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<th><strong>Title</strong></th>
<th>Knowledge transfer in humanities and social sciences: What are they?</th>
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Partnership Projects with Social Service Organizations: Combining Knowledge Generation and Knowledge Utilization

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Introduction

- In science, KT activities involve research with heavy investments, and is linked with development of technologies with substantial commercial potentials
- The products of knowledge transfer can be seen in the forms of patenting, licensing, contracts and spin-offs

- Collaborative activities rather than commercial activities are more common in HSS
- Five forms of KT in HSS:
  - Contract research (Generation of new joint)
  - Joint research (Generation of New Knowledge)
  - Consultancy (Utilization of accumulated knowledge)
  - Training (Utilization of accumulated knowledge)
  - Personal mobility (Utilization of accumulated knowledge)
Knowledge Transfer at College of Liberal Arts and Social Sciences (July 2010-June 2011)
- 107 contract and collaborative research
- 44 consultancy projects
- More than 100 community services
- 160 advisory/editorial boards
- Others, attending conferences, seminars, press conferences......

In my own collaborative partnership projects, my KT activities involves a combination of (i) contract research, (ii) training, (iii) consultancy
- Additional features: (i) service provision
- A combined knowledge generation and knowledge utilization project with a self-developed model called:

SET

- Service provision
- Training frontline worker
- Evaluating outcomes

- Service provision
- Training frontline worker
- Evaluating outcomes
Objectives

- Provide Cognitive-Behavioural Therapy (CBT) intervention for at least 1000 people with mild to moderate depressive symptoms in Hong Kong
- Evaluate the outcomes of the intervention
- Train 16 frontline social workers to use CBT for people with depressive symptoms in group and workshop formats
- Develop trainee and client manuals

Recruitment Process

- Recruitment – 33 agencies applied
- Selection – 9 units (20 social workers for 1 ½ year training)
- Service types:
  - Integrated family services (6)
  - Community mental health services (3)
  - Counseling services (1)
  - Social Welfare Department
- Geographical locations:
  - Hong Kong, Kowloon, New Territories

Training

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<tr>
<th>Training</th>
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<tbody>
<tr>
<td>Theoretical bases of CBT and in-house practices</td>
<td>3 days</td>
</tr>
<tr>
<td>Observation</td>
<td>Observing CBT in action (workshops and groups run by trainers)</td>
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<tr>
<td>Co-running of CBT groups and workshops</td>
<td>Demonstration and coaching by trainers</td>
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<tr>
<td>Group consultation</td>
<td>3 monthly meeting</td>
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Three-day training (1)

- Theoretical framework of cognitive therapy
- Cognitive therapy and depression
- CBT structured group processes
- Cognitive and behavioural techniques
- Case conceptualization
- Roles of worker
Three-day training (2)

- In-house practices – understanding your negative automatic thought patterns, dysfunctional rules, attitudes and values
- Skills demonstration and practices:
  - Cognitive techniques - scaling techniques, disputing, use of daily dysfunctional thought record worksheet, the 5-Steps, cognitive-continuum, advantages and disadvantages
- Behavioural techniques: activity chart, activity ruler, life plan

Three-day training (3)

- Practical issues in running:
  - Workshops
  - Groups
  - Through video viewing and sharing
- Logistics:
  - Research-related: When to submit questionnaire, how to facilitate group members to fill out the questionnaires, etc...
  - Service-related: Pre-group interview, report-back format, etc...

Training manuals and materials and books

- 《駕馭焦慮：「認知治療」自學/輔助手冊》
- 《走出抑鬱的深谷：「認知治療」自學/輔助手冊》

CBT group (workshop) in action

- 3 hours per session, 10 sessions per group
- Structured format: Mood check, review of home work, group contents of the week, homework and one-sentence feedback
- Action-oriented
- Group members’ sharing and feedback
### Group content

<p>| | |</p>
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</table>
| One | Warm-up  
Thought, behaviour and emotion: How are they related?  
Thought and depressive mood |
| Two | Understanding one’s emotion  
Exploring whether one’s thought is related to behaviour and emotion |
| Three | Finding one’s own pattern of negative automatic thought  
Exploring pleasurable activity |
| Four | Developing cognitive and behavioural strategies to handle one’s emotion  
Exploring pleasurable activity |
| Five | Further consolidate cognitive-behavioural strategies  
Exploring pleasurable activity |
| Six | Dysfunctional rules and attitudes: How is it related to depressive mood  
Exploring pleasurable activity |
| Seven | Developing cognitive strategies to modify one’s dysfunctional rules  
Self-reward exercise |
| Eight | Developing cognitive strategies to modify one’s dysfunctional rules  
Examining one’s daily living pattern: How does it contribute to depressive moods? |
| Nine | Rethinking and reorganizing one’s daily living pattern |
| Ten | Rethinking and reorganizing one’s daily living pattern  
Termination |

