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The Efficacy of Child Parent Relationship Therapy when Conducted in an Online Format on Levels of Parental Acceptance

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The Efficacy of Child Parent Relationship Therapy when Conducted in an Online Format on Levels of Parental Acceptance

by

Brenna M. Hicks

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
Department of Leadership, Counseling, Adult, Career and Higher Education College of Education University of South Florida

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Keywords: online therapy, parental acceptance, child-parent relationship therapy, filial therapy, family therapy, parental involvement

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Dedication

This dissertation is dedicated to God the Father, the giver of every good and perfect gift. And to Jesus, my Lord and Savior, for offering abundant life. “Now all glory to God, who is able, through His mighty power at work within us, to accomplish infinitely more than we might ask or think.” - Ephesians 3:20
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Abstract

Children's mental health is a topic of concern, not only in the escalating number of children who meet diagnostic criteria for disorders, but also for the practitioners desiring to treat them effectively. Parental involvement in treatment results in more favorable outcomes with longer treatment gains observed, thus reducing mental health issues.

An additional factor in children's mental health is the effect of levels of parental acceptance toward the child. Parental acceptance is a positive outcome that has been observed in previous studies conducted with Child-Parent Relationship Therapy (CPRT).

There are many reported barriers to seeking treatment for mental health issues, including time, cost, distance, and access. Online therapies have been found to reduce or eliminate most barriers to treatment, and is a preferred format for certain populations. To date, however, there have been no studies conducted on whether CPRT is effective in increasing levels of parental acceptance in an online format.

Eight participants from around the world completed the ten-week CPRT training in an online format. Levels of parental acceptance were measured by the Porter Parental Acceptance Scale (Porter, 1954; PPAS) in self-reported pre- and post-treatment assessments. A perception survey was also conducted to assess participants'
perception of the process of an online parent training format, including benefits and challenges.

This mixed-methods study found that an online version of CPRT does significantly increase parental acceptance levels. Participants also reported positive perceptions of the online training format. Positive themes reported in the survey responses related to convenience, community, access, and user experience.
Chapter One: Introduction

The mental health needs of children have increased within the last few years and are becoming more recognized as a necessary consideration for the comprehensive treatment of the child and family affected by dysfunction. Merikangas, Nakamura, and Kessler (2009) reported a growing prevalence of mental disorders in children, even as high as a quarter of the population. Interestingly, while recognition of the importance of early and effective treatment for children and their families has become more commonplace, significant barriers still exist (Corrigan, 2004; Richards et al., 2014). These obstacles to treatment, including access to therapists trained in children’s mental health, financial implications of weekly sessions, and the social and emotional stigma associated with therapy, prevent needed intervention. As therapists move toward higher levels of integration of traditional approaches and current technological capabilities, there is a unique and timely opportunity to explore the efficacy of offering therapeutic interventions in an online format.

Background of the Problem

The mental health needs of children are more evident than ever before, requiring an increased focus on providing effective and age-appropriate interventions. As practitioners seek to discover empirically validated treatments for children, it is important to note the reports of researchers who recommend including parents in treatment for better outcomes (Diamond & Josephson, 2005). Further, when parents are able to offer
higher levels of parental acceptance, their children’s psychological adjustment and mental health improves (Teichman & Kefir, 2000).

**Children’s mental health.** In a report by the Surgeon General more than ten years ago, it was estimated that more than six million children in the United States alone would meet diagnostic criteria for a mental disorder (United States Public Health Service, 2002). Costello, Egger, and Angold (2005) indicate that the prevalence of mental health disorders in children and teens is a median estimate of 12%, after synthesizing more than a decade of research. Other studies report far greater prevalence of mental disorders in youth, one documenting rates as high as 25% worldwide within the previous year (Merikangas et al., 2009).

The United States Department of Health and Human Services (1999) notes that children who meet criteria for a mental disorder suffer in several capacities: with peers, at home, and at school. Also reported is that more than 20% of children with a mental disorder face at least minimal, and often significant, impairment (United States Department of Health and Human Services, 1999).

The long term effects of undiagnosed or untreated child mental health disorders can be pervasive and significant. Merikangas et al. (2009) report that upwards of one third of children diagnosed with mental disorders in childhood will continue to meet criteria throughout their lifetimes. Untreated, childhood mental health disorders can become more of a challenge to effectively manage and treat, potentially even contributing to the development of comorbidity or co-occurring disorders (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). This awareness is reflected in the recommendation made by the Centers for Disease Control and Prevention (2013) that
timely diagnosis and empirically supported interventions, guided by recent findings and current data, is critical not only for children but for parents and the community as well.

**Child-parent relationships.** The nature of child-parent relationships is dynamic and complex. Studies reveal that children and parents are equal agents in constructing the nature and quality of the relationship (Kuczynski, Harach, & Bernardini, 1999). Further, parental involvement influences positive outcomes in therapeutic interventions (Diamond & Josephson, 2005). Finally, levels of parental acceptance are directly linked to children’s psychological adjustment and mental health (Teichman & Kefir, 2000).

**Bidirectionality.** Kuczynski and his colleagues (1999) developed a model representing the nature of child-parent relationships, acknowledging the reciprocal and transactional nature of each interaction. The history between the parent and the child, as well as the history of their relationship, influences the current and future interactions over time. This model emphasizes the interdependence of behaviors, and the impact on the child, parent, and relationship.

**Parental involvement.** Diamond and Josephson (2005) state that the inclusion of parents in the treatment of child mental health disorders increases the success and yields more positive outcomes than treatment for the child alone. Specifically, the growing involvement of parents in treatment is evidenced by this: “family risk factors and treatments now play an important role in many Practice Parameters set forth by the American Academy of Child and Adolescent Psychiatry” (p. 873).

**Parental acceptance.** Research supports the importance and the influence of parental acceptance in the lives of children and their upbringing (Lee & Chyung, 2014; Giotsa & Touloumakos, 2014; Teichman & Kefir, 2000). While there is a noted difference
between self-reported parental acceptance and a child’s perception of the level of parental acceptance, the impact remains significant on children’s mental health and psychological adjustment.

**Therapies.** Given the importance of early treatment for child mental health disorders, and the impact that parental acceptance has on children’s psychological adjustment, there must be consideration of effective interventions to address child-parent concerns and their relationship. Until recently, the lack of empirical support and practitioner application of family-oriented therapies was evident. In fact, the literature predominantly focused on the child and therapist relationship, unless the parents were needed as liaisons in the therapeutic work (McGuire & McGuire, 2001).

This is shifting to a more inclusive model, wherein the parent is considered a change agent within the therapeutic relationship for the child. However, at the root of these shifts is a deeply engrained and empirically supported approach that values the child’s ability to grow and create positive change from within their own strength; one such model is Child-Centered Play Therapy (CCPT).

**Child-Centered Play Therapy (CCPT).** Child-Centered Play Therapy has roots in Rogerian principles, stemming from Rogers’ (1951) person-centered approach. Rogers agreed with the foundation of humanism, but incorporated a strongly held belief that the client possessed the ability to change if given adequate therapeutic conditions to do so. The expansion of this model to children is credited mostly to Rogers’ student and later colleague, Virginia Axline (1947), who applied client-centered values to the unique needs of children through the medium of Play Therapy.
**Filial therapy.** The CCPT model values the characteristics that make each child an individual, but includes a trained therapist working with the child. While therapists report success with CCPT, offering parents the opportunity to better participate in the Play Therapy process is often helpful or desired. An extension of CCPT, Filial Therapy was created as a framework that builds upon the bond and experiences within the child-parent relationship, and trains parents to implement Play Therapy techniques with their children in a therapeutic manner.

**Child-Parent Relationship Therapy (CPRT).** One specific Filial Therapy model with substantial empirical support is Child-Parent Relationship Therapy (Landreth & Bratton, 2006; CPRT). This manualized treatment trains parents to conduct weekly play sessions with their child of focus after learning Play Therapy skills and principles. The parent then assumes the role of the therapeutic change agent for the child and in the child-parent relationship, in lieu of a therapist working with the child directly.

**Online therapy.** In 2013, the U.S. Census Bureau reported almost 84% of households in the United States have a computer, and more than 74% of households use the internet. Further, computer ownership and internet use are more likely among “young, Whites or Asians, the affluent, and the highly educated” (File & Ryan, 2014), which closely mirrors participants who may be likely to participate in CPRT. With continued growth of computer ownership and internet use worldwide, practitioners are continuing to seek online therapy options to better serve their clients’ mental health needs. Additionally, there is a growing trend toward modifying traditional, face-to-face therapy into an online format.
Interestingly, practitioners have documented successful mental health treatment online and with an integration of technology in their therapeutic services. Online therapy offers benefits that traditional counseling sessions cannot, and actually reduces or eliminates the most commonly cited barriers to attending a face-to-face session with a clinician (Anderson, Rothbaum, & Hodges, 2000).

**Statement of the Problem**

It is apparent that many children and their parents need mental health treatment and do not receive it. The few empirically validated interventions for children and their parents are often not widely accessible due to geographical, financial, or social factors (Anderson et al., 2000). There are also barriers to seeking and receiving therapy in a traditional, face-to-face context such as cost, distance, and stigma (Richards et al., 2014). However, the vast majority of families in the United States use computers and the internet (File & Ryan, 2014). An integration of an empirically supported mental health treatment for children and their families based in play therapy and online internet technology has not been explored, thus limiting the reach and options afforded to families in need of therapeutic interventions.

**Significance of the Study**

Within the last few decades, children and their families have become more of a focus within the provision of mental health services. Not only has there been a marked increase in demand and need for interventions for children, but researchers have noted several key considerations for the mental health treatment of families with young children. First, the inclusion of parents in mental health treatment increases positive outcomes (Diamond & Josephson, 2005). Second, children’s mental health is greatly
impacted by levels of parental acceptance (Teichman & Kefir, 2000; Giotsa & Touloumakos, 2014; Lee & Chyung, 2014). Third, there are several well-researched and empirically validated treatment models available to practitioners who work with children and their families, including Child-Parent Relationship Therapy (Landreth & Bratton, 2006). Finally, it is probable that parents with young children are more likely to be internet users and technologically savvy (Internet User Demographics, 2014), indicating a need for the exploration of integrating an existing intervention and an online format to aid children and their families with their mental health concerns.

In light of these considerations, it seems likely that existing empirically validated interventions for children and their families would be made available online to serve more families. Interestingly, while there are other intervention models that have been effectively offered online (Dittman, Sanders, Faruggia, Palmer, & Keown, 2014; Vismara, McCormick, Young, Nadhan, & Monlux, 2013), CPRT has only been offered in the traditional, face-to-face setting. This warrants investigation of the integration of CPRT and online technology, to best serve and meet the needs of children and their families.

Considering the documented barriers to entering into a therapeutic relationship in a clinical setting (Corrigan, 2004; Richards et al., 2014), offering an effective training in an online format would offer more breadth to therapeutic services. Reducing the mental health issues for children through proven interventions is paramount, and one such treatment is CPRT.
Investigating an online format of CPRT, as in the study proposed here, addresses these concerns, and provides a solution to a gap in the existing body of literature in the following capacities:

1. CPRT, although empirically supported in a traditional, face to face setting, has not been tested in an online format.
2. Families who may not take advantage of clinical treatments for a variety of reasons would be afforded a more convenient and accessible form of therapy.
3. CPRT has been shown to positively impact levels of parental acceptance.
4. Children with parents who demonstrate high levels of parental acceptance experience more psychological adjustment and increased mental health.
5. Parental involvement in child or family mental health treatment positively affects outcomes and gains.

As a result of addressing this gap in the literature, it is likely that offering CPRT in an online format will positively impact parental acceptance levels, and therefore children’s mental health. Further, children and parents will have greater access to a proven intervention for treating the mental health needs of children and their families.

**Purpose of the Study**

The purpose of this mixed-methods, exploratory study was to investigate the impact that an online version of CPRT has on levels of parental acceptance, as well as explore parental perceptions of CPRT in an online format. The quantitative data was analyzed with a correlated means t-test, and assessed data generated from responses on the Porter Parental Acceptance Scale (Porter, 1954; PPAS). The qualitative analysis
included thematic coding, and incorporated data collected from responses on a post-treatment survey. This data will help to inform and guide future research conducted.

The author’s objectives of this study were:

1. To explore the effects of an online format of CPRT on parental levels of acceptance;
2. To investigate parental perceptions of completing a parent training online;
3. To gain awareness of the challenges and benefits of the process of an online format.

Research Questions

This exploratory study aimed to answer the following questions:

1. To what extent does an online format of CPRT affect levels of parental acceptance of children?
2. What are the parental perceptions of the process of online parent training, including benefits and challenges?

Research Hypotheses

H$_1$: There will be a statistically significant increase in the self-reported levels of parental acceptance from pre-treatment to post-treatment.

H$_0$: There will not be a statistically significant increase in the self-reported levels of parental acceptance from pre-treatment to post-treatment.

Rationale. Other studies conducted implementing CPRT as the treatment model in a traditional, face-to-face setting have demonstrated positive treatment outcomes for levels of parental acceptance, as measured by scores on the PPAS (Porter, 1954). There have consistently been statistically significant increases in reported parental
acceptance levels with varied child and parent populations, as well as presenting issues within the family.

Considering the positive outcomes in a traditional, face-to-face setting on levels of parental acceptance after participating in CPRT, and with the belief that an online format will provide the same manualized treatment and instruction, the hypothesis is that the positive impact on parental acceptance levels will remain.

**Conceptual Assumptions**

Most therapeutic work occurs as a result of the alliance between the therapist and the client. This is true even for children in therapy, as the work occurs during the sessions behind closed doors while parents wait in the lobby. In this scenario, the parent is only marginally involved, to the extent of bringing the child to appointments and paying for the sessions. Filial therapy runs counter to this model, as the parent works as a collaborator with the therapist and participant with the child in the treatment. The parent becomes the change agent, implementing new strategies and techniques to equip the child to make changes while focusing on the child-parent relationship.

Child-centered play therapy, an adaptation of Rogers’ (1951) client-centered approach, is rooted in the belief that individuals have within them the capacity to grow and self-actualize within the confines of an accepting and congruent relationship. This foundation drives the interactions and playtimes that children and their parents experience during the process of CPRT. When the child is afforded freedom, acceptance, and opportunity to explore needs and wants in a safe environment, positive change can be observed.
It is important to note the connection made between the dynamics of the child-parent relationship; parental acceptance, parental stress, and child behavior are all interrelated. In other therapeutic models, the problem behaviors of the child are the focus, and the treatment is merely reduction to that end. Filial therapy, and more specifically CPRT, is grounded in establishing and nourishing a healthy bond between the child and parent by positively changing the relationship. As communication and respect increase between the child and parent, so do parental levels of acceptance toward the child; and therefore child behavior problems and parental stress levels decrease.

**Conceptual Framework**

Parent training in a therapeutic context incorporates theoretical foundations with practical application. Due to the complexities of the child-parent relationship, it is salient to have a model by which the interactions are evaluated and understood. Children and parents cannot maintain a relationship without reciprocal processes, each individual equally affecting both the other individual, and the relationship as a whole.

Therefore, Kuczynski and his colleagues’ (1999) model of bidirectionality is a very relevant and appropriate model within which CPRT can be framed. According to Kuczynski et al. (1999), children and parents interact rather than just react to each other and operate within basic assumptions about the relationship. Likewise, there is dualism present at all times; both between the individual and the interaction and between the interaction and the relationship. Essentially, there develops a two-way cause and effect, as further explained as such:
the daily out-of-control behaviors and the ineffective parenting behaviors are viewed as separate from, yet contributing to, the decay of the overall parent-child relationship over time. The parent-child relationship is further embedded in and influenced by external relationships, which in turn are embedded within larger sociocultural historical systems. (Kent & Pepler, 2003, p. 132)

This model of bidirectionality clearly explains and demonstrates the importance of the relationship between the child and parent, aligned with CPRT’s principle that if work is done to improve the relationship, the other concerns of stress, acceptance and behaviors resolve themselves. As such, Kuczynski and his colleagues’ (1999) model of bidirectionality will serve as the conceptual framework for this study.

