

Cover page

Official title of the study: Effects of a Brief Mindful Parenting Program for Hong Kong Chinese Impacted by Social Unrest: A randomized trial

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BACKGROUND RESEARCH

Since the 2014 umbrella movement, there has been increasing research interest in how social unrest affects family relationship. A qualitative study found intra-familial conflict and different levels of renegotiation in the family relationships of active participants and bystanders in the movement (Ho et al., 2018). Another study of young adults and their family members reported that lower relationship quality and lower congruence in their political attitudes predicted more serious subsequent family conflicts, suggesting a close relationship between political and family life (Chan et al., 2018). The study also suggested that some families may have stronger resilience, while others experience serious and persistent conflicts.

This division between the generations matches with the findings of some earlier studies. For example, A greater dissatisfaction has been found among the young than the older generation (Wong, Zheng, Wan, 2017). This observation is consistent with the trend of the younger generation's growing participation in the political movement as they search for a way to express their dissatisfaction towards existing social and political structures (Lam-Knott, 2018). However, expectation of total obedience of children and a lack of personal space to express dissatisfaction are still common in many Hong Kong families (Shek & Sun, 2014). However, parental behavioural and psychological control predict adolescent risk behaviour (Shek, 2007). There should be a reconsideration of the overemphasis on family harmony and strict parental control, and a search for parenting principles that balance younger family members' need for security and identity with continuing family bonding.

Studies have shown that social unrest and exposure to community violence have a strong detrimental impact on adolescent mental health (Vorhies, Guterman, & Haj-Yahia, 2011). A supportive family environment is the most consistent mediator of this impact (Cummings et al., 2009). Studies in Northern Ireland, where a significant proportion of adolescents were exposed to community conflict, emotional insecurity and family cohesion predicted subsequent adolescent delinquency and aggression (Cummings et al., 2016; Taylor et al., 2016). Mental health issues, particularly post-traumatic stress (PTS), are common in social unrest, but they are moderated by positive parental mental health and positive parenting (Dubow et al., 2012).

Post-traumatic stress is caused by actual or threatened death or serious injury, direct exposure to violence, witnessing a significant person's exposure to violence or an accident, or indirect exposure through hearing aversive details of the event (American Psychiatric Association, 2013). Core symptoms of PTS include re-experiencing the trauma, avoidance, and a persistent sense of threat. Prolonged PTS may lead to issues with affective dysregulation, negative self-concept, and relationship disturbances (Cloitre et al., 2018). Studies indicate that 6–20% of individuals develop post-traumatic stress disorder after a potentially traumatic event (Kahana et al., 2006). Other mental health issues including depression, anxiety, paranoid ideation, and aggression have been found in adolescents with extensive exposure to community violence (Al-Krenawi & Graham, 2012). Adolescents living with parents who have different life values and exert high psychological control may lack a buffer against the threat of mental health problems during social unrest. Thus, this age group is at the highest risk of developing chronic mental health issues after exposure to traumatic life experiences (de Jong et al., 2015).

Two core mechanisms – security and connection, and emotion regulation – are crucial to adolescent mental health in a context of social unrest. This project aims to support parents so that they can provide a safe and trustful environment to meet adolescents' needs after experiencing traumatic events (Gewirtz, Forgatch, & Wieling, 2008). Given the current social unrest, parents and adolescents need emotion regulation strategies that can promote positive affective change and facilitate empathy and reconciliation in families and communities (Cehajic-Clancy et al., 2016).

The content design of prevention and intervention programmes combines mindfulness skills with psychoeducation as a strategy for promoting security, connection, and emotion regulation (Chambers et al., 2009). Mindfulness training has been widely adopted as a therapeutic approach for reducing emotional distress and promoting psychological well-being, including PTS (Banks et al., 2015; Gu et al., 2015). A study in Israel showed that after being presented with anger-inducing information related to political conflict, participants in a mindfulness workshop were more supportive of conciliatory policies and the effect was mediated by a reduction in perceived threat and improvement in emotion regulation (Alkoby et al., 2017). In emotionally charged situations that may lead to verbal and physical aggression, mindfulness on the soles of the feet is a specific technique that enable individuals to manage their emotional arousal by shifting the focus of attention to a neutral physical body part (Singh et al. 2011). A recent study of Chinese adolescents suggested that teaching parents Mindfulness on the Soles of the feet could reduce the aggressive behaviour of their adolescent children (Ahemaitijiang et al., 2019). A pilot study of Hong Kong secondary school students is in progress.