### Group materials used

![Group materials used](image1.png)
Evaluation objectives:
- To test the efficacy of CBT groups for people with mild to severe depressive symptoms in Hong Kong
- To examine if cognitions (i.e. dysfunctional attitudes and perfectionism) were related to depressive symptoms and quality of life

Hypotheses:
- The participants in the experimental group would have fewer depressive symptoms, fewer dysfunctional attitudes, less discrepancy and high standards, and a better quality of life than the participants in the control group at the end of the group intervention.
- Changes in dysfunctional attitudes and perfectionism (discrepancy and high standards) would be linked to a change in depressive symptoms.

The inclusion criteria:
- Aged 18 to 60 years
- Mild to severe depressive symptoms as indicated by the Chinese version of the Beck Depression Inventory (C-BDI).

The exclusion criteria:
- Psychosis or severely acute depressive symptoms
- Attempted suicide or displayed suicidal ideation in the three months before the interview

Procedures
- Sources: self referred by reading the flyers in family service centres, clinics and referred by psychiatrists, social workers, psychologists and other professionals
- Pre-group interviews
- Experimental group received 10 sessions CBT in group format (i.e. each group had about 8 members)
- Control group received no intervention
Randomization took place at the agency level. As soon as recruitment reached a certain number, potential group members would be randomly assigned into ex or con groups.

Experimental groups led by 2 trainees and 1 trainer.

3 trainers: 2 were teaching staff of universities (one had/has CT qualification), 1 was experienced social worker with training in mental health and CBT.

Participants:
- 364 potential participants (Final number was 322). Reasons for drop-out before randomization (17): Did not feel comfortable in group setting, severe depression and active suicidal thoughts.
- Drop-out during the group sessions: 11 from control, did not want to wait for services (8), hospitalized (2), suicidal attempt (1), 4 from experimental, did not want to continue in groups.
- Advertisements: Hospitals, psychiatric clinics, integrated family service centers, and community centers.
- Hong Kong Island, Kowloon (East and West), and the New Territories (Shatin, Tuen Mun, and Tung Chung).

Instruments:
- The Beck Depression Inventory (BDI), (Cronbach’s α = 0.90).
- The Almost Perfect Scale-Revised Version (APS-R) (Cronbach’s α = 0.73 to 0.87).
- The Abbreviated Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-18) (Cronbach’s α = 0.90).
- The Dysfunctional Attitude Scale (DAS) (Cronbach’s α = 0.92).
- All scales were validated for use with Chinese.
- Self-administered.

Fidelity to treatment:
- All CBT groups followed the same manual and protocols.
- Video-tapes of sessions 1, 4, 7 of 3 randomly selected CBT groups were reviewed by two independent judges (with clinical expertise) to rate the fidelity to treatment according to a rating sheet developed by the research team.
- Concordance rate between the two judges were high.
Demographic profile:
- Age (M = 42.72 years, SD = 8.73)
- Female (n = 250, 77.6%)
- Unmarried (n = 76, 23%), Married (n = 178, 55%)
- Secondary education (n = 190, 60% had completed a secondary education, tertiary education (n = 90, 28%)
- Full time employment (n = 127, 39%) Unemployed (n = 48, 15%)
- Duration of illness (M = 4.8 years, SD = 5.1)
- Had depression (n = 218, 67%)
- Receiving psychiatric depression (n = 200, 62%)
- Taking medication (n = 208, 65%)
- There was no significant difference between the experimental and control groups at pretest (all p > 0.22)

Table 1: Outcome Measures at Pre-Test and Post-Test, and Between-Group Difference (N=322)