**Graphic representation.** The nature of child-parent relationships can be graphically represented as three separate and distinct, yet related diagrams that depict their complex interactivity (Figures 1, 2, and 3). The relationship is driven by interactions (Figure 1), which are influenced by behaviors (Figure 2) and affected by influencers (Figure 3). These systems can operate independently, but also impact each other and the relationship interactivity as a whole. These diagrams, based loosely on Kuczynski’s (2003) presentation of the transactional models of bidirectionally, offer a visual representation of the factors that shape child-parent relationships.

**Relationship interactions between child and parent, Figure 1.** As more and more research has emerged following Bell’s (1968) seminal work on child-parent relationships, it has become clear that the nature of these relationships must be viewed in terms of long-term, transactional processes. The history of interactions between the child and parent is just as significant as the current interaction. As such, the past history
that is shared between the child-parent dyad provides expectations to current
interactions. These infinite interactions that occur over time not only transpire as an
independent transaction within the relationship, but then serve to influence future
interactions. Both the child and parent are shaped by the other as a result of the
previous interaction, and this process continues for the duration of the relationship.

*Figure 1: Relationship interactions between child and parent*

**Relationship behaviors in the child-parent relationship, Figure 2.** Just as
transactions over time continually shape the child-parent relationship, the behaviors of
the child and parent also influence the relationship. The relationship itself operates as a
distinct third component, affected by and affecting behaviors within the dyad. Therefore,
past behavior is both affected by and affects the relationship, as does current and future
behavior. It can be thought of as interdependence of behaviors, for the child, parent,
and relationship. Further, the assumption is made that the behaviors of the child and parent are equal in their agency and influence in the relationship.

*Figure 2: Relationship behaviors in the child-parent relationship*

*Relationship influencers for the child and parent, Figure 3.* Influencers, both internal and external, also impact the child-parent relationship. An additional contributing element to influencers is that not only is the child-parent relationship involuntary in nature, but so are the influencers that affect the child, parent, and the relationship. The influencers that impact the relationship are social, cultural, individual, behavioral,
emotional, psychological, biological, and physical. As these influencers change due to circumstances, growth, or adjustment, the nature of the relationship between the child and parent must change as well. It represents a completely dynamic process.

Figure 3: Relationship influencers for the child and parent

Conceptual Hypotheses

As the transactional models of bidirectionality (Kuczynski et al., 1999) posits and the conceptual graphic representations above reflect, child-parent relationships are co-
created, co-shared, and co-exist amidst internal, external, behavioral, longitudinal, and transactional factors. Therefore, if the past or current relationship interactions or behaviors are negative, the future relationship is affected negatively. Conversely, if children and parents are given tools and skills to create positive behaviors, communication, and interaction, it affects the future relationship positively as well.

Child-Parent Relationship Therapy operates under the fundamental assumption that creating positive change in the child-parent relationship requires focusing on the bond between the child and parent. When mutual respect, understanding, communication, and acceptance are introduced to the dyad through the skills and techniques in CPRT, improvement is noted in every subsequent interaction, behavior, and influencer that impacts the child-parent relationship. Therefore, the conceptual hypotheses are formed under the recognition that CPRT addresses the major components of the transactional models of bidirectionality (Kuczynski et al., 1999), and therefore will effectively and significantly influence the child-parent relationship in a positive manner.

**Definition of Major Terms**

**Child-centered play therapy.** This is the model upon which CPRT was created. It is based on Rogers’ (1951) client-centered approach to therapy, which espouses individuals are capable and willing to grow and create positive change within the safety and confines of a warm and accepting relationship. When children are afforded unconditional acceptance, opportunities to explore their desires in a safe environment, and freedom from restriction, healthy self-actualization occurs.
**Filial therapy.** Filial Therapy was created by Bernard and Louise Guerney (1969) as a method of strengthening the child-parent relationship through play therapy principles. A trained therapist teaches and instructs the parent to set limits, build self-esteem, listen effectively, and reflect the child's feelings in at-home play sessions. This creates a safe environment where acceptance and understanding provide an opportunity for the child to process and explore emotions and needs, individually and within the context of the child-parent relationship. Filial Therapy can be provided individually or in a group setting.

**Child-Parent Relationship Therapy (CPRT).** This is the specific, manualized protocol that professionals trained in play and filial therapy use to educate parents to implement play therapy skills into their parenting approach. This approach trains parents to respond in such a way to their children that therapeutic growth and change occur, as the parent acts as the change agent. This training includes weekly instruction with the therapist, homework assignments, video-recorded playtimes with the child of focus, and supervision and feedback during group sessions.

**Online format.** Online format is defined as the method by which CPRT is provided to parents. This includes login access to the restricted area of the website; video delivery of the manualized instruction; synchronous group sessions to address questions, concerns, and homework; watching of weekly playtime videos for feedback; and comment boards for support and encouragement amongst the group members.

**Bidirectionality.** This is the construct explaining the complex nature of child-parent relationships developed by Kuczynski and his colleagues (1999). It explains that children are changed by their parents and parents are changed by their children through
each interaction within the child-parent relationship. Every aspect of the child and parent is viewed within the framework of the longitudinal and transactional process of the child-parent dyad.

**Levels of parental acceptance.** Levels of parental acceptance is defined as the parents’ score on the PPAS (Porter, 1954), and further indicated by scores on the following subscales: Loves Child Unconditionally, Appreciation of the Child’s Unique Makeup, Recognition of the Child’s Need for Autonomy and Independence, and Respect for the Child’s Feelings and Right to Express Them.

**Perception of the process.** Perception of the process is defined as the self-reported responses to a post-treatment survey. This survey will request thoughts, comments, benefits, challenges, recommendations, and suggestions about their involvement and participation in an online parent training program.

**Weekly playtime.** Weekly playtime is defined as 30-minute video-recorded playtimes that the parent conducts with his or her child of focus at home, implementing and practicing the skills taught in the group session.

**Child of focus.** Child of focus is defined as the child, between the ages of two and ten, selected by the parent to participate in weekly playtimes.

**Scope and Delimitation of the Study**

For the purposes of this study, the author limited the scope to the effect that CPRT has on levels of parental acceptance. Other studies that have been conducted with CPRT include the effect the intervention has on levels of parental stress, perceived parental empathy, and child behavior problems. Although these are important to consider, these were not the focus of this study.
The participants in this study were limited to parents who have children between the ages of three and 10. Parents of teenagers were not included, nor were parents who specifically wished to participate in a parent training for assistance with behavior problems in their child. While there are certainly other reasons that parents would choose to take a parent training, especially with older children, those parents were not included in this study. CPRT is designed to increase the bond, communication, and respect between children and their parents, thereby positively impacting mental health of the child and family. Although behavior problems are often resolved or reduced as a result of participating in CPRT, that was not the focus of this study.

Further, the participating parent chose one child with whom to conduct the weekly playtimes, even if the parent had more than one child. Although the parent may have wanted to work with more than one child at a time, this selection of a child of focus aligns with the structure and method of CPRT and will be implemented in this study.

The parent training model for this study was CPRT, with integrity to the model and fidelity to the manualized approach paramount. Although there are many other parent training interventions for children and their parents which could be compared on levels of efficacy that have foundations outside of child-centered play therapy, these were not included in this study.

The nature of the perceived behavior problems of the child of focus was also not of interest in this study. In other CPRT research, assessments provide specific details about behavioral areas of concern and are further analyzed to determine efficacy of the treatment in the measurement of reduction of unwanted behaviors. However, this
remained outside the scope of this study, with the exception of the mention of behavioral changes in the survey responses.

**Summary and Overview**

Children’s mental health is extremely important to current and future functioning and success. Unfortunately, the mental health needs of children are often not effectively identified nor treated. This has emotional, social, and psychological ramifications for children and their families (Merikangas et al., 2009). Further, if the child begins therapeutic treatment for a mental health issue, parental involvement in therapy increases outcomes and longevity of gains (Diamond & Josephson, 2005).

Due to the unique influence of child-parent relationships on both parties, every transaction between the child and parent affects subsequent interactions. These can positively or negatively impact the dynamic in the relationship (Kuczynski et al., 1999). Levels of parental acceptance within the child-parent relationship also influence psychological well-being for children (Teichman and Kefir, 2000).

There are therapeutic models that build upon the unique strengths and bond of children and their parents. Child-Centered Play Therapy, and the inclusion of parents in the treatment through Filial Therapy, are effective models of treatment for children’s mental health issues. More specifically, CPRT is empirically supported for children and their parents as an effective treatment option (Bratton, Ray, Rhine, & Jones, 2005).

There are often children who go untreated for their mental health issues due to a variety of factors. Some commonly reported barriers to traditional treatment are distance or location, access to therapists specialized in children, high cost, and negative stigma (Richards et al., 2014). However, the majority of families with young children have
computers and use the internet (Internet User Demographics, 2014) and could potentially be better served through an online intervention for their mental health needs.
Chapter Two: Literature Review

Children’s mental health is a significant concern with lasting implications, for the children, but also families and society as a whole. The mental health needs of children are becoming more prominent and pervasive (Merikangas et al., 2009), and considering the factors that influence positive outcomes in treatment is more pertinent than ever before.

One of the factors that contributes to children’s mental health is the child-parent relationship. Studies indicate that parental involvement in therapy promotes better outcomes and longer-lasting gains for the child, and positively impacts the family system as a whole (Silverman & Hinshaw, 2008; Cates, Paone, Packman, & Margolis, 2006).

It is also demonstrated in the literature that levels of parental acceptance can positively or negatively influence children’s psychological well-being and mental health. The levels of parental acceptance, both perceived and reported, affected both children’s and teenagers’ psychological adjustment.

It follows, then, that addressing the mental health needs of children would require an early and effective treatment, involve parents in the process, and increase levels of parental acceptance. All three components are met with the child-centered play therapy model of filial therapy, Child-Parent Relationship Therapy (Landreth & Bratton, 2006).
Children’s Mental Health

The Department of Health and Human Services (2001) reports that children who need mental health treatment who actually receive it may be as low as seven percent, even though the prevalence rate of children’s mental health disorders and diagnoses is as high as 25% within the last year (Merikangas et al., 2009). Considering the extent to which children are affected by mental health disorders both in prevalence and daily functioning, early diagnosis and interventions are paramount. Unfortunately, studies report that it is common to observe significant delays between the initial symptoms and the decision to seek treatment for children, even with empirically supported therapeutic interventions available (Kessler et al., 2005).

Possibly more concerning is that current literature indicates that only a small percentage of children are receiving mental health treatment. While some studies report as many as half of minors with mental health disorders receive appropriate interventions (Merikangas et al., 2009), the Department of Health and Human Services (2000) records a much lower rate of 20% of children who are identified and treated. In a subsequent report the following year, the Department of Health and Human Services (2001) reported that a mere seven percent of children who should receive help from mental health professionals are treated.

The impact that child behavioral and mental health disorders can have on society is significant. Chronic problems with behavior and conduct in childhood is directly and positively correlated with antisocial behavior in adulthood (Gross et al., 2014). Further, 65% of children whose aggression and behavioral problems begin in preschool and continue at age seven are still struggling with mental health problems in adulthood; this
also commonly leads to criminality and juvenile delinquency (Broidy et al., 2003). Also noted is the more pervasive the childhood disorders are and the longer left untreated, the more likely the child will be limited in earning potential as well as productivity in adulthood (Currie & Stabile, 2006).

Upon reviewing the data, it becomes very clear that untreated child mental health disorders affect more than just the child. Additionally, programs designed to intervene and assist children struggling with behavioral and mental health issues are costly and mount quickly. Gross and her colleagues (2014) note that the cost per child that society must bear can surpass more than $60,000 once “mental health services, grade retention, special education, and juvenile justice involvement” are considered (p. 2). It is therefore extremely important to prevent the longterm burdens on the child and the community by early identification, intervention, and treatment.

**Child-Parent Relationship**

As each interaction between the child and parent influences the next, increasing communication and understanding to yield a healthy child-parent relationship is important. Further, parental involvement and parental acceptance are both correlated to mental health in children, and are shown to positively impact treatment outcomes and psychological wellbeing.

**Model of bidirectionality.** The literature indicates that the child-parent relationship serves as a third party when considering the impact of interactions on both the child and the parent (Kuczynski et al., 1999). Each conversation and communication equally affects the child, parent, and the relationship forever and continually.
**Origins.** The formation of theoretical underpinnings for child-parent interactions originated with Bell's (1968) research on the effects that parents have on their children, Hartup's (1978) “social mold” model describing child-parent socialization, and Sameroff’s (1975) focus on the reciprocal and recurrent interactions between children and their parents over time. Interweaving elements from all three and integrating new research, Hinde and Stevenson-Hinde (1987) expanded upon the former frameworks to make note of the difference between child-parent relationships and child-parent interactions. With further expansion of the theory and recognition of the dualism in child-parent relationships, Lollis and Kuczynski posited in 1997 that “the behaviors of the parent and child are linked, one giving rise to the other, in cycles of reciprocal causality” (as cited in Kent & Pepler, 2003, p. 131).

Kuczynski and his colleagues (1999) then integrated three decades worth of research and enlarged its application to develop the model of bidirectionality. This model operates with four major tenets: bidirectional causality, the child-parent interaction in the relationship, power having interdependent asymmetry, and equal agency.

**Application.** Bidirectional causality assumes that children change their parents and parents change their children while interacting with each other. This takes place over time through a continuous process that remains reciprocal. The child-parent interaction tenet assumes that both the child and parent have interest in sustaining the relationship in which the child’s development and behaviors are simultaneously supported and constrained. The tenet of power assumes that there is an interdependent asymmetry within the child-parent power balance, allowing for both children and parents to employ their own resources as a result of their culture, development, and the quality
of their relationship with each other. Finally, the tenet of equal agency assumes that every interaction between a child and parent hinges upon purposeful, strategic, and goal-driven characteristics (Kent & Pepler, 2003).

While it is reportedly somewhat arbitrary to make a distinction between child-parent relationship and child-parent interaction, it is worthwhile to note that there exist different perspectives. Child-parent relationships are viewed through a macroanalytic lens, while child-parent interactions are microanalyzed. Regardless of perspective, however, current research indicates that relationships and interactions are bidirectionally interconnected. Therefore, "the interactions in which parents and children engage are the building blocks for the relationship that parents and children have together and the resulting relationship at the same time provides the dynamic context for their interactions" (Lollis & Kuczynski, 1997, p. 442).

Similarly, Pettit and Arsiwalla (2008) reported that the perspectives on child-parent relationships needed to be reevaluated and reinterpreted after Bell’s (1968) research was disseminated. It became clear that merely studying the effects that parents had on their children did not address the multitude of other influences, warranting a more comprehensive and varied perspective to include "the conditions under which child or parent effects may be more or less potent, and on how growth over time in parent or child attributes may hinge on the early and continuing history of the parent-child relationship" (p. 711).

These beliefs that emerged regarding the intricacies and complexity of child-parent interactions serve to support an approach that includes both the child and parent in mental health treatment. According to bidirectional causality, one cannot separate nor
remove the influence of children and their parents; therefore, a child’s behavior issues cannot be addressed independently of their role and relationship within the child-parent dyad.

**Parental involvement.** Taking into consideration the influence of bidirectionality on the child-parent relationship, it is prudent to involve parents in the therapeutic process for mental health issues. Parental involvement in child therapy has been proven to greatly influence therapeutic outcomes. While there is clearly a distinction between family therapy and parental involvement in children’s therapy, several studies indicate that “family-based treatments” are effective and beneficial (Diamond & Siqueland, 2001; Liddle & Rowe, 2004; Sprenkle, 2002). In fact, Shadish and Baldwin (2002) conducted a meta-analytic review of 162 studies, and reported that such therapies are equally as effective as other interventions, and significantly more effective than no treatment.

