PCIT on children aged 8 or above was also examined. Among 34 children aged 8 and 9 recruited in this project, 27 of them had completed the treatment and were involved in this study. The study demonstrated that 66.7% of them had completed the treatment with satisfactory outcome. PCIT was also found to be effective with established child abuse and high risk cases as well as children with SEN, with success rates at 64.5% and 68.8% respectively. The qualitative findings also supported the positive results of the quantitative study. PCIT was found to be effective with these groups of children and parents.

Limitations of the PCIT project and Studies

4.4 Despite the favorable project results, there were limitations of the service. First, drop-out rate of the service should be further reduced because the effectiveness study highlighted that the drop-out families were more likely to be families in adversity, including families with lower income and on CSSA, single parents, older children, children with more behavioral problems, and parents with higher stress as well as more negative emotion. Second, the majority of the participants were still mothers and there was room for engaging more fathers in the project. Third, the service mainly targeted children in early childhood and the completers of PCIT may experience difficulties to adjust interaction with their children and the learnt parenting techniques when their children step into early adolescence. Finally, although PCIT is a protocol-driven treatment program, the success of the service hinges on the implementation of PCIT by the therapists. The therapist needs extra knowledge in order to work with challenging clients including children with comorbid developmental disorders, parents with mental illnesses, couples in conflicts, etc.

4.5 There were some limitations in the research. One limitation is that both quantitative and qualitative study analyses were based on successful cases with complete data only. As there were some differences between successful and unsuccessful cases, such as children age and family monthly income, the exclusion of unsuccessful cases in both quantitative and qualitative analyses might limit the evaluation of PCIT effectiveness on participants from different backgrounds. The second limitation was the insufficient amount of follow-up assessment data in this study for examining the maintenance of treatment gains in the project. This was because many participants considered it time-consuming to attend a follow-up session. Instead, they preferred telephone contact in which on-site observation and follow-up measures could not be carried out. The third limitation was that the measures of change in children behaviors solely depended on the reports of participated parents. Therefore, the generalization of treatment effect in school and in other settings was not known.

Recommendations on Improving PCIT Services

Retaining the potential drop-out families

4.6 To appeal for more leisure time for children

Among the drop-out cases, the most common drop-out reason as reported by the parents was “Busy Schedule” (37.7%). Under the social environment which emphasizes “Winning at the starting line” in Hong Kong, many children have hectic schedules which are filled up with academic tasks and extracurricular activities. Some parents thus considered that weekly sessions of PCIT for 14 to 20 weeks were demanding to their families, and some even rejected service as the time slots of treatment clashed with those of their learning activities. Indeed, children need more free time to relax and spend with their families. The authors and TWGHs PCIT team thus appeal for limiting the number of examinations and homework and eliminating the competitive school places allocation system so as to reduce academic stress imposed on young children. Meanwhile, education and welfare settings have to join hands to encourage children to have more leisure time with their parents.

4.7 To broaden the availability of PCIT with computer and mobile technology

Computers and mobile technologies have been incorporated in some social service settings for delivering counseling in recent years. An internet-based PCIT (I-PCIT) service has been developed in the U.S. to serve families residing in underserved communities, and its randomized control trial studies showed that it was as effective as in-clinic PCIT. (Comer at el, 2015; Comer at el, 2017) Adopting video-conferencing in PCIT seems to be a possible way to reduce traveling time and mitigate the issues of geographic barriers for service users. It can also help approach family members that can hardly attend in-clinic service due to the fear of stigma.

Supporting parents and children aged 8 years or above

4.8 To adapt PCIT to older children

Although the success rate of the children aged 8 years was lower than that of the younger children subgroup, PCIT still brought a lot of benefits to these older children and their parents. With limited evidence-based intervention for reducing disruptive behaviors of school-aged children available in Hong Kong, it’s worthy making PCIT applicable in school environment and delivering PCIT professional training to school personnel and stationing social workers in primary schools.

4.9 To deliver a follow-up program after treatment completion

In response to the request from PCIT completers on supporting them when their children got older, follow-up service for them should be enhanced. Further parenting notes can be delivered upon treatment completion and parenting education programs can be held regularly to support them using PCIT skills consistently, such that the treatment effect can be maintained even when the children transit to later developmental stages. Furthermore, collaboration between PCIT therapists and school social workers or educational psychologists in primary schools, such as case referrals to school personnel, school-based parent group etc, is also important to support these children.

Engaging more fathers in PCIT

4.10 To make PCIT father-friendly

The data in qualitative study informed the team that fathers’ involvement in the treatment had beneficial effects to consistent parenting and better couple cooperation. Therefore, PCIT therapists should work hard to encourage both parents to attend the PCIT treatment. In particular, fathers’ participation can be encouraged by offering convenient treatment session time for all family members. If long commitment makes fathers reluctant to come, or they cannot regularly join the treatment, invitation to the intake and teaching sessions can be sent. Their presence can mean support for their spouses, and therapists can motivate them further in the face-to-face encounter. Using video conferencing to provide PCIT can be an innovative way to recruit more fathers. For publicity, as word of mouth recommendation and information technology seems to be attractive for man, inclusion of father PCIT graduates in sharing their experience in participating in PCIT can be considered in making promotion video for the service.

Serving child abuse cases

4.11 To disseminate PCIT in nursery schools

PCIT is an evidence-based practice which was listed as one of three identified “Best Practices” in the area of child abuse in Kaufman’s report. (Kaufman, 2004) The present study further demonstrated that PCIT could be an effective intervention for Chinese families with child abuse. With an aim to strengthen the early prevention and identification work of child maltreatment, it is suggested to disseminate PCIT service in pre-primary institutions, coinciding with the launch of a kindergarten social work service pilot scheme by the Government next year.