<table>
<thead>
<tr>
<th>Metric</th>
<th>CBT Group</th>
<th>Control</th>
<th>ANCOVA</th>
</tr>
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<tbody>
<tr>
<td>Pre Post</td>
<td>Pre Post</td>
<td>CBT vs Control</td>
<td></td>
</tr>
<tr>
<td>C-BDI</td>
<td>M(SD)</td>
<td>M(SD)</td>
<td>F</td>
</tr>
<tr>
<td>Pre Post</td>
<td>0.9(0.49)</td>
<td>0.54(0.48)</td>
<td>0.9(0.49)</td>
</tr>
<tr>
<td>Q-LES</td>
<td>M(SD)</td>
<td>M(SD)</td>
<td>F</td>
</tr>
<tr>
<td>Pre Post</td>
<td>2.9(0.54)</td>
<td>3.24(0.58)</td>
<td>2.8(0.55)</td>
</tr>
<tr>
<td>Perfectionism - Discrepancy</td>
<td>M(SD)</td>
<td>M(SD)</td>
<td>F</td>
</tr>
<tr>
<td>Pre Post</td>
<td>4.95(0.81)</td>
<td>4.74(0.97)</td>
<td>5.16(1.5)</td>
</tr>
<tr>
<td>Perfectionism - High Standards</td>
<td>M(SD)</td>
<td>M(SD)</td>
<td>F</td>
</tr>
<tr>
<td>Pre Post</td>
<td>4.65(0.97)</td>
<td>4.31(1.11)</td>
<td>4.69(0.99)</td>
</tr>
<tr>
<td>DAS</td>
<td>M(SD)</td>
<td>M(SD)</td>
<td>F</td>
</tr>
<tr>
<td>Pre Post</td>
<td>4.02(0.74)</td>
<td>3.69(0.76)</td>
<td>4.14(0.8)</td>
</tr>
</tbody>
</table>

Table 2: Effect Sizes of the C-BDI, Q-LES, Perfectionism-Discrepancy, Perfectionism-High Standards & DAS Scales in Comparing the Post-Test Scores of the Experimental and Control Groups (N=322)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Cohen’s d</th>
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<tbody>
<tr>
<td>C-BDI</td>
<td>0.74</td>
</tr>
<tr>
<td>Q-LES</td>
<td>0.61</td>
</tr>
<tr>
<td>Perfectionism - Discrepancy</td>
<td>0.22</td>
</tr>
<tr>
<td>Perfectionism – High Standards</td>
<td>0.32</td>
</tr>
<tr>
<td>DAS</td>
<td>0.44</td>
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</tbody>
</table>

Table 3: Percentage of Participants in the Experimental Group who achieved an improvement in the C-BDI at Post-Test (N=163)

<table>
<thead>
<tr>
<th>C-BDI</th>
<th>N</th>
<th>Total % Improved</th>
<th>% Recovered (RCI&gt;1.96)</th>
<th>% Remitted (RCI&gt;1.28)</th>
<th>% Improved (RCI&gt;0.84)</th>
<th>Total % Deteriorated</th>
<th>% Deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Test &amp; Post Test</td>
<td>163</td>
<td>82.6% (N=133)</td>
<td>7.45% (N=12)</td>
<td>19.88% (N=32)</td>
<td>45.34% (N=73)</td>
<td>17.4% (N=28)</td>
<td>2.48% (N=4)</td>
</tr>
</tbody>
</table>
Discussion

Hypothesis 1 was largely confirmed: substantial decrease in depressive symptoms, better quality of life, and fewer perfectionist (i.e., high standards) and dysfunctional attitudes than control group at the end of the treatment.

82.6% in the experimental group showed improvement in depressive symptoms, 20% considered clinically remitted and 7.5% recovered.

Hypothesis 2 was also largely supported: Cognitive variables – perfectionism (high standards) and dysfunctional attitudes – significantly predicted depressive symptoms and quality of life of the participants in the experimental group.

Overall outcomes of this KT project:

A total of 1022 people with depressive symptoms or depression benefited from our workshop and groups.

22 social workers were trained to use CBT (i.e., 5 units have continued to run the groups and workshops regularly).

2 manuals and 1 client workbook have been published.

4 journal articles have been generated.

Current community partnership projects using SET model:

- Cognitive-behavioural therapy for parents with young children with disabilities in Hong Kong, Caritas Social Services, Hong Kong
- Cognitive-behavioural therapy for parents with adult children with disabilities in Hong Kong, Caritas Social Services, Hong Kong
- Cognitive-behavioural therapy for older adults with chronic pain in Hong Kong, Yan Oi Tong Social Services, Hong Kong
- Cognitive-behavioural therapy for school-aged adolescents in Hong Kong, Yan Oi Tong Social Services, Hong Kong
- Cognitive-behavioural therapy for adolescents and young adults with psychosis and emotional disorders in Hong Kong, Baptist Oi Kwan Social Services, Hong Kong

Other related KT projects, please visit http://ssweb.cityu.edu.hk/apss/home.aspx, then research unit – CCBT.
The End