The inclusion of parents in therapeutic treatments has not only increased positive outcomes, but it has also proven effective with many childhood mental health issues. Including both children and parents in interventions has been found to be effective with obsessive-compulsive disorder (Barrett, Healy-Farrell, & March, 2004), and attention-deficit hyperactivity disorder and oppositional defiant disorder (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001). Other studies have demonstrated efficacy with depression (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002), and anxiety (Ginsberg & Schlossberg, 2002).

Research has also demonstrated that when parents are involved in the treatment with their children, learned coping strategies are especially helpful for the emotional well-being of the entire family (Mendlowitz et al., 1999; Silverman & Hinshaw, 2008).
Further, positive gains observed during the therapeutic process continue after the sessions have ended when parents continue to implement the skills to build a stronger relationship with their child(ren) (Cates et al., 2006). There is also evidence that when both parents are involved in treatment with their children, levels of marital functioning are higher; this leads to a positive influence on the child’s reaction and response to the intervention as a whole (Bagner, 2013).

One of the marked changes in recent practice for treating both children and parents is the shift in the roles that parents play in therapy. Parents are now not only included in the process, but encouraged to participate in such capacities as encouragement and support, instructors, joint or assistant therapists, or as clients (Diamond & Josephson, 2005). By including parents in a more prominent manner during treatment, therapists are able to offer more comprehensive interventions to treat a wider range of disorders, and children achieve more positive outcomes and more long-lasting gains from the interventions.

**Parental acceptance.** Parental acceptance has been shown to greatly influence not only children’s mental health, but also psychological adjustment. However, it is important to acknowledge that the study of parental acceptance is not new or novel. Much of today’s understanding of parental acceptance and its influence in the lives of children stems from one of Schaefer’s (1961) orthogonal dimensions of parenting behavior: acceptance-rejection. This dimension measures the level to which the parent does or does not demonstrate positive emotions toward their child. According to Teichman and Kefir (2000), these are displayed in the expressions of “understanding,
consent, expression of emotions, encouragement, and response to the child’s expectations” (p. 194).

Although there are studies that span the last five decades on this topic, a brief perusal of current literature reveals it is still garnering attention and research. A recent study examined the effect that perceived parental acceptance had on children’s psychological adjustment in Bangladesh (Uddin, Khaleque, Aktar, & Hossain, 2014). Uddin and colleagues (2014) report that perceived parental acceptance from both mothers and fathers was significantly correlated with both boys’ and girls’ psychological adjustment.

Another study measuring the same relationship between children’s psychological adjustment and parental acceptance was conducted in Korea (Lee & Chyung, 2014). Lee and Chyung (2014) indicate that both maternal and paternal acceptance significantly and highly predicted boys’ and girls’ psychological adjustment.

Expanding the study to pre-adolescents in Greece rather than children, researchers investigated the correlation between perceived parental acceptance and psychological adjustment of pre-adolescents (Giotsa & Touloumakos, 2014). The authors report that there is significant correlation between boys’ psychological adjustment and paternal acceptance. Interestingly, is that girls’ psychological adjustment is significantly correlated by maternal acceptance. In both cases, however, psychological adjustment for pre-adolescents regardless of gender is predicted by perceived levels of parental acceptance (Giotsa & Touloumakos, 2014).

Hare, Marston, and Allen (2011) also conducted a study with adolescents, assessing the statistical relationship between perceived maternal acceptance and
emotional communication. This longitudinal study indicated that the higher the perception of maternal acceptance in early adolescence, the greater both the observed and self-reported emotional communication three years later (Hare et al., 2011).

Not only is it clear that pre-adolescents’ psychological adjustment is highly correlated with parental acceptance and that the perceived parental acceptance early in adolescence affects emotional disclosure years later, the impact of parental acceptance reaches farther than just the emotional and psychological health of children. Another related study reports evidence that adolescents’ perceptions of parental rejection or acceptance influences their likelihood to use and attitude toward the use of psychoactive substances (Teichman & Kefir, 2000).

A study conducted in Bosnia and Herzegovina with sexually abused children and adolescents, who are especially sensitive to parental acceptance and rejection, revealed that there was a significant relationship between maternal parental acceptance and their psychological adjustment (Vural, Hafızoğlu, Türkmen, Eren, & Büyükuysal, 2012). Though these children and adolescents were court ordered to receive psychological evaluations, these results support other data indicating the importance of parental acceptance for the general psychological health and well-being of children and adolescents.

Rooted, in part, in the overwhelming evidence that parental acceptance can either help or hinder children’s mental health and psychological adjustment, Landreth and Bratton (2006) included an assessment to measure levels of parental acceptance as part of the CPRT curriculum. The Porter Parental Acceptance Scale (PPAS; Porter, 1954) assesses the degree to which the parent demonstrates acceptance of the child in
the following four subscales: respect for the child’s feelings and his or her right to
express them; appreciation for the unique makeup of the child; recognition that the child
needs autonomy and independence; and unconditional love.

One of the foundations upon which CPRT is built is that when parents interact in
more respectful and supportive manners with their children, behavior problems are
reduced by nature of the improved communication and bond established between the
parent and child. Parental acceptance, measured by the subscales of the instrument, is
one significant indicator of a healthy child-parent relationship (Landreth & Bratton,
2006).

Child-Parent Therapies

There has been recent development in the literature demonstrating the
importance of including families in treatment (Sprenkle, 2002). Further, science-based
therapeutic interventions for families seeking assistance have been also noted (Liddle,
Santisteban, Levant, & Bray, 2001).

As support for treating children and their families grows, Lebow (2008) notes that
providing treatment to children and their families is no longer as static and regimented
as it once was. There is more freedom and liberty afforded to clinicians as they offer
interventions tailored to each child and family. With this freedom comes the flexibility to
offer individual or group sessions to parents or children as part of the process of skill-
building, establishing plans for upcoming meetings, or creating and strengthening bonds
(Diamond, Siqueland, & Diamond, 2003).

Interventions that include children and parents have been found to be effective in
and of themselves, but also have benefit used collaboratively with other treatments. In
fact, “engaging parents in the treatment process … can contribute to better treatment engagement, retention, compliance, effectiveness, and maintenance of gains” (Diamond & Josephson, 2005, p. 872).

**Child-centered play therapy.** An adaptation of other theories, child-centered play therapy focuses on the child’s innate ability to change and grow, given an environment conducive to doing so. Therapists are trained to encourage the child by wholly accepting him or her, without expectation or direction.

**Historical origins.** Several theorists, including Vygotsky, Winnicot, and Piaget, noted the importance of play for children in their growth and development. Play affords children the opportunities to develop skills, express their wishes and needs, and gain mastery over situations (Brodin, 2005). Landreth (2002) discusses children’s discovery process during play, relative to themselves, others, and the world around them.

Although there are several theoretical influences evidenced in the literature, play therapy has origins in Piaget’s (1951) play stages and Axline’s (1947) child development research. Child-centered play therapy, a model of play therapy, has its foundation in Roger’s (1951) Client Centered Theory. By modifying and implementing the core conditions of genuineness, empathy, and unconditional positive regard, Axline (1947) expanded these to five required principles when treating children; these include permissiveness, acceptance, reflection of feelings, rapport, and respect for the child’s autonomy.

Axline’s (1947) principles, eight core tenets of child-centered play therapy, were later revised by Garry Landreth (2002) and are frequently reported as guidelines for
working with children, helping to create the accepting environment necessary for self-reflection and self-discovery. The eight principles are:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist must accept the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behaviour.
5. The therapist maintains a deep respect for the child’s ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child’s.
6. The therapist does not attempt to direct the child’s actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make to the child aware of his responsibility in the relationship. (Axline, 1947, pp. 73-74)

Through Landreth’s (2002) expansion of Axline’s (1947) foundational concepts, general objectives in therapy were established in lieu of specific goals. The child’s ability and right to guide his or her journey dictates that the therapist respect and allow for self-
directed play therapy sessions, inherently believing in the child’s capacity for change through actualization. Landreth (2002) indicates that the objectives for child-centered play sessions are:

1. Develop a more positive self-concept.
5. Become more self-reliant.
7. Experience a feeling of control.
8. Become sensitive to the process of coping.
9. Develop an internal source of evaluation.
10. Become more trusting of self. (p. 80)

In order for the child to fully benefit from child-centered play therapy, the therapist must embrace the child’s instinctual drive to grow, yet all the while not pushing the child in that direction with therapeutic directives or structure (Landreth, 2002). The power of the self-guided process encourages and allows for the development of self-esteem and decision making skills, as well as increased self-responsibility. The freedom to make choices is significant to the process as it is afforded in play sessions, but prohibited in most other interactions with adults at school or at home. Change in the child emerges as an internal locus of control is developed, with methods for self-regulation and self-control in place.
The Association for Play Therapy (2009) explains the play therapy experience as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (para. 2). Of note, however, is that this process can only occur within the confines of the relationship between the child and the therapist who genuinely and wholly accepts the child at his or her deepest core. Behaviors and attitudes become overshadowed by the belief that the child is innately good and able to effect change within him or herself.

Once the child is able to trust in the therapist’s complete and unconditional regard, it is then that the child will begin the self-discovery and self-exploration process necessary for change (Axline, 1974).

This process, based on the belief that the child will use toys as his or her words and play as his or her language, is not rooted in therapeutic conversation with the child. Rather, it becomes a complex dance of feelings, behaviors, and actions between the therapist and child, allowing for the freedom of expression of their inner world. Often, due to age or past experiences, a child is unable to effectively verbally communicate his or her desires and needs. The child-centered therapist not only recognizes this, but embraces the power of play to provide the outlet for such expression (Landreth, 2002).

**Filial Therapy.** Filial therapy, with theoretical underpinnings of play therapy, embraces the role that parents play in a therapeutic intervention. Parents are heavily involved in therapy, trained to implement skills and techniques with their children, both in conjunction with and independent of the therapist.
**Historical origins.** There is paucity in the literature regarding the beginnings of filial therapy previous to the 1960s. However, the earliest origins of filial therapy can be traced back to the turn of the twentieth century, in 1909, when Sigmund Freud worked with the father of a five year old boy named Hans. During these sessions, Freud (1959) instructed the father how to respond during play sessions with Hans to alleviate his anxious and phobic behaviors.

Additionally, in the middle of the century, there is documentation of play sessions with children and parents at home modeled after Axline’s sessions (Baruch, 1949). Then almost a decade later, there are recorded play sessions with a daughter to overcome emotional issues (Fuchs, 1957), and specific details of home play sessions documented with a child and his or her parents (Moustakas, 1959).

To this point, however, these sessions were viewed merely as helpful play times. While there was evidence of the initial understanding and awareness of the power of play between a child and his or her parents, and even the promotion of parents in the role of the therapeutic change agent, there was no formal training, supervision, or processing of the sessions.

In the early part of the 1960’s, the Guerneys (1969) officially developed the filial therapy process, largely from the work of Rogers (1951) and Axline (1947). The Guerneys recognized the impact that parents have on their children, stemming from their emotional connection, and capitalized on that relationship for the benefit of the child (B. Guerney, 1969). Heavily involving the parent in therapy, in a partnership with the therapist, was unheard of at that time.
By recognizing the influence and significance that parents have in their child’s life, the Guerneys (1969) worked to educate and equip parents who were previously lacking information and tools to effectively parent their children. Rather than dwelling on the emotional, social, or behavioral concerns in their child, they switched the focus to becoming an agent for change by responding differently.

Several decades later Rise VanFleet (1994), who trained under the Guerneys, also worked with children and families using a filial therapy model. VanFleet modified the Guerneys’ approach both by creating three distinct phases in treatment, as well as implementing the process with individual families instead of in a group setting.

**Model.** Filial therapy is typically conducted within an average of 10 to 20 sessions, and therefore traditionally a short-term treatment. It is a didactic model, including a psychoeducational format, that provides skills and information to families facing problems as a result of unexpected situations for which they are ill-equipped (VanFleet, 2011).

Filial therapy is conducted with several constructs guiding its foundation and implementation (VanFleet, 2011). Foremost, it is process-oriented and rooted in the belief that relationships within the family are strengthened by the principles of play. As this occurs, goals for the children, parents, and family unit are achieved. Additionally, therapists trained in play therapy who implement the model effectively impact the goals as well, so treatment fidelity is crucial.

Second, both children and parents are empowered through filial therapy. As relationships are the focus, rooted in a perspective that children and parents can effectively address and repair the majority of their own issues, children and parents are
able to openly communicate with each other. The loving and safe environment established in filial therapy sessions carries over into the family environment as well.

Third, parents are treated as co-therapists. The relationship between the parents and therapist is one of symbiosis and collaboration, and recognizes what the parent can offer about their child(ren). The therapist educates and trains the parent with skills and principles of play therapy, and the parent offers continual insight and information regarding the nature of the relationship.

Finally, the value of play is recognized and embraced by the therapist. Play serves as a method to improve communication, strengthen bonds between family members, and reduce problems and concerns among family members. Through the implementation of a model that is sensitive to developmental considerations, the majority of issues decrease or are corrected as both children and parents gain awareness about themselves, others, and the world through playing (VanFleet, 2011).

**Child-Parent Relationship Therapy**

Garry Landreth, with extensive experience working with children and play therapy, joined the Guerneys in implementing filial therapy training in the late 1960s within the academic setting. At that time, the Guerneys’ model included two-hour weekly meetings for a full year (B. Guerney, 1969). They eventually streamlined it to six months, but Landreth wished to shorten the required commitment for parents to make it more practical for families.

After working within the length of an academic semester, typically fifteen to seventeen weeks, Landreth realized that four months of weekly sessions yielded substantial attrition rates. Upon reducing the training to ten weeks, and co-authoring a
10-session model called Child-Parent Relationship Therapy (CPRT), he was able to retain participants and found positive outcomes similar to the longer alternatives (Landreth & Bratton, 2006).

CPRT is defined as:

a therapeutic intervention that can help children by teaching parents basic child-centered play therapy principles and methods to use with their children. Parents learn to become a constructive force for change in their children’s behaviors and attitudes by utilizing basic play therapy skills in once-a-week 30-minute play sessions with their children. Throughout the process, parents receive on-going training and direct supervision from a trained play therapist. (Bratton, Ray, Rhine, & Jones, n.d., p. 1)

Landreth and Bratton (2006) created this model for use with children ages two to 10 and their parents, as a “parent education adaptation” (Van Fleet, 2011, p. 154). CPRT is a ten-week model requiring weekly sessions for the therapist and parents. This treatment model is traditionally implemented in a group of six to eight parents. While CPRT has been offered in an individual setting as well, it is preferable that it is conducted in a group context because of “the group dynamics feature and the vicarious learning that is always available to parents” (Landreth & Bratton, 2006, p. 114).

Following the weekly meeting between the parents and the therapist, the parent then video records a thirty-minute special play time with the child of focus at home. This play time offers the parent the opportunity to implement and practice the skills discussed in the therapist session as well as to become more comfortable with the application of previously learned skills. The special play time is watched with the group
in the following session, and allows for feedback, discussion, and supervision for each parent. Additionally, viewing the special play time offers the other parents the chance to gain perspective, insights, and learn from each other through modeling of the skills (Landreth & Bratton, 2006).

Throughout the course of the 10 weeks, homework assignments are also required, as a means by which the parent remains engaged and invested in the treatment in between sessions. These assignments are reviewed early in each session, which allows for stories and personal experiences to be discussed and processed. Homework is one element of the process, as “experiential activities including demonstrations, role play, and supervision of videotaped home play sessions are crucial to parents’ success in learning the skills and are utilized liberally throughout each training session” (Landreth & Bratton, 2006, pp. 114-115).

The CPRT manual includes three assessments to measure the efficacy of the treatment. Each of the assessments is unpublished, but has been consistently implemented for decades as pre- and post-treatment measures to monitor and confirm differences in scores as a result of therapy. The assessments included with CPRT are the Filial Problems Checklist (FPC), Porter Parental Acceptance Scale (PPAS), and the Measurement of Empathy in Adult-Child Interaction (MEACI).

The FPC and PPAS (Porter, 1954) are self-report assessments. The PPAS (Porter, 1954) measures the level of parental acceptance exhibited toward the child of focus; the FPC measures how the child’s behavior is perceived by the parent. The MEACI, however, includes direct observation of parents and their child of focus by a trained observer during the video-recorded special play time, and requires
comprehensive training and necessitates inter-rater reliability. Not all assessments are required or implemented every time CPRT is conducted, but offer the therapist a wide range of options to measure outcomes (Landreth & Bratton, 2006).

As the quality of the relationship between the child and parent has been significantly correlated with both emotional and behavioral issues in childhood as well as mental health, it is especially helpful that CPRT increases the bond and communication between the child and parent (Vural et al., 2012). Unfortunately, however, this training is not always readily available for families due to geographical location, lack of training centers, or access to practitioners.

Online Therapy

When online therapy emerged in the 1990’s, the initial impressions were not favorable; there was skepticism about its practicality and criticism that it could not compete with traditional face-to-face sessions (Goss, Robson, Pelling & Renard, 1999). In recent years, as more online therapy sessions have been conducted and more research has been reported, there is support that it is not only effective, but favored in certain circumstances (Anthony, 2010).

The literature reveals that there are many barriers to seeking therapy even after individuals acknowledge their need and want for professional help, citing both internal and external factors (Corrigan, 2004). Several of the external factors reported are extended waiting times for an appointment, inconvenient hours or service, and lack of privacy in waiting rooms. Richards and colleagues (2014) report additional barriers including negative views of psychological and psychopharmacological treatment, resistance to change, personal stigma, and financial cost. It is not surprising then that a
significant number of individuals who schedule an initial session never go, and 40% of first-time clients do not return for a follow-up appointment (Garfield, 1986).

Online therapy provides effective solutions to these concerns; clients seek and receive treatment from their homes, it is convenient, and easily accessible. Also, clinicians are integrating their therapy services with technology, noting benefits for their practice and their clients. There are several studies reporting on this fusion of mental health and technology from more than a decade ago: therapists and clients are afforded conveniences not provided in traditional counseling sessions (Anderson et al., 2000); improvement and modifications can be made on existing therapies (Heimberg & Coles, 1999); and information and interventions can reach further and meet the needs of the underserved (Bouchard et al., 2000).

Within the last five years, a run of studies on the topic have emerged, incorporating technology in unique and constantly expanding methods. For example, clients have participated in mental health treatment in virtual realities (Riva, 2009); through emails, chat rooms and videos (Simpson, 2009); and with cellular phones (Prezziosa, Grassi, Gagglioli & Riva, 2009).

In addition to the growing channels for technology in therapeutic interventions, there are reported benefits providing a rationale for their integration. Among the benefits are cost effectiveness (Hollinghurst et al., 2010); efficacy with anxiety (Hoffman, 1999; Riva, Molinari & Vincelli, 2002); efficacy with depression (Richards & Richardson, 2012); and reduction in excessive and binge drinking (Chiauzzi, Green, Lord, Thum & Goldstein, 2005; Linke, Brown & Wallace, 2004). More importantly, Nicholas, Gutwin, and Paterson (2013) reported that when working with children and adolescents in
clinical settings, online information and support “emerg[ed] as a viable and desired resource” (p. 862).

**Ethical considerations.** As a result of increasing frequency of online mental health interventions, there have been newly formulated guidelines on ethical considerations for professionals working with clients online as the practice becomes more commonplace (American Counseling Association, 2005; American Mental Health Counselors Association, 2000). Similarly, the International Society for Mental Health Online has been established and provides suggestions and recommendations (2004). These guidelines, while designed to provide clinicians with assistance and documented procedures for legally and ethically offering online therapies, do not completely alleviate the concerns that practitioners often raise.

Concerns regarding ethical issues for current practice are noteworthy (Finn & Banach, 2002), and include privacy, avoiding harm, competence, informed consent, and licensure reciprocity, among others (Midkiff & Wyatt, 2008). Of course, the duty to report in cases of neglect, abuse, or suicidal ideation must be addressed in the same manner as traditional sessions, per state legislation and local procedures (Rosik & Brown, 2001).

Wells and Mitchell (2007) surveyed more than 2000 social workers, psychologists, therapists, and other professionals about their perceptions of online mental health treatment. Their results indicate that the largest concerns were similar to those found in the literature, including confidentiality of client information, liability, misinformation, inadequate training, and reciprocity. However, the majority of those surveyed expressed interest in receiving materials regarding the provision of “online
treatment, selecting online treatment approaches, criteria regarding who would most benefit from this approach or when to stop use of online treatment” (p. 456), even with their reservations. Further, those practitioners currently offering therapeutic services online report feeling confident in their management of ethical and legal concerns and believe they are still within their scope of practice (Manhal-Baugus, 2001).

**Efficacy of Child Parent Relationship Therapy in Parent Populations**

Many individual studies have been conducted to measure the efficacy of CPRT, supporting its efficacy and applicability in treatment for children and their parents. The breadth of efficacy reported for CPRT is evidenced by the diverse populations and wide array of presenting problems. Research demonstrates efficacy with single parents (Bratton & Landreth, 1995); mothers who were incarcerated (Harris & Landreth, 1997); incarcerated fathers (Landreth & Lobaugh, 1998); abusive or neglectful parents (Kellam, 2004); and court-ordered parents (Goodwin, 2003; Walker, 2007).

Bratton and Landreth (1995) conducted an experimental study with single parents of children between the ages of three and seven. All parents completed assessments before and after the treatment, and participated in two twenty-minute play sessions that were recorded before and after treatment. The instruments that were included in the data collection were the PPAS (Porter, 1954), MEACI, the FPC, and PSI. Pre- and post-treatment assessments were scored and confirmed. The video taped sessions were rated according to the MEACI, and inter-rater reliability was checked and confirmed.

For parents in the experimental group, an ANCOVA revealed a significant difference in parental acceptance levels and empathic behavior towards their children,
and a significant decrease in parental stress levels and child behavior problems when compared to the control group.

Harris and Landreth (1997) conducted a condensed, twice-weekly sessions for five weeks, CPRT model with incarcerated mothers with children between the ages of three and 10. Mothers completed pre- and post-treatment assessments, including the PPAS (Porter, 1954), PSI, and the FPC. They were also video-recorded in a play session with their child before and after treatment to allow for the MEACI. An ANCOVA was conducted and compared the mean scores for parents in the experimental group to the control group means for all hypotheses.

Results indicated that there were significant differences in parental empathy, parental acceptance, and child behavior problems. There was not a significant reduction in parental stress, possibly reflective of the increased stress levels of mothers while incarcerated and the strain of being separated from their children.

While Harris and Landreth (1997) limited their study of CPRT to incarcerated mothers, Landreth and Lobaugh (1998) conducted the ten-week CPRT protocol with incarcerated fathers who had children between the ages of three and seven. This experimental design assigned sixteen fathers either a treatment group or a control group. The PPAS (Porter, 1954), PSI, FPC, and the Joseph Preschool and Primary Self-Concept Scale (JSCS; Joseph, 1979) were conducted as pre- and post-treatment assessments. An ANCOVA tested the difference between the two groups’ post-treatment mean scores for all hypotheses.

Outcomes indicated that there were statistically significant increases in parental acceptance and child self-concept, as well as significant reductions in parental stress
and child behavior problems. This is interesting, as Harris and Landreth (1997) did not see a reduction in parental stress in their maternal population.

Kellam (2004) conducted a modified CPRT with 37 abusive or neglectful parents, and measured gains on the PPAS (Porter, 1954), PSI, and CBCL. This study included eight, one and a half hour sessions of traditional CPRT material, but also included three units from the control group parenting training material, as pertinent for the abusive and neglectful parenting styles. On all three measures, there were no significant differences found between the experimental group and control group in mean scores. None of the F ratios for main effects were significant at the <.05 level, and all three hypotheses were rejected.

Goodwin (2003) conducted an eight-week condensed version of CPRT with court-ordered, maltreating parents. While initially Goodwin (2003) collected both quantitative and qualitative data in the study, the former was dropped due to faking good responses on the self-reported CAP assessment. The themes that emerged from the qualitative data is that the court-ordered, maltreating population is unique in their needs and participation, but that CPRT is a viable choice for this population to better a relationship with their children.

Walker (2007) also conducted CPRT with maltreating parents who were court-ordered, in partnership with a community-based child abuse prevention group. Participants were randomly assigned to the experimental CPRT group or the control group consisting of agency developed, didactic treatment surrounding parenting topics. The Child Abuse Potential Inventory (CAP) was conducted as a self-report assessment for child maltreatment, along with the PSI to measure parental stress levels.
The results in this study confirmed that CPRT significantly reduced parental stress in this population. However, three-quarters of the responses on the CAP pre-test were invalid due to participants excessively faking good, thus making it impossible to infer whether CPRT reduces the potential for child abuse.

**Critical analysis.** Bratton and Landreth (1995) implemented an experimental design along with semi-random assignment of participants. These methodological decisions increased the internal validity of the study. Fidelity to the CPRT model was another strength. However, a small sample size reduces generalizability and limits the reach of the intervention without additional research.

Harris and Landreth (1997) implemented inter-rater reliability checks during the treatment, and reported high reliability coefficients for pre-coding, midpoint, and post-coding ($W = .8923, .7275, .8185$, respectively). This consideration is certainly a strength of the study. Additionally, the controlled outcome methodology increased internal validity. However, due to extremely high attrition rates ($57\%$), the random assignment of participants to either control or experimental group was abandoned to ensure an even distribution of participants between the two groups, reducing statistical conclusion validity of the study. Finally, the traditional CPRT model of ten weeks was modified to prevent further attrition rates, but reduced fidelity to the protocol, potentially altering results without conducting further analysis.

Landreth and Lobaugh (1998) also implemented an experimental, controlled outcome methodology, increasing internal and statistical conclusion validity. However, the recruitment of inmates can confound results, as motivation to participate might be skewed. The researchers did screen and require that participants met inclusion criteria;
however, being offered special play time with your child in a prison setting is a privilege that would be highly desired. This calls into question whether outcomes would be similar in other research that did not have strict regulations about time spent with children.

Kellam (2004) modified both the material and session protocol for CPRT with this population, and implemented a condensed duration of the treatment, which reduced fidelity to treatment in this study. Further, the participants were required to take these courses, and this likely affected their honesty and self-disclosure on the self-report measures. No objective measures were conducted to measure efficacy of the training, reducing construct validity. Finally, this was a dissertation and not a peer-reviewed study published in a reputable journal.

Goodwin (2003) employed a mixed-methodology in a controlled outcome study, but later discarded the quantitative data because of participants faking good responses on the self-report assessments and the author’s perception that it clouded the richness found in the qualitative data. The small sample size limits generalizability and power, similar to the Bratton and Landreth (1995) study. Finally, as Kellam’s (2004) study, this was a dissertation and not peer-reviewed.

Walker (2007) implemented controlled outcome, randomized methodology as well thereby increasing internal validity. An additional measure to strengthen internal validity was pre-testing both groups to control for any statistical differences. One of the major concerns, however, is that there was no control for the potential effect of other interventions while participating in this study. These parents were court-ordered to receive treatment, but many received other services simultaneously, possibly confounding the outcomes.
Another consideration is the high attrition rate in this study. While the author acknowledge that this population is known for high mortality in studies, a 23% attrition rate drastically reduces power in the study. Finally, participants were from one city and its surrounding suburbs. This limits external validity, as it is difficult to know whether the results would translate to a wider and more broadly dispersed population of court-ordered, maltreating parents.

**Efficacy of Child Parent Relationship Therapy in Child Populations**

CPRT has demonstrated efficacy with child behavior problems (Johnson-Clark, 1996); children with pervasive developmental disorders (Beckloff, 1998); child victims of sexual abuse (Costas & Landreth, 1999); children with learning disabilities (Kale & Landreth, 1999); children who are chronically ill (Tew, Landreth, Joiner, & Solt, 2002); child witnesses of domestic violence (N. Smith & Landreth, 2003); and children with a life-threatening illness (Steen, 2005).

Johnson-Clark (1996) measured the effect of CPRT on child behavior problems and parental rejection of their children in a randomized study. Parents were assigned to CPRT, a play only group, or a control group. Parents who received CPRT indicated a significant reduction in child behavior problems from pre-treatment to post-treatment tests. Further, there was a statistically significant reduction in parental rejection after treatment, still evident two months post-treatment at a follow-up assessment.

Beckloff (1998) conducted a quasi-experimental design study on 23 parents of three to 10 year olds diagnosed with Pervasive Developmental Disorder. Parents who received CPRT, as compared to the control group, scored higher in levels of parental
acceptance and the child’s need for autonomy on the PPAS (Porter, 1954). Of note, however, is that the findings were not statistically significant.

Costas and Landreth (1999) conducted CPRT with non-offending parents of children who were victims of sexual abuse, in a controlled outcome study. The training groups were formed based on location by convenience sampling, but were randomly assigned to either the treatment or the control group. An ANCOVA on pre- and post-assessments indicate parents in the experimental group scored significantly higher on levels of parental acceptance and parental empathy than the control group. There was also a significant reduction in parental stress levels in the CPRT group. However, there were no differences between the experimental and control group on children’s behavior problems.

Kale and Landreth (1999) conducted traditional CPRT protocol on 22 parents of children with learning difficulties, between the ages of three and ten years old. Parental acceptance levels were significantly higher than the control group, and parental stress levels were significantly lower on the mean total score as compared to the control group. Interestingly, there was no significant difference on any subscale of the CBCL between experimental and control groups, from either the parent report or the teacher report.

Tew and colleagues (2002) conducted traditional CPRT on 23 parents of children who were facing chronic illness between the ages of three and 10. An ANCOVA was conducted to reveal a significant increase in parental acceptance levels, as well as significant changes on two of three subclass of the PPAS (Porter, 1954). There were also significant reductions in in parental stress levels and child behavior problems.
N. Smith and Landreth (2003) conducted an intensive CPRT program with mothers of children who had been witnesses of domestic violence. Mothers were either in a homeless shelter or a domestic violence shelter at the time of the study. This intensive CPRT model was condensed into ten, one and a half-hour sessions over the course of two to three weeks, rather than once weekly for 10 weeks. The special play times were included in the weekly training sessions, reducing the training portion to 20-45 minutes in length, to allow for a 30-45 minute play time.

An ANCOVA was conducted and determined statistically significant decreases in child behavior problems. Significant differences in scores on each of the subscales of the CBCL were also noted. Children’s self-concept was significantly higher than those in the control group on the JSCS, and mothers in the experimental group scored significantly better on the total score for empathy and acceptance as measured by the MEACI as compared to the control group.

Steen (2005) conducted traditional CPRT with parents of children with a life-threatening illness. Seven participants were involved in the study, but only two completed the entire training. This was a qualitative, collective case study design and the author largely reported observed behaviors and outcomes, based on researcher notes and transcribed conversations, sessions, and voicemails. There were increases in communication between child and parent in the play session and at home, an increased cooperation with medical procedures, an increase in confidence in parenting skills, and an increase in child self-coping skills and confidence.

**Critical analysis.** Johnson-Clark (1996) implemented random assignment to one of three groups, increasing internal validity. Further, a follow-up assessment to measure
longitudinal effects of CPRT as an intervention increases external validity, and provides more than just a point in time gain assessment. However, this is a dissertation and is not peer-reviewed nor published in a journal.

Beckloff (1998) also employed an experimental design strengthening the internal validity of the study, but did not include random assignment of participants. The parents were assigned to either the control group or the experimental group based on schedules, lessening the statistical conclusion validity of the study. However, Beckloff was trained and supervised directly by the authors of CPRT, Landreth and Bratton, so fidelity to the treatment protocol was extremely high.

Costas and Landreth (1999) implemented an experimental design, but did not employ random assignment to the participants, either. There was also a small sample size in the study (n=26), limiting generalizability. A strength of the article was the blind assessor methodology. Raters were not aware of whether they were rating pre- or post-treatment responses, increasing construct validity by ensuring that bias was controlled. Additionally, this study included a unique population, with non-offending parents of children who had been sexually abused. To an extent, these parents had been victimized themselves when their children were violated, creating a very unique population to whom parent training can be offered.

Kale and Landreth (1999) had an extremely high attrition rate, with 46% of the original sample dropping out of the study. This drastically reduced the sample size, and indicates that CPRT might not be well-suited for this population, as other studies report a much lower attrition rate. Further, this sample was recruited from two small schools in North Texas, limiting generalizability. One additional consideration is that learning
difficulties in this study were very loosely defined, as parents were permitted to report perceived difficulties without any discussion of validating or diagnostic information to confirm there was indeed a learning disability.

Tew and colleagues (2002) implemented a controlled outcome design, but report that there were not enough participants to randomly assign parents; therefore, those who were not able to attend all of the required sessions were placed in the control group. This affects statistical conclusion validity, as the argument could be made that those parents in the experimental group were more motivated or invested in the training, potentially adding a confounding variable.

However, all three leaders were highly trained in play therapy, and met weekly to consult with each other on treatment and protocol, highly increasing fidelity of the treatment. However, to conduct statistical analyses, all three training groups were pooled to create one experimental group data set. As each group was trained with different leaders, the authors eliminated the possibility of measuring changes in participants relative to one group leader over another when they pooled the data, thus reducing construct validity.

N. Smith and Landreth (2003) implemented this study with a very small sample (n=11), limiting generalizability. Further, mothers in this sample were recruited from either a homeless shelter or a domestic violence shelter, which indicate very different environments and experiences. This lack of continuity in the environment may have been a confounding variable, as stress levels, living arrangements, and circumstances would have varied from one to the other. Finally, this CPRT study implemented a very
condensed and modified version of CPRT, reducing fidelity and integrity of the training, as the amount of manualized instruction was drastically reduced.

Steen (2005) implemented a qualitative methodology, which has its place and function in research, but did not include any formal assessments or measures to monitor specific goals and outcomes. Further, the families were recruited exclusively within the oncology department, rather than offering the training to anyone with a child facing a life threatening illness. This limits generalizability, and possibly explains the very small sample size of seven, with only two who completed the training. Finally, the small number of participants required that CPRT be conducted individually, preventing a group dynamic which has been proven to positively affect the outcomes.

**Efficacy of Child Parent Relationship Therapy in Diverse Populations**

Due to the child-centered approach of CPRT, many studies have confirmed that CPRT is a culturally sensitive modality effective with diverse cultural and ethnic groups (Baggerly & Parker, 2005; Garza & Bratton, 2005; Post, McAllister, Sheely, Hess, & Flowers, 2004). Additionally, CPRT has a unique approach that focuses on the uniqueness of each individual and family, making it especially cross-culturally responsive (Landreth, Bratton, & Lin, 2010).

CPRT has been effectively implemented with Chinese parents (Chau & Landreth, 1997); Korean parents (Jang, 2000); Native Americans (Glover & Landreth, 2000); immigrant Chinese families (Yuen, Landreth, & Baggerly, 2002); Korean parent immigrants (Lee & Landreth, 2003); an African American mother (Solis, Meyers, & Varjas, 2004); a Jamaican mother (Edwards, Ladner, & White, 2007); German mothers (Grskovic, & Goetze, 2008); Latino parents (Ceballos & Bratton, 2010); Israeli parents
(Kidron & Landreth, 2010) and Iranian mothers (Alizadeh, Abu Talib, Abdullah, & Mansor, 2011).

Chau and Landreth (1997) conducted a traditional ten-week CPRT model with thirty-four Chinese parents of children two to 10 years old. An ANCOVA determined that parents in the experimental group scored significantly lower on empathic interactions when compared to the control group. There was also a significant increase on the total score on the PPAS (Porter, 1954), and significant positive changes on all three of the subscales as well. A significant reduction in parental stress levels was also reported.

Jang (2000) conducted CPRT on thirty Korean mothers of children ages three to nine years old. To prevent attrition, the ten-week program was condensed into eight sessions over four weeks. Parents in the experimental group were found to exhibit significantly higher levels of empathy as compared to the control group, but this study found no significant differences between the control and experimental groups on main effect or any of the subscale measures on the PPAS (Porter, 1954), indicating that CPRT did not significantly influence or increase levels of parental acceptance with this sample.

There were also no significant differences between the control and experimental groups on main effect or either of the subscale measures on the PSI, indicating that CPRT did not significantly influence or decrease levels of parental stress with this sample. There was a reduction in reported parental stress levels in the experimental group, however, though not statistically significant. There was also a significant decrease in behavior problems for children in the experimental group.
Glover and Landreth (2000) conducted traditional CPRT on 21 mothers and grandmothers of children in a controlled outcome study with Native Americans. Outcomes revealed positive gains on total score and each of the subscales of the PPAS (Porter, 1954), though none were statistically significant at the .05 level. There was only a minimal decrease in reported parental stress levels after completing CPRT, and similar decreases were observed in the control group as well, indicating that CPRT did not statistically decrease stress levels even though there was a reduction in scores on the PSI.

Although there was an increase in score on the JSCS for self-esteem in children who participated in CPRT, these results were not significant at the .05 level. However, there were significant decreases in total scores for parental empathy, as well significant changes on the three subscales on the MEACI.

Yuen, Landreth, and Baggerly (2002) conducted traditional CPRT with immigrant Chinese families in Canada. Thirty-five parents of children between the ages of three and ten who volunteered for the study were randomly chosen for either the control group or the experimental group.

Based on the data, parents in the experimental group scored significantly higher on parental acceptance levels, as evidenced by significant changes on all four of the subscales. Parents also scored significantly lower on total mean score on the PPAS (Porter, 1954), with significant changes on both the child and parent domain subscales. There were significantly fewer behavior problems reported for children in the experimental group, and parents scored significantly lower on total mean score for parental empathy as compared to the control.
Lee and Landreth (2003) conducted traditional CPRT with 32 Korean parent immigrants of children between the ages of two and 10 years. Parents in the experimental group showed significantly lower scores in parental empathy when compared to the control group, as well as a significant decrease in parental stress levels. There was also a significant increase in parental acceptance levels for the experimental group.

Solis, Meyers, and Varjas (2004) conducted traditional CPRT with an African American mother and her six-year-old son, in a qualitative case study design. Semi-structured interviews, parent questionnaires, journals, and training sessions were all included in the data collection process in this study. Themes and patterns were identified and analyzed, including blind coding debriefing, and inter-rater agreement was reached for each code.

Four general themes were identified regarding perceptions of the training, related to the structure, content, effectiveness, and congruence of training to parenting practices. Three themes were identified regarding the effect that CPRT has on the participants, related to changes in the parent, changes in the child, and changes in the child-parent relationship.

While there is evidence that CPRT effective for this mother, she reported difficulty accepting some of the skills that ran counter to her own upbringing, and did not report changes in acceptance levels or parental stress levels. The parent reported positively about the treatment process of weekly sessions, but expressed concern for the time requirement. Positive changes were observed in the mother, child, and in their relationship.
Edwards, Ladner, and White (2007) conducted CPRT with an immigrant Jamaican mother and her four year old daughter in a single case study design. Data were collected through demographic data; audiotapes of two interviews; audiotapes of the training sessions; videotapes of the 30 minute special play times; observations of child-parent interactions; parent journal; and field notes from the researcher.

Data was analyzed and coded, after transcribing the interviews and training sessions. Six general themes emerged: content, structure, play, the mother, the child, and the relationship. The mother reported acceptance of most of the skills and found the content agreeable. The time commitment and constraints with schedules were reported as concerns. She was able to focus on spending time with her children consciously, and she also reported that she learned more about her child’s characteristics and personality as a result of the CPRT.

Jamaican parents have a tendency to put the child-parent relationship in a place of high value. This study reveals that CPRT is partially congruent with Jamaican culture and practice. She reported that she embraced some of the skills, but would not alter her parenting completely. She instead integrated the skills learned in CPRT into her parenting practices. She did indicate that she appreciated the psychoeducational element of CPRT, as she valued education and practical learning experiences.

Grskovic and Goetze (2008) conducted a condensed CPRT with 33 German mothers experiencing parental stress. This controlled-outcome study grouped mothers based on the week in which they entered the treatment facility. In total, there were eight sessions in the condensed model, and the mothers were encouraged to have five play times with their child of focus that were videorecorded. Mothers met six times with the
other mothers for group discussion, and twice with the researcher for individual feedback sessions.

The assessments that were implemented were the CBCL, and two additional informal German assessments measuring parental styles. Results indicate that mothers in the experimental group reported significantly fewer internalizing and total behavior problems. The additional assessments revealed CPRT had a positive impact on positive attention and nondirectiveness for mothers in the experimental group, as compared to the control group.

Ceballos and Bratton (2010) conducted traditional CPRT with 48 low-income Latino parents of children with behavioral concerns and academic risk factors in a school setting. Spanish versions of the CBCL and PSI were administered as pre- and post-treatment assessments. An ANOVA was conducted to determine the significance of changes observed after completing CPRT.

The study revealed that there was a significant reduction in child behavior problems. Additionally, thirteen of the sixteen children who scored in the clinical range on the pre-test for internalizing behaviors moved to normal levels after CPRT. The four children who scored borderline on the pre-test moved to the normal range after CPRT. For externalizing problems, nine of the 11 children who scored in the clinical range pre-treatment moved to normal levels. The six children who were in the borderline range pre-treatment all moved to normal range after CPRT. Further, 90% of children who presented in the clinical range pre-treatment moved to normal ranges on the Total Problem Scale after CPRT.
There was also a statistically significant decrease in parental stress levels after completing CPRT. Additionally, in the final session, participants were asked to share feedback about participating, and comments most frequently included: feeling closer to their child, realizing the importance of spending time with their child, being more patient with their child, and witnessing a decrease in spanking and yelling.

Kidron and Landreth (2010) conducted a condensed and intensive version of CPRT with Israeli parents of children between the ages of two and ten years old, consisting of two sessions weekly for five weeks. A MANCOVA was conducted to determine simultaneous effects of treatment conditions on the variables.

The study indicated that child behavior problems were not significantly reduced as compared to the control, but there was a significant decrease in the main effect score for the experimental group on the Externalizing Behavior Subscale. Parental empathy was also significantly increased, as measured by a significant decrease in the mean total score on the MEACI. Parental stress levels were also significantly lower on the PSI for those who completed CPRT.

Alizadeh, Abu Talib, Abdullah, and Mansor (2011) conducted traditional CPRT with 86 Iranian mothers of elementary school children in Tehran, Iran. This controlled-outcome study included a pre- and post-treatment CBCL. There was a significant reduction in scores for total mean score on the CBCL for mothers in the experimental group, and a significant reduction in internalizing behaviors on the subscale as well.

**Critical analysis.** Chau and Landreth (1997) implemented a controlled outcome study, which was a bolster to internal validity. Another strength is the use of empirically validated and assessed instruments that have documented reliability and validity.
However, as a substantial percentage of participants could not read or speak English, the researcher audio recorded a translation of each instrument to help them answer the questions. Construct validity was clearly affected with the use of assessments that were not normed on the Chinese population and had to be translated, potentially changing the meaning or losing the intent of the questions. Finally, Chinese parents are a very specific population with whom this study was conducted, limiting generalizability outside of Chinese culture, but this study does indicate that CPRT is helpful and appropriate for cultures other than those who are English speaking.

Jang (2000) conducted a controlled-outcome study as well. One of the strengths noted in this study is the inter-rater reliability that was confirmed among raters on the MEACI. The coefficient of reliability was established between .95 and .96, certainly sufficient. This study also included qualitative elements for thematic data analysis, and although not generalizable, indicate that CPRT with a Korean population increased mothers’ sensitivity to their children, improved marital communication with their husbands, and improved other familial relationships. This study demonstrates that CPRT is effective with Korean families for increasing communication and empathy within the child and parent relationship.

One of the strengths in the Glover and Landreth (2000) study was the detailed reporting of reliability and validity on the assessments chosen for the study. Further, Native American populations typically employ a different parenting style than Whites, and CPRT is well-suited for the value of child independence and nonjudgmental parenting approach that is common in this population. However, this study was conducted only with Native-American females, making generalizability very difficult.
Although there were not significant changes on the PPAS (Porter, 1954) and PSI as a result of the CPRT treatment, it is evident that CPRT does positively impact parental empathy with this population.

Yuen et al. (2002) implemented a controlled-outcome, randomized study with Chinese immigrants, who typically do not seek mental health services, and therefore are at risk of feeling isolated and remaining underserved as compared to the general population. Another strength is that the study included fathers as well as mothers, with fathers comprising almost thirty percent of the sample. This increases external validity. Though accurate translation of ideas or concepts may have been a compounding variable in the assessments when provided in Mandarin or Cantonese, this study clearly demonstrates that CPRT is a valid and effective resource for immigrant Chinese families, and is a culturally sensitive option for therapists.

Lee and Landreth (2003) implemented a randomized, controlled-outcome design increasing internal and statistical conclusion validity. Also, information about the participants in the study was very clearly and explicitly presented, as well as attrition and modifications to the CPRT protocol. However, the authors report that although the assessments used have empirical support, none of those administered have been normed on the Korean population. A final concern is that there was no mention of gender of parent participants, therefore preventing replication and limiting external validity as it is unknown if this study included mothers, fathers, grandparents, or a combination.

However, considerations and perceived weaknesses aside, this article provides support for the efficacy of CPRT with culturally diverse populations. Further, this reveals
effective application even for those who predominantly speak a language other than English and are first generation immigrants to the United States.

Solis et al. (2004) conducted an exploratory study on one African American mother, making generalizability pointless. Further, the authors acknowledge that none were of the same ethnicity as the mother in the study, and that their own cultural factors may have influenced their clinical assessment. However, positive changes were noted in both the mother and the child, despite differences in its approach to traditional child-rearing practices that she reported implementing in the past.

Edwards et al. (2007) single case study design renders generalizability useless, and the participant was acquired by convenience sampling, another concern. The researcher knew the participant previously, and this may have influenced both of their perceptions and reflections. Further, CPRT is traditionally conducted in a group setting, to take advantage of the dynamic of peer-modeling. Considering Jamaican culture is very familial and communal in child-rearing, as reported by the mother, in this case CPRT might have been better offered in a group setting so that feedback and shared experiences would have been influential and helpful. However, even in an individual setting, CPRT did prove effective in producing positive outcomes for a Jamaican mother and her daughter.

Grskovic and Goetze (2008) implemented a controlled-outcome study, but the participants were acquired through convenience sampling, as they were all residential patients in a facility. Further, each mother received counseling from the center, so it is difficult to know if the positive results would have been evident with CPRT alone. Another concern is that no attempt to equate the groups on age or gender were made,
and children vary drastically developmentally and emotionally. With a condensed version of the training, it is difficult to know what outcomes would have been observed if the complete ten weeks would have been provided, especially since the authors reported that the mothers in the experimental group improved on their skills over time.

Germany is known for being "somewhat more traditional and less receptive" (Grskovic & Goetze, 2008, p. 47) than other countries to mental health interventions. Considering this is the first study of its kind conducted in Germany, it provides positive outcomes supporting CPRT with this population.

Ceballos and Bratton (2010) conducted a study that has many strengths, including cultural accommodations and language translation to best meet the needs of the participants. A personal phone call was made every week by the lead researcher to connect and remind them of the session, and an extra initial session was offered to provide them with an opportunity to socialize and interact.

Additionally, reliability and validity was reported on the Spanish versions of the two assessments implemented in the study. However, as the CBCL is parent self-report, and they experienced the effects of CPRT themselves and the way in which they view their child, more objective measures might have been accurate in measuring true child behavioral change, rather than solely on parental perception of differences.

Finally, the sample was predominantly Mexican, even though there were participants from Central and South America. This limited geographical area limits generalizability to all Latinos. However, there is evidence that CPRT is very effective in reducing child behavior problems and parental stress levels in Latino immigrants; even those who are low-income and considered at-risk.
Kidron and Landreth (2010) implemented a controlled-outcome study, but did not rely on random assignment. Therefore, the control group was comprised of those who could not participate in the CPRT classes, due to their job or lack of child care. There is a possibility of motivation acting as a confounding variable, as those who participated may have been more invested or involved in their parenting from the start. Further, the authors report that the first author was required to rate twelve of the 54 tapes herself, as raters’ attrition rates were extremely high. This introduces a potential for high bias in the study.

There is also the question of self-report assessments in this study, as the participants were told that the training would help them to relate better with their children. There is a possibility that knowledge influenced their self-reporting, potentially rating their children more favorably than those in the control group. However, this study does offer empirical support for CPRT not only with another culture, but in another part of the world entirely. Conducting CPRT with cultural groups while they remain in their country and therefore immersed in their culture speaks to its sensitivity and adaptability.

Alizedah and colleagues’ (2011) design and methodology is very sound in this study, and is seen as a strength. Random assignment increases statistical conclusion validity. Another perceived strength is introducing a very different parenting approach to Iranian mothers in a pilot study. This certainly fills a gap in parenting programs available in Iran.

Perceived limitations are that this was only conducted with mothers, and it would be helpful to include fathers to determine if CPRT is equally effective for both genders. Also, while other studies typically include a child age range of seven or eight years, this
study only included children in third, fourth, or fifth grade. This limits the ability to expand findings to younger or older children.

Finally, none of the children reported clinical range scores pre-treatment on the CBCL, making it difficult to determine if the same results would have been replicated with children who had severe behavioral problems before participating in the CPRT treatment. Construct validity is affected by this discrepancy. However, children in this study were reported to decrease significantly in their behavior problems, clinical range aside. In Iranian culture, where “most parent training models recommend strategies for changing the child,” (Alizadeh et al., 2011, p. 1906), it is important to recognize the cultural applicability and sensitivity of CPRT as a treatment option that these results reflect.

**Meta-Analytic Studies on CPRT.** There are two well-known meta-analytic studies offering a glimpse into the broad applications of CPRT. These reveal the positive outcomes of the child-centered play therapy model.

*LeBlanc & Ritchie (2001).* LeBlanc and Ritchie (2001), after analyzing 42 studies from 1950 to 1996, found a medium effect size (ES = .66). They also reported that not only did length of treatment have an effect on the results, but that there were more positive outcomes for play therapy treatment groups when compared to non-play therapy groups.

*Bratton, Ray, Rhine, & Jones (2005).* This meta-analytic study was conducted with 93 controlled-outcome play therapy studies ranging from 1942 to 2000 (Bratton, Ray, Rhine, & Jones, 2005). Bratton et al. (2005) found a large effect size (ES = 1.15), and that child-centered treatments were significantly higher than non-child-centered
interventions. They acknowledged the efficacy of play therapy for children, but also emphasized the influence of parents in the treatment process, as the filial therapy outcomes were better than play therapy outcomes. Bratton et al. (2005) reported when play therapy is delivered to a group of parents who conduct weekly supervised play sessions with their child, the result is a very large effect size in fewer sessions…The results of this research indicate that if a child and a parent are both firm candidates, filial therapy would be the most effective intervention. (p. 386)

*Landreth, Bratton, & Lin (2010).* Landreth, Bratton, and Lin (2010) further analyzed the data from Bratton et al. (2005), including only those with controlled-outcome, CPRT studies. This resulted in 32 studies involving 916 participants. All of the studies were deemed either experimental or quasi-experimental in design, and all but four established treatment fidelity to the manual and protocol. The positive outcomes reported were evidenced across varied populations and diverse presenting problems.

**Recent literature review.** In a sampling of recent literature from within the last seven years, CPRT was found effective with children and parents facing divorce within the family (Dillman Taylor, Purswell, Lindo, Jayne, & Fernando, 2011). Employing a mixed methodological approach, Dillman Taylor and colleagues (2011) reported a reduction in parental stress and child behavior problems with an increase in child-parent connection in children of divorce and their parents.

While Dillman Taylor and colleagues (2011) analyzed qualitative responses about the process of CPRT and found that parents reported positive perceptions of the group process and the training, another study assessed only parental perceptions of process
and outcome (Edwards, Sullivan, Meany-Walen, & Kantor, 2010). Edwards and colleagues (2010) implemented an ethnographic methodology to analyze parental perceptions of both the effectiveness and acceptability of CPRT, finding positive perceptions in the areas of knowledge and confidence, communication, relationships, and reduction in child behavior problems.

Garza, Watts, and Kinsworthy (2007) noted that CPRT meets the recommendations emerging as best practices for families in treatment, which are the inclusion of the parents as partners with the therapist and building strong child-parent bonds. The authors included positive outcomes on a case study family who had been a part of a CPRT group, including mastery of skills, increase of confidence in parenting, and better communication between children and their mother (Garza et al., 2007).

Sheely and Bratton (2010) conducted a pilot study on the efficacy of CPRT with low-income, African American families in a school setting. Results indicated a statistically significant decrease in child behavior problems and parental stress levels. Additionally, there was a large treatment effect on both measures, demonstrating the applicability and practicality of the findings (Sheely & Bratton, 2010).

Carnes-Holt and Bratton (2014) also piloted a study implementing CPRT with adoptive families. Results demonstrated statistically significant outcomes on all measures when compared to the control group relative to decreased child behavior issues and increased parental empathy. There were large treatment effects, showing practicality and applicability of the treatment (Carnes-Holt & Bratton, 2014).
Deducible Consequences

As more attention is paid to children’s mental health with a growing awareness of its importance and necessity (Goldfine, Wagner, Branstetter, & McNeil, 2008), practitioners and families alike are seeking empirically validated and supported treatments. Further, parental involvement in the treatment process is not only encouraged, but increases positive outcomes (Diamond & Josephson, 2005).

Child-centered play therapy, and the filial therapy approach CPRT, have both been proven effective with many presenting problems and diverse populations. Studies have shown that child behavior problems and parental stress levels decrease after the intervention, and parental acceptance and empathy increase. CPRT remains one of the most widely researched and efficacious treatments for the mental health needs of children and their parents, making it a comprehensive option for practitioners providing services to families.

However, there are many barriers to seeking and completing treatment, preventing children and parents from receiving the mental health treatment that they need and or want. Richards and colleagues (2014) note that there is often a paucity of trained practitioners resulting in a waiting list for clients, which lessens the effect of early intervention.

Interestingly, it appears that there is a gap in the literature regarding the integration of CPRT with children and their parents and an online version. This could be potentially detrimental to an increasing number of potential clients who are internet users, but might not pursue traditional group CPRT therapy or have access to those trained in CPRT in their area.
Considering the documented success of CPRT in traditional face-to-face sessions, the growing trends of integrating mental health services with technology, and the similarity of those who are likely to participate in online mental health intervention and CPRT clients, it is salient to assess whether CPRT is effective in increasing parental acceptance when offered in an online format.

**Summary and Overview**

As the mental health needs of children are more widely recognized and valued, practitioners must have treatment options available to them to offer services to children and their families. Offering an empirically supported training in an online format could be extremely valuable to clinicians and families alike who might not otherwise enter into a therapeutic partnership due to geography, time, finances, or embarrassment.

CPRT, proven effective in a face-to-face setting, is not currently available online, and no studies have been conducted to measure the efficacy of an online format. Further, research clearly demonstrates the importance of parental acceptance on children’s mental health, and studies have indicated that the field of children’s mental health is overwhelmed by the number of children meeting diagnostic criteria for mental health disorders but not receiving appropriate treatment. Additionally, parents’ involvement in the process of therapy increases positive outcomes for the child and the family. By providing CPRT in an online format, all three of the aforementioned concerns can be addressed.

CPRT, rooted in Child-Centered Play Therapy which values unconditional acceptance and respect between child and parent, instructs parents how to create an environment during at-home play sessions that allows for children to explore their
feelings about themselves and the child-parent relationship. Parents are active participants in the treatment with the child, which has been proven effective in improving the gains of the intervention. This special playtime required in CPRT, in previous studies, has positively influenced self-reported levels of parental acceptance. Higher levels of parental acceptance, in published research, have been shown to positively influence children’s mental health.

Therefore, it stands to reason that by offering CPRT in an online format, there will be evidence of positive influence on children’s mental health, positive influence on levels of parental acceptance, and greater accessibility to an empirically validated intervention for children and their parents, increasing the reach of practitioners to offer assistance to families needing mental health treatment.

This study aims to address these concerns by:

1) Investigating the effect CPRT has on parental acceptance levels;
2) Offering CPRT in an online format to extend the reach and accessibility of training for children and their families; and
3) Exploring the perception of the process of an online version of CPRT to inform future studies.
Chapter Three: Design and Methods

Children’s mental health issues are a growing concern, and children and their families are requiring more treatment options than ever before. If the mental health needs of children are not effectively addressed with timeliness, children, their parents, and society must bear the weight of additional concerns that emerge (Gross et al., 2014; Broidy et al., 2003; Currie & Stablie, 2006).

Parental involvement has been shown to positively impact therapeutic outcomes, and including parents in therapy has become part of good practice (Diamond and Josephson, 2005). Further, levels of parental acceptance also significantly impact children’s mental health and psychological adjustment (Lee and Chyung, 2014; Giotsa & Touloumakos, 2014).

Additionally, many families with young children are likely to prefer a virtual therapy, as compared to a traditional clinical setting for several reasons, including stigma, time, cost, and distance (Corrigan, 2004; Richards et al., 2014). In order to best meet the changing needs of children and their families, clinicians will need to implement new and different strategies to best provide interventions for this unique population. One such option could be adapting a traditional face-to-face model, empirically supported in a clinical setting, into an online version that can reach more clients and serve those who may not seek services otherwise. What follows are the methods by which the author investigated the impact of an online format of CPRT on levels of parental acceptance and assessed the parental perceptions of the process of an online parent training.
Validity

**Internal validity.** This study administered the PPAS (Porter, 1954) as a means by which to measure the effect that CPRT in an online format has on levels of parental acceptance. This instrument has empirically supported reliability and validity, reported in multiple studies. To further ensure internal validity, inclusion criteria requires that participants must not have taken a parenting program within the last two years, nor their children participated in counseling within the last two years. This is an additional measure to reduce confounding variables that may affect the outcome, increasing internal validity.

**External validity.** This study collected demographic data on the participants, and aimed to include a varied and diverse group to increase generalizability of the results. Further, by including a qualitative component through the perception survey, triangulation of data can enhance the external validity of the results by including multiple perspectives about the online parent training and its benefits.

**Research Questions**

1. To what extent does an online format of CPRT affect levels of parental acceptance of children?

2. What are the parental perceptions of the process of online parent training, including benefits and challenges?

**Research Hypotheses**

$H_1$: There will be a statistically significant increase in the self-reported levels of parental acceptance from pre-treatment to post-treatment as measured by the PPAS (Porter, 1954).
H₀: There will not be a statistically significant increase in the self-reported levels of parental acceptance from pre-treatment to post-treatment as measured by the PPAS (Porter, 1954).

Research Design

The author conducted a mixed methods study to inform the counseling literature about implementing an online version of CPRT. The research questions required both quantitative and qualitative data, as this topic of study has no previously established base of literature or research. Considering CPRT has not been provided virtually, this study serves as the foundation upon which additional modifications or improvements can be built to offer it online and ensure efficacy of treatment.

This study implemented a mixed methods simultaneous triangulation design, collecting both qualitative and quantitative data through different sources in a single phase of data collection (Creswell & Plano Clark, 2007). Both sets of data were assigned equal weight, and the results of the data analyses were presented collectively after the interpretation of the results to offer both quantitative measures of outcomes and qualitative perspective of the process.

In this study, the quantitative data answered Research Question One. This data was collected through scores on the PPAS (Porter, 1954) pre- and post-treatment. The qualitative data serves as the answer to research question two, collected through a brief semi-structured survey provided at the end of treatment. By combining both quantitative and qualitative data, a more holistic and full picture emerges (Punch, 2009).
Participants

Parents who had an online connection to the author through her website and social media channels were offered an opportunity to participate in the study through advertisements. This included all parents affiliated with The Kid Counselor blog, The Kid Counselor Family Newsletter, and The Kid Counselor on Facebook.

Population. The pool of potential participants was International. Within the month of October 2014, visitors to the author’s website have represented 137 countries worldwide. Of those 137 countries, 48 had ten or more visitors to the author’s site within that month. The seven countries most highly represented in site visits for October 2014, with more than 100 visits each, were the United States, Canada, the United Kingdom, Australia, Denmark, India, and South Africa.

As of November 2014, fans of the author’s page on Facebook were comprised of 92% women and 7% men. Of the fans of the author’s Facebook page, the following are the most applicable age ranges to the study and their percentage breakdown:

(a) 18-24 yrs old - 4%
(b) 25-34 yrs old - 34%
(c) 35-44 yrs old - 40%
(d) 45-54 yrs old - 10%

As of November 12, 2014, the nationality of the fans of the author’s Facebook page are 74.6% American, 4.1% Australian, 4.0% Canadian, and the United Kingdom comprises 2.2%. The remainder of the 52 countries represented are one percent or less of the total number of fans.
Sample. The recruitment emails and social media advertisements for this study yielded interest from 49 potential participants. Of those 49, thirty-one potential participants qualified through meeting initial inclusion criteria. Of those thirty-one potential participants, 22 completed the Informed Consent and were admitted into the study. Of those 22 participants admitted, 15 completed the first week’s requirements and began the ten week study in the sample.

Although the initial study sample was comprised of 15 participants, throughout the ten week study seven more participants either withdrew voluntarily or did not meet compliance criteria and were informed that they could no longer participate. This high attrition rate reduced the final total of study participants to eight.

Instruments

There were two instruments administered to collect data from the participants in this study. The PPAS (Porter, 1954) was conducted to collect quantitative data, measuring levels of parental acceptance in the participants. The semi-structured survey was conducted to collect qualitative data, assessing parental perceptions of the process of an online parent training, including benefits and challenges.

Porter Parental Acceptance Scale. The PPAS (Porter, 1954) was administered to the participants pre- and post-treatment to assess levels of parental acceptance. Blaine Porter, as part of his doctoral dissertation at Cornell University, created an assessment that measured parental acceptance levels in 1952. His study investigated the relationship between marital adjustment and parental acceptance levels. The PPAS (Porter, 1954) was discussed in an article in the Journal of Home Economics two years later. Porter (1954) reported that the questions on the assessment were crafted from
an “operational definition of parental acceptance, and a conceptual scheme was used to
guide the construction of the responses” (Burchinal, Hawkes, & Garner, 1957, p. 66).

The PPAS (Porter, 1954) is an unpublished instrument, but has been used with
permission by the author frequently in filial therapy studies. The PPAS (Porter, 1954) is
included in the CPRT training manual for practitioners to administer to parents as part of
the standard pre- and post-training assessment process. The PPAS (Porter, 1954)
measures parental acceptance, “a core element in the communication of empathy and a
fundamental condition needed to facilitate a child’s development of positive self-
worth” (Bratton, Landreth, Kellam, & Blackard, 2006, p. 249).

The PPAS (Porter, 1954) is a self-report inventory that measures parental
acceptance levels as indicated by the feelings and behaviors expressed with, toward, or
about their child. There are four components of parental acceptance, represented by
four subscales in the instrument, measured with ten multiple-choice responses. The four
subscales include: respect for the child’s feelings and their right to express them;
appreciation of the child’s uniqueness; recognition of the child’s need for independence
and autonomy; and unconditional love.

The PPAS (Porter, 1954) is simple to administer and requires approximately
twenty minutes to complete. Each of the twenty questions has five possible responses,
measuring from high acceptance to low acceptance. A scoring key for the PPAS (Porter,
1954) is provided with the CPRT manual for therapists to use. Each of the forty
responses is assigned a numerical value ranging from one to five, based on the
response provided by the parent. The total score is calculated by adding the point
values together for all forty items on the assessment. The four subscales are calculated
by adding ten specific item values together, as indicated on the scoring key. The range of possible total score is 40 to 200 points; the possible range for each subscale is ten to 50 points. Questions on the assessment:

describe situations in which children express behavior and verbalizations or unique characteristics indicating becoming, or attempting to become, independent. Each item is repeated twice, inquiring (1) How the parent feels about the situation and (2) What the parent does about the situation. (Straus & Brown, 1978, p. 180)

**Subscales.** The four subscales, designed to measure specific components of parental acceptance, were designed to reflect an operational definition of the term. Porter (1954) indicated that an acceptant parent is one who:

(1) regards his child as a person with feelings and respects the child’s right and need to express these feelings

(2) values the unique make-up of the his child and does what he can to foster that uniqueness within the limits of healthy personal and social adjustment

(3) recognizes the child’s need to differentiate and separate himself from his parents; to become an autonomous individual, and

(4) loves his child unconditionally. (pp. 176-177)

*Respect for the child’s feelings.* Porter (1954) explained this component of parental acceptance as a parent who does “not become emotionally disturbed because the child expresses negative feelings. He realizes that such feelings need to be expressed for the maintenance of good mental health” (pp. 176-177). The sum of the responses to questions 11, 17, 19, 21, 23, 25, 29, 32, 35, and 36 comprise this
 subscale. An example question from this subscale measuring respect for the child’s feelings is:

When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:

a. feel annoyed

b. want to know more about what excites my child

c. feel like punishing my child

d. feel that I will be glad when my child is past this stage

e. feel like telling him to stop

Appreciation for the child’s uniqueness. Porter (1954) discussed this element of parental acceptance as a parent who “allows the child to be different from every other child and feels all right about it and accepts the child’s limitations” (p. 177). The sum of the responses to questions 12, 13, 18, 22, 26, 27, 31, 33, 39, and 40 comprise this subscale. An example question from this subscale measuring appreciation for the child's uniqueness is:

When my child misbehaves while others in the group are behaving well, I:

a. see to it that my child behaves as the others

b. tell my child it is important to behave well when in a group

c. let my child alone if the others are not disturbed by the behavior

d. ask my child to suggest an alternative behavior

e. help my child find an alternative behavior to enjoy while not disturbing the group
Recognition of the child’s need for independence. Porter (1954) indicated that this expression of parental acceptance is a parent who “allows and encourages the child to become increasingly independent and does not resist the growth toward independence” (p. 177). The sum of the responses to questions 14, 15, 16, 20, 27, 28, 30, 34, 37, and 38 comprise this subscale. An example question from this subscale measuring recognition of the child’s need for independence is:

When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:

a. realize that my child is growing up
b. feel pleased to see my child’s interests widening to other people
c. feel resentful
d. feel that my child doesn't appreciate what I have done for him/her
e. wish that my child liked me more

Unconditional love. Porter (1954) explained this component of parental acceptance as a parent who “offers support and love at all time - shares his child’s joys and sorrows; supports him in failures as well as successes” (p. 177). The sum of the responses to questions 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 comprise this subscale. An example question from this subscale measuring unconditional love is:

When my child expresses angry and hateful things to me, my degree of feeling of affection is:

a. much more than usual
b. a little more than usual
c. the same
d. a little less than usual

e. much less than usual

**Reliability.** Porter (1954), after conducting his own testing, documented a split-half reliability correlation of .766, which was modified to .865 by the Spearman Brown Prophecy formula, significant beyond the .01 level. Burchinal, Hawkes, and Garner (1957) explored the internal consistency of the PPAS (Porter, 1954), and by an item analysis determined that 39 of the 40 items identified a distinction between low and high scoring parents, at the .001 level of probability.

**Validity.** Construct validity of the assessment was determined by the agreement of at least three of five expert judges on each of the forty items (Porter, 1954). The judges rated the possible choices for each question; one reflecting low parental acceptance and five reflecting high parental acceptance. There was a disagreement amongst the judges in less than 20% of the responses, indicating that the PPAS (Porter, 1954) is a valid measurement of parental acceptance levels.

Item validity has also been established for the PPAS (Porter, 1954). Burchinal and colleagues (1957) report:

Thirty-five of the items had t values in excess of 3.46. It is quite clear that the items discriminated consistently between high and low scorers, justifying the assumption of a high degree of item validity when the total test score is the criterion. (p. 66)

**Semi-structured survey.** The semi-structured survey was administered to participants post-training to provide qualitative data about the process and perceptions
of the online parent training. The survey was written by the author as a means to gain insight into the participants’ experience of completing a parent training online.

This eight question survey included the following:

1. Please discuss the perceived benefits of an online format for parent training.
2. Please discuss the perceived drawbacks of an online format for parent training.
3. Please indicate what you liked best about the online format.
4. Please indicate what you liked least about the online format.
5. Please suggest ways to improve the online format in the future.
6. Please provide one word expressing your feelings about the parent training that you just completed.
7. a) Would you complete an online parent training again, as a result of your experiences in this study?  b) Why or why not?
8. Are there any additional comments you would like to share about the training, the online format, your experiences, etc?

Pilot testing. As the post-treatment survey was created for this study and had not been pilot tested for clarity or richness of data yielded from the questions, the author pilot tested the survey with three individuals who had previously completed online training. The existing survey was only modified to exclude the words “parent training,” and rather stated “online training.”

The three individuals represented varied ages, occupations, and online training experiences. In each case, the individual provided sufficient and appropriate responses to the survey questions, and offered only positive feedback about the survey itself. One
individual mentioned that it might be favorable to not have to type the responses, but there were no other modifications or changes suggested. The author felt that the richness of data yielded from the survey was sufficient and appropriate to be implemented with study participants.

**Data Collection**

**Recruitment.** Upon receiving approval from the Institutional Review Board at the University of South Florida, parents were offered the opportunity to volunteer to participate in the study. Those parents who were affiliated with the author’s newsletter subscription, and for whom the author has email addresses, received a pre-notice email with information about the study and inclusion criteria, through the email distribution service Mail Chimp (please see Appendix A). An individual email was sent to each email address in the list, after confirming with a member in the Information Technology department at the University of South Florida that there were no protocols for ensuring confidentiality when sending emails unless the email contains protected health information under the Health Insurance Portability and Accountability Act (HIPAA). Therefore, the author believes that appropriate measures were taken to protect confidentiality of participants through email recruitment.

Three days following the initial email, a second email was sent with additional information about the study and a link to the secure website where the online training took place (Appendix B). Finally, one week after the initial email, one additional reminder email was sent to ensure that any parent who meets criteria could still volunteer if they chose (Appendix C).
Since these three emails did not yield forty-two qualified participants, several advertisements of the study and information about the training were posted to the author’s social media channel, Facebook, for further recruitment (See Appendix D). The author also posted printed versions of the online advertisements at four local libraries, a local children’s ministry, a local preschool and a flyer was sent home to one hundred students and their families at a local private school.

Following the recommendations of Dillman at al. (2009), the author sent a pre-recruitment email, a recruitment email with a link to the study website, and then a follow-up reminder email during the recruitment process. Further, based on Perkins’ (2011) strategies known to significantly influence participation and response, the author increased the amount and frequency of contacts with participants through multiple emails, personalized the invitations to participate, and crafted the email messages purposefully, reinforcing the trustworthiness of the sender.

**Procedures**

Upon receiving the second email with the link to the study, the participants clicked through to access a preliminary data collection page on the study website, www.brennahicks.com/study. This page required first and last name, Country of residence, State/Province, City/Town, postal code, email address, and confirmation of the following eligibility requirements:

(1) Are you the parent or primary caregiver for a child between the ages of three and ten?

(2) Do you have the ability to conduct an uninterrupted 30 minute play session with your child each week?
(3) Do you have high speed internet?

(4) Do you have a video camera, and the ability to upload recorded videos to YouTube?

(5) Do you have an internet connected device with a webcam that can access Google Hangouts?

(6) Do you have or will you create a free Google account to log into Google Hangouts?

(7) Do you already possess, have access to, or have the means with which to buy the required toys for the special play times?

***Link was provided to the list of required toys

(8) Are you able to commit to 10 weekly online training sessions, 10 weekly Google Hangout group sessions, and 7 weekly special play times with your child?

(9) Do you read, write, and speak English fluently?

(10) Have you taken any parenting training programs within the last two years?

(11) Has your child been in counseling within the last two years?

(12) Do you commit to completing a pre-treatment assessment and a post-treatment assessment, as well as a post-treatment survey?

(13) Are you available during one of the following time slots for a synchronous, group session in Google Hangout lasting approximately 45 minutes?

   (a) Monday at 10am EST
(b) Monday at 9pm EST
(c) Wednesday at 10am EST
(d) Thursday at 9pm EST
(e) Saturday at 10am EST

** NOTE: This will require someone else to take care of your children during this time!

There was conditional logic built into the inclusion criteria form that determined if the parent met the eligibility requirements. The parent needed to answer yes to questions one through eight, and eleven through thirteen. The parent needed to answer no to questions ten and eleven. If the parent met all requirements upon submission, they were automatically directed to a page with an embedded Informed Consent electronic signature document, via Right Signature (See Appendix E). This also triggered an email to the parent with instructions and information about the final requirement of consenting to participate in the study (Appendix F), along with a copy of the Informed Consent Document. After reading the informed consent information, the parent volunteered to participate in the study by typing in their name as an electronic signature and clicking the “submit” button.

After the author reviewed the submissions, potential participants were either included or excluded from the study based on completion of requirements. Potential participants who both met inclusion criteria and completed the informed consent were included in the study; potential participants who either did not meet inclusion criteria, who did not complete the informed consent, or both, were excluded. All potential participants received an email indicating their status in the study, either included or
excluded (Appendices G & H). If included in the study, they were supplied with a unique login name and password to the website.

After logging in, the parent gained access to all of the required material for each week. The content was schedule-posted rather than accessible all at once, making the training more like the traditional face-to-face model of CPRT with specific, weekly content and material.

The website contained all of the required materials for the participants:

(1) An embedded training video for each week.

(2) A link to the .pdf of the weekly session material from the parent handbook of the CPRT manual.

(3) A comment section to allow for comments, questions, and thoughts to be posted during or after watching the weekly video.

(4) A Frequently Asked Questions (FAQ) section to offer suggestions, recommendations, and answers pertaining to the training or the online requirements. The author continued to add to this forum as new questions were posed throughout the training.

(5) Tutorials for technology-driven requirements of the training, such as uploading a video to YouTube, logging into Google Hangouts, and creating a Google account.

(6) The toy list requirements as taken from the CPRT manual.

(7) The PPAS (Porter, 1954), in an online format.

Each week, the parent was responsible for watching the training video with the weekly material when it was convenient. Most of the training videos were approximately one hour long. These videos included discussion of the weekly skills, practice, and homework assignments for the week. These videos were posted in the weekly dashboard on the website.

Parents were also required to login to Google Hangouts at their assigned group time and participate in the weekly live, synchronous sessions that allowed for discussion of concerns, peer support, group dynamics, and review of one or two parents’ weekly special play time session. This group meeting lasted approximately 45 minutes.

Beginning in the third week, parents were required to record a 30 minute special play time with their child of focus. This is designed to give them an opportunity to practice their learned skills, communicate through playing with their child, and increase the child-parent relationship. Parents were required to upload at least one of their seven videos to YouTube during the training to be viewed during the synchronous group session.

At the end of the ten week training period, parents were asked to complete the PPAS (Porter, 1954) for the post-treatment scores. They were also asked to complete the post-treatment survey to assess their perceptions of the process of an online parent training. Upon completion of both post-treatment assessments, they received a certificate of completion of CPRT in an online format.

**Compliance criteria.** Throughout the ten week training, there were participants who either withdrew voluntarily from the study, or those who were informed that they could no longer participate for not meeting compliance criteria. If a participant missed
four group Hangouts, without arranging to join a different group for a makeup session, she was excluded from the study. This was to ensure that data collected in the post-treatment assessment would reflect differences due to the training and not chance. In either case, all pre-treatment data from participants who did not complete the ten week training was removed from the data pool and was not included in the analyses.

**Online security.** The unique login with which the participants were provided had no personally identifying information, protecting confidentiality. The participants also created or used an existing google account username to login to Google Hangouts. This was whatever the participant chose, and may or may not have included identifying information, such as names or dates. The participants also either created or used an existing YouTube username to upload special playtime videos. This username was also whatever the participant chose, and may or may not have included identifying information, such as names or dates.

In both cases, however, the participants had the option of creating a username that would have protected their confidentiality. Participants were informed of this (see Appendix K) prior to beginning the study, and encouraged to decide whether or not they wished to create a new username for either platform if their existing username had information that they did not wish to be visible to others in the study.

Important to note, however, is that the visibility of their username was limited in both platforms. The Google Hangout in which they met each week was by invitation only, and included at most eight other participants. The other invited participants were able to see usernames and click on Google profiles, but this was exclusive to participants and accessibility was granted to no one outside of the group. Their profile
information was customizable to be visible only to whom they chose, which could have been only those in the CPRT study circle or no one at all. Google Hangouts are encrypted, as evidence by “When you message or talk with someone on Hangouts, your information will be encrypted so that it’s secure. This includes your Hangouts conversations and video calls on a web browser” (“Hangouts Help,” 2015).

When the participants uploaded special playtime videos to YouTube, they were instructed to make the video private and accessible only by the author. The researcher then accessed the video on YouTube and screen shared the video with the participants in the group in Google Hangouts via the Screen Share Tool. The special playtime videos were never viewable by the public nor to any of the other participants at any time.

**Fidelity to protocol.** As this is an investigative study regarding CPRT in an online format, there have been no other studies that implemented pre-recorded training videos to cover the material and skills from the manual. To ensure fidelity to the protocol, two master’s level therapists trained in Filial Therapy and CPRT were asked to watch the training video for week one. Both therapists indicated that there was no deviation from the manualized treatment and that there was complete fidelity to the CPRT protocol.

**Statistical Analyses**

**Assumptions.** This study operated under several assumptions, and are as follows. First, the author assumes that the parent participants will be honest and forthcoming in their responses on both the PPAS (Porter, 1954) and the perception survey. This assumption is made based upon the preservation of their confidentiality, the
anonymity under which they will respond to the questions, and the volunteer status that they will maintain with no penalty for withdrawing from the study.

Second, the author assumes that the pre- and post-treatment correlated means t-test methodology is appropriate for the quantitative element in this study. This assumption is made based on the precedent set in previous studies on the efficacy of CPRT, which includes a measure of parental acceptance conducted before treatment and after treatment to measure changes as a result of the intervention.

Third, the author assumes that the qualitative survey is an effective method of gaining insight and information to inform future studies that integrate traditional therapeutic approaches with online formats. This assumption is made based on this initial investigation of CPRT in an online format, yielding data to guide follow-up research by exploring perceptions about the process and the experiences of the participants to offer a more comprehensive analysis.

Finally, the author assumes that criteria for a t-test were met. Berg and Latin (2008) report that the researcher should examine the following criteria:

1. Data are drawn from normally distributed populations.
2. Data represent random samples from the population.
3. Variance in each group is similar.
4. Data are absolute, interval, or ratio. The data should be continuous and have equal intervals (p. 146).

**Research Question One.** The PPAS was administered pre- and post-training to assess the extent to which an online format of CPRT affected levels of parental acceptance of children. With the collected data from both iterations, a correlated means
t-test was conducted on total mean score, as well as the mean scores on the four subscales of the instrument. Data was entered into a statistical analysis program to yield the standard deviation, p value, effect size, and mean scores for the participants’ responses.

**Research Question Two.** The semi-structured survey was administered post-training to provide insight into the parental perceptions of the process of online parent training, including benefits and challenges. With the open-ended responses provided by the participants, themes were identified and coded by the researcher.

Due to the small sample size in this study, if the word, phrase, or idea was duplicated by more than one participant in response to one of the questions, the author coded that as a theme in the data. Considering two participants responding with the same or similar answer represented 25% of the sample, the author felt that this was an effective method for identifying themes in the responses.

**About the Researcher**

The study design required that the author have interaction with the participants as the trainer and facilitator of the online format of CPRT, and thus it is prudent to note the author’s qualifications. The researcher has extensive experience working with children and their families in the areas of Play and Filial Therapy. She received her master’s degree in Community and Mental Health counseling and is a licensed mental health counselor. She also received a graduate certificate in Play Therapy, indicating she completed a total of twelve hours of graduate course work in Introduction to Play Therapy, Group Play Therapy, and Filial Therapy.
Previous to full-time courses for her doctorate, she ran a private practice serving children ages two to fifteen and their families, offering individual, group, and filial therapies. She offered CPRT in her practice to parents and caregivers, and was approved through the Pinellas County Court System to provide the program for court-ordered parenting classes.

She has maintained a blog and social media presence since 2006, offering Play Therapy and parenting advice. She writes articles on her website and email newsletters to her subscribers, providing helpful information to thousands of individuals. She has presented on Play Therapy at state conferences, guest blogged on parenting sites, has been referenced as an expert in national publications, and has been featured in international news sources.

She has also taught online undergraduate courses at the University of South Florida for the past four years. During this time, she became a Certified Online Educator through the Innovative Education Department at the University of South Florida.

Summary

The author collected both quantitative data from the PPAS (Porter, 1954) and qualitative data from the perception survey in this study. Both were analyzed simultaneously to provide breadth and richness of data that better informed the literature about an online version of a traditional parent training program. The results of these data analyses are presented in Chapter Four.
Chapter Four: Results

The purpose of this study was to explore the effects of an online format of CPRT on parental levels of acceptance; to investigate parental perceptions of completing a parent training online; and to gain awareness of the challenges and benefits of the process of an online format. By understanding the outcomes and perceptions of an online parent training, therapeutic services can be improved and expanded to better serve children and their families. The research questions were:

1. To what extent does an online format of CPRT effect levels of parental acceptance of children?
2. What are the parental perceptions of the process of online parent training, including benefits and challenges?

Response Rate

During the recruitment phase, 49 potential participants expressed interest in the study. Of that group, 31 met inclusion criteria and qualified for the study, but only 22 of those 31 potential participants completed the Informed Consent and were admitted into the study. However, 15 participants began the ten week study by completing the pre-training assessment. Due to higher than normal attrition rates, another seven participants were lost during the ten-week training and eight participants completed the study.
**Attrition.** In order to account for attrition rates during the study, a review of other online therapy studies was conducted to determine average rates of attrition reported. Since there are no studies implementing an online version of CPRT for comparison, other mental health treatment programs offered exclusively online were reviewed, finding that the attrition rates vary dependent on several factors.

First, studies open to the general public tend to have higher rates of attrition than those whose participants are limited to clinical or trial-based designs (Titov, Andrews, Choi, Schwencke, & Johnston, 2009). Further, studies that are self-directed or self-guided without any therapist involvement have much higher attrition than those with a therapist (Ruwaard, Broeksteeg, Schrieken, Emmelkamp, & Lange, 2010; Andersson, Carlbring, & Grimmel, 2008). In fact, studies show that even the slightest involvement of a human for live support in an online treatment increases engagement and reduces attrition rates of the participants (Titov et al., 2010; Marks & Cavanaugh, 2009). Interestingly, Hebert, Vincent, Lewycky, and Walsh (2010) explored predictors of adherence and attrition in their study. They discovered that the attrition rate of 17% in their study was predicted by the severity of the symptoms and psychiatric comorbidity of the participants. They also reported that adherence to treatment was predicted by “behavioral control, social support, and intention to complete the program” (p. 141).

According to other published studies, the reported attrition rates for online therapies during treatment average around 20% (AL-Asadi, Klein, & Meyer, 2014). A meta-analytic study of 22 e-mental health studies revealed a range of 0-52% attrition rates, with a median rate of 20%; in other words, 80% of participants who began
computerized treatment completed all stages of the program (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010).

The author wished to recruit until forty-two parents met inclusion criteria to account for a projected 20% attrition rate. However, after more than three weeks of recruitment without reaching this goal, recruitment ended when the author reached twenty-two fully qualified participants. However, only fifteen participants began the study by completing the first week’s requirements. Throughout the course of the ten week training, seven more were lost due to attrition. This attrition rate of 47% was significantly higher than other reported rates for online therapies found in the literature.

**Power.** An a priori analysis revealed that this study required thirty-four participants to attain a medium effect size (.15), a power of .80, and alpha of .05. These criterion are considered standard for this type of research (Faul, Erdfelder, Buchner, & Lang, 2009), and although Cohen (1988) does not address correlated means t-tests in his writing, he does recommend a power of .80 for behavioral research. Although a power of .80 was planned with the intention of including 34 participants, the study was underpowered as a result of recruitment and attrition challenges.

**Completers vs Non-completers.** As a result of the high attrition rate and the underpowered study, a post hoc analysis of pre-training assessment scores on the PPAS (Porter, 1954) for those who did not complete the ten-week training was conducted to investigate any differences in those who completed the training versus those who did not complete the study. An independent means t-test was conducted on the total mean scores and on the mean scores for each of the subscales. The results from these t-tests are presented in Table 1.
The t-tests revealed that there were no statistically significant differences in scores on the pre-training assessment between those who did or did not complete the training. However, on the total mean score (M=149; M=140.88; t(13)=1.16, p=0.267) and two of the subscales: child’s need for independence (M=43.57; M=39.13; t(13)=2.04, p=0.622) and unconditional love (M=34; M=30.88; t(13)=0.9, p=0.384), the non-completers scored higher on levels of parental acceptance than those who completed the training. On the appreciation for the child’s unique makeup subscale, the non-completers reported a lower score by two points (M=34.75; M=36.75). On the respect for the child’s feelings subscale, non-completers reported a lower mean score than those who completed the training (M=34.57; M=36), but the difference was less than two points. All five of these scales had small effect sizes less than 0.5.

Table 1 Differences in Completers and Non-Completers

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean Score - Completers</th>
<th>Mean Score - Non-Completers</th>
<th>Effect Size</th>
<th>T-value</th>
<th>Degrees of Freedom</th>
<th>P value</th>
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<tr>
<td>Total Scale</td>
<td>140.88</td>
<td>149</td>
<td>0.3062</td>
<td>+1.16</td>
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<tr>
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<td>-0.7</td>
<td>13</td>
<td>0.496</td>
</tr>
<tr>
<td>Subscale - Independence and Autonomy</td>
<td>39.13</td>
<td>43.57</td>
<td>0.4924</td>
<td>+2.04</td>
<td>13</td>
<td>0.622</td>
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<tr>
<td>Subscale - Child’s Feelings</td>
<td>36</td>
<td>34.57</td>
<td>0.1481</td>
<td>+0.54</td>
<td>13</td>
<td>0.598</td>
</tr>
</tbody>
</table>
Demographic Data

Demographic data collected from this assessment revealed that all participants were female (n=8, 100%). Three of the participants (n=3, 38%) were from international countries; two from South Africa and one originally from Norway living in England. The remaining five (n=5, 63%) were Americans living in the United States.

Of the eight participants, seven (n=7, 88%) reported their race to be not Hispanic or Latino and one (n=1, 13%) reported her race to be Hispanic or Latino. All eight of the participants (n=8, 100%) reported that their ethnicity as White.

Six (n=6, 75%) of the participants were married, two were unmarried (n=2, 25%). Two participants (n=2, 25%) reported an annual household income less than $15,000 per year. One participant (n=1, 13%) reported an income between $25,000-$34,999. Three participants (n=3, 38%) reported an income between $75,000-$99,999. The final two participants (n=2, 25%) reported an annual income of more than $100,000 per year.

Three (n=3, 38%) of the participants were stay-at-home moms, and two of the participants (n=2, 25%) were graduate students. The other participants were a counselor (n=1, 13%), graphic designer/illustrator (n=1, 13%), and software product owner (n=1, 13%).

The range of ages of participants was 24 to 39, with a mean age of 33 years (M=33). Education levels varied, but every participant completed at least two years of college. One participant (n=1, 13%) had two years of college education, another (n=1, 13%) had three years of college education. Two additional participants (n=2, 25%) completed a four year degree. Two participants (n=2, 25%) completed one year of post-
graduate education, and the final two participants (n=2, 25%) completed three years of post-graduate education.

The participants had children ranging from three to ten years old, with a mean age of six years old (M=6). Six participants (n=6, 75%) chose to work with male children of focus, and two participants (n=2, 25%) chose to work with female children of focus. Demographic data on the participants are presented in Table 2.

**Research Question One**

The PPAS (Porter, 1954) was completed by all eight participants, both prior to and at completion of the ten week training. This forty question assessment measures levels of parental acceptance in a self-report instrument. The total score and the four subscales were calculated so that correlated means t-tests could be performed with the data. The results of these t-tests are presented in Table 3.

**Total score.** The results of the t-test indicate that there was a statistically significant increase in levels of parental acceptance after completing CPRT in an online format. The total mean score before the training (M=140.88) and after the training (M=164) reflect an increase of almost 24 points with a large effect size of 0.8206; SD(pre)=16.80508, SD(post)=13.07123, p=0.009859, n=8.

**Subscales.** There was also evidence that the online format of CPRT significantly increased the mean scores on two of the four subscales on the PPAS (Porter, 1954); respect for the child’s feelings and their right to express them, and recognition of the child’s need for independence and autonomy. On the other two subscales, loves child unconditionally, and appreciation of the child’s unique makeup, the differences were not
### Table 2 Sample Demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
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<tr>
<td>Counselor</td>
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<td>13</td>
</tr>
<tr>
<td>Graphic Designer/Illustrator</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Software Product Owner</td>
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<td><strong>Marital Status</strong></td>
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</tr>
<tr>
<td>Three years of graduate school</td>
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<td>25</td>
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<tr>
<td><strong>Children of Focus</strong></td>
<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>6</td>
<td>75</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>25</td>
</tr>
</tbody>
</table>
statistically significant, even though there was an increase in mean scores on both of these subscales.

Table 3 Inferential Statistics

| Scale                                | Mean Score - Pre-training | Mean Score - Post-training | Effect Size | Standard Deviation - Pre-training | Standard Deviation - Post-training | P value  
|--------------------------------------|---------------------------|-----------------------------|-------------|-----------------------------------|-----------------------------------|---------
| Total Scale *                        | 140.88                    | 164                         | 0.8206      | 16.80508                          | 13.07123                          | 0.009859
| Subscale - Unconditional Love        | 30.88                     | 33.38                       | 0.2894      | 8.40812                           | 12.72722                          | 0.450003
| Subscale - Unique Makeup             | 34.75                     | 39.63                       | 0.4729      | 5.92211                           | 5.52753                           | 0.198576
| Subscale - Independence and Autonomy *| 39.13                     | 46                          | 0.9177      | 5.02671                           | 3.6645                            | 0.000486
| Subscale - Child's Feelings *        | 36                        | 44.38                       | 0.8834      | 3.74166                           | 3.5431                            | 0.001583

* Indicates a statistically significant increase in score.

Respect for the child’s feelings. The mean score before the online CPRT training on this subscale (M=36) was more than eight points lower than after the training (M=44.38) with a large effect size of 0.8834; SD(pre)=3.74166, SD(post)=3.5431,\( p=0.001583, n=8. \) This indicates a statistically significant change in this subscale as a result of participating in the online format of CPRT.

Recognition of the child's need for independence. The mean score before the online CPRT training on this subscale (M=39.13) was almost seven points lower than after the training (M=46) with a large effect size of 0.9177; SD(pre)=5.02671, SD(post)=3.6645, \( p=0.000486, n=8. \) This indicates a statistically significant change in this subscale as a result of participating in the online format of CPRT.
Appreciation for the child’s uniqueness. The mean score before the online CPRT training on this subscale (M=34.75) was almost five points lower than after the training (M=39.63), with a small effect size of 0.4729; SD(pre)=5.92211, SD(post)=5.52753, p=0.198576, n=8. While this reflects an increase in parental acceptance on this subscale, it was not statistically significant.

Unconditional love. The mean score before the online CPRT training on this sub scale (M=30.88) was almost three points lower than after the training (M=33.38), with a small effect size of 0.2894; SD(pre)=8.40812, SD(post)=12.72722, p=0.450003, n=8. Once again, this reflects a slight increase in parental acceptance, though not statistically significant.

Research Question Two

A post-training survey was conducted with all eight participants, inquiring about their perceptions of an online training experience (see Appendix J). This eight question assessment collected perceived benefits, challenges, feedback, and thoughts from the participants. There were duplicate responses noted on two pairs of questions; one and three, and two and four. Therefore, the participants’ responses on those two pairs of questions were combined to eliminate redundancy in the results. Themes were identified in the responses and summarized.

Positive perceptions. As noted, the responses to the following questions were aggregated: Please discuss the perceived benefits of an online format for parent training; and Please indicate what you liked best about the online format. Several themes were identified from their responses and are presented as the positive perceptions of the online training.
**Convenience.** All eight (n=8, 100%) of the participants mentioned the convenience of an online format and the flexibility that it allowed. This was reflected in six different themes that were identified across both questions, as noted below.

*Working at their own pace.* Five of the participants (n=5, 68%) indicated that the ability to work at their pace was a benefit. Without a scheduled meeting time, participants were able to process the information, practice the skills, and watch the videos several times if necessary to fully digest what they were learning. One participant responded: “With this format, working through the material at my own free time, as well as doing play sessions at home, meant there was a more relaxed atmosphere, and we could achieve the milestones of each week smoothly.” Another participant said, “Watching the videos/doing the homework in my own time was very valuable.”

*Accessibility.* Half of the participants (n=4, 50%) reported that the online training format allowed participants to watch videos and complete the requirements whenever desired or during convenient times. This was especially important for those in different time zones. Further, they were provided access to the training materials and videos twenty-four hours a day, allowing them to re-watch the skills which would have not be possible in a traditional, face-to-face format. One participant replied:

Having access to the training videos throughout the week, you are able to watch it at a time that is most convenient for you (and your family). If you only have 15 minutes to spare you can watch the rest of the video later or even go back and watch it over and over.

*No driving.* Half of the participants (n=4, 50%) indicated that not having to drive somewhere for the training sessions each week was also a benefit. The participants not
only received the training videos online, but also met in online groups. Neither of these components required leaving the house and driving to a common location to meet. One participant said: “I didn't have to make the time for a class that I had to drive to and from as well. Time is so limited with the whole family as it is.”

*From home.* Four of the participants (n=4, 50%) indicated that they believed that completing the entire training at home was also a benefit. They were not required to leave the house and it required less coordination for other family members. There was another theme that emerged related to staying at home; not having to arrange daycare or childcare to participate (n=2, 25%). One participant indicated, “I liked that I could do it from home and take less time away from the family.” Another participant reported:

I love that we could do everything at home. With more than one kid it would be impossible for some people to get this type of training one on one if they had to bring their other kids or arrange daycare.

*Global access.* Three of the participants (n=3, 38%) expressed that being able to access the training from anywhere in the world was beneficial. Several of the participants were from other countries. Another theme related to global accessibility was accessing the training anywhere in the world, even while traveling or on vacation (n=2, 25%). One participant said:

The online format makes it possible to have access to parent training even if you are on the other side of the globe! We live in