Serving SEN cases

4.12 To support SEN children with multi-disciplines
While PCIT effectiveness on SEN children was proven in this study, the therapists also shared that it was challenging to serve those with comorbid conditions or higher severity. For these difficult SEN children, PCIT is suggested to be one component of a multifaceted treatment, which targets to reduce children behavioral symptoms and to enhance their parents' competence in parenting in particular. Multi-disciplinary interventions such as children rehabilitation trainings and school accommodation are also important to support these children and their families in more comprehensive ways. Thus, collaboration with other helping professionals is necessary.

Offering staff training

4.13 To equip PCIT therapists with knowledge on working with challenging cases
Staff training should be provided to enrich therapists' understanding on children development, and knowledge in intervening with couples, children with ASD and those who have experienced traumatic events.

Recommendations on research on PCIT

4.14 To investigate the connection between housing conditions and treatment impact
Living space and home environment of local families differ greatly from those of the families in western countries. Some children and families receiving PCIT in this study were living in confined space or even subdivided flats (usually of only 60-150 square feet). Therefore, some participating parents reported difficulties in finding suitable time-out area and to implement PDI at home. The correlation between housing condition and treatment impact will be an interesting topic for future PCIT research in the process of localizing PCIT in Hong Kong.

4.15 To examine the impact of PCIT on other specific groups
It is worthy examining the PCIT effectiveness on specific groups such as those with siblings and parents with mental health problems. Reasons of dropping out from service, relationship between treatment homework completion and treatment impact and content analysis of parent-child dialogues are also some possible topics for future research studies.

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Appendix 1: Focus Group Questions Guide

1. 你為甚麼參加親子互動輔導？
2. 你對這親子互動輔導的整體印象是怎樣？
3. 你覺得這親子互動輔導對你及孩子有沒有幫助，若是有，那一方面？是甚麼元素幫助到你(可參考問題 7 的輔導元素)？你和孩子的關係有何轉變?孩子的服從性有何不同?
4. 你覺得親子互動輔導是否令你的夫婦或家庭關係有所轉變?
5. 如果你是夫婦一同參與親子互動輔導，你認為這個經驗對你/對你管教子女/對你接受親子輔導/對你完結輔導後持續實踐所學有沒有幫助?
6. 你在接受這親子互動輔導服務過程中遇到甚麼困難？這些困難怎樣獲得解決？
7. 你對這親子互動輔導服務有甚麼意見及建議改善之處？
   - 利用單面反光鏡及耳筒接收器直接指導的形式
   - 從單面反光鏡觀察另一半接受直接指導
   - 親子一同遊戲
   - 家課方面
   - 工作員方面
   - 事前事後檢討方面
   - 工作紙方面
8. 你會推薦這個服務給其他家長嗎？怎樣才能接觸到這些有需要的家長？

Appendix 2: Locations of PCIT Services

總辦事處 Main Office	
東華三院家庭成長中心 九龍黃大仙竹園南邨貴園樓地下 109-110 室 電話：2267 6322	TWGHs Centre on Family Development Unit 109-110, Kwai Yuen House, Chuk Yuen South Estate, Kowloon TEL : 2267 6322

以下單位須先以電話預約安排接見 電話 2267 6322
Prior telephone booking of appointment for the following centres Tel: 2267 6322

其他服務單位 Other Service Centres	
東華三院屯門綜合服務中心 新界屯門井財街 27 號井財街政府服務大樓 2 樓及 3 樓	TWGHs Tuen Mun Integrated Services Centre 2/F & 3/F, Tseng Choi Street Government Services Complex, 27 Tseng Choi Street, Tuen Mun
東華三院賽馬會天水圍綜合服務中心 新界天水圍天恒邨停車場大廈 6 字樓 2 號單位	TWGHs Jockey Club Tin Shui Wai Integrated Services Centre Unit 2, 6/F, Tin Heng Carpark Building, Tin Heng Estate, Tin Shui Wai, N.T.
東華三院賽馬會大角咀綜合服務中心 九龍大角咀通州街 28 號頌賢花園商場 9 號	TWGHs Jockey Club Tai Kok Tsui Integrated Services Centre Shop No. 9, G/F, June Garden, 28 Tung Chau Street, Tai Kok Tsui, Kowloon
東華三院賽馬會沙田綜合服務中心 新界沙田銀禧花園第三至四座平台	TWGHs Jockey Club Shatin Integrated Services Centre Level 3, Block 3 & 4, Jubille Garden, Shatin, N.T.
東華三院余墨緣綜合服務中心 九龍深水埗富昌邨富潤樓服務設施大樓 5 樓	TWGHs Yu Mak Yuen Integrated Services Centre Level 5, Fu Yun House, Ancillary Facilities Block, Fu Cheong Estate, Shamshuipo, Kowloon
東華三院陳嫻幼兒園 九龍秀茂坪秀明道秀富樓地下 2 樓	TWGHs Chan Han Nursery School Unit No. 2, G/F, Sau Fu House, Sau Ming Road, Sau Mau Ping (I) Estate, Kowloon
東華三院洪王家琪幼兒園 新界粉嶺祥華邨祥和樓 104-108, 113-115 號地下	TWGHs Hung Wong Kar Gee Nursery School Units No. 104-108, 113-115, G/F, Cheung Wo House, Cheung Wah Estate, Fanling, N.T.
東華三院香港鑪峯獅子會幼兒園 新界葵盛西邨 10 座地下	TWGHs Lions Club of the Peak, Hong Kong Nursery School G/F, Block 10, Kwai Shing West Estate, N.T.