Hypotheses of the study

The current study will test the following three hypotheses based on the literature:

- (i) Parents participate in a brief mindful parenting program will experience less depressive symptoms, anxiety symptoms, post-traumatic stress symptoms, family conflicts, and higher family functioning and interpersonal mindfulness than parents from wait-list control.
- (ii) Effects of the program will sustain at 3-month follow up.
- (iii) Parents with higher exposure to political unrest will predict the severity of the symptoms at pretest and follow-up.

RESEARCH PLAN AND METHODOLOGY

Study design

This study uses a multi-site, randomized control trial. The effects of this intervention will be tested using a two-arm randomized controlled trial, comparing the mindful parenting program (Arm 1), to waitlist control group (Arm 2). Assessments will be made before (T0), 1-month follow up (T1), and 3-month follow-up (T2). The programme effects will be tested using both between-subject (comparison of the two arms) and within-subject (comparison of measures at T1, T2, and T3).

Sample size estimation. An estimated 340 parents will be recruited and randomised into an intervention group and a wait-list control group. The sample estimation is based on an expected effect size of .33 for family functioning in the PI's pilot study, with an estimated drop-out rate of 15%, a two-tailed α error of 5%, 80% power, and a test of two independent groups.

Recruitment of participants. Inclusion criteria are: (1) parents of an adolescent with the age between 10 to 21; (2) parents with a score of Patient Health Questionnaire (PHQ-9) score of 2 or above. Exclusion criteria are: 1) parents with current self-reported psychiatric diagnoses of psychosis, alcohol or substance abuse, 2) parents experiencing personal or family crisis in last six months; (3) parents cannot speak Chinese.

The research project will be announced and promoted in five non-governmental organizations, and social media. All interested parents will be given an information sheet and a four minute video explaining the nature of the study. After providing consent to participate the study, a research assistant who is blinded to the personal data of the participants, will administer the random assignment using computer generated programming. Participants will be randomly assigned to mindful parenting program (Arm 1), or waitlist control group (Arm 2).

Procedures

Program plan. The themes and content are based on a brief mindful parenting program developed by the same principal investigator (Lo et al., 2016, Lo et al., 2019). Psychoeducation of stress and coping in the context of parenting relationship is infused. Instructors for the program possess a PhD in psychology or social work, a specialist in psychiatry, and foundational professional training in mindfulness-based cognitive therapy.

Implementation and assessment. After the first assessment (T0), caregivers who meet inclusion criteria will be randomized into Arm 1 or Arm 2. After the intervention, two time points will be used to assess the intervention outcome and sustainable effect at one month and three month. Programs are delivered in group format and will be conducted in five sites, including the P-I's university and the service units of NGO collaborators. To ensure intervention fidelity, all program sessions will be audio-recorded and an independent rater will listen to 20% of the selected clips on random basis, and assess whether each element in the intervention protocol has been implemented with consistency. Higher concordance rates will signify greater fidelity to the intervention protocol, which will be carefully monitored throughout the study.

An Ethical approval for this study has been obtained from the Research Office of the Hong Kong Polytechnic University.

Measures

All measures of the variables are summarized in Table 1 below. In line with the study objectives and hypotheses, primary outcome variables include parental depression. Secondary outcome measures include anxiety, post-traumatic stress, perceived family functioning, family conflicts, and interpersonal mindfulness.

Data Analyses

Quantitative data analyses: Intervention effects. All analyses will be carried out according to the intention-to-treat approach. (Moher et al., 2010). MANOVA will be used to evaluate the effects of the mindful

parenting (Arm 1), relative to waitlist control group (Arm 2), and the analyses of the primary and secondary outcome measures. In addition to the immediate programme effects, outcomes measured at T1 and T2 will be compared, to assess whether maintenance effects will be sustained at 3-months.

Table 1. Outcome variables and measures

Study variables and measures
Depression - Measured by the Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001), 9 items
Anxiety - Measured by the Generalized Anxiety Disorder 7-item (GAD-7, Kroenke, et al., 2016), 7 items
Post-traumatic stress - measured by the International Traumatic Questionnaire (ITQ, Cloitre et al., 2009), 6 items
Family functioning - Measured by 5 item, <i>Family APGAR Scale</i> (Smilkstein, Ashworth, & Montano, 1982), with five subscales in adaptation, partnership, growth, affection, and resolve.
Family conflict - measured by Conflict Tactics Scale (CTS-2, Straus & Gelles, 1979), 16 items
Interpersonal mindfulness - measured by the <i>Interpersonal mindfulness in Parenting Scale</i> (Duncan, 2007, Lo et al., 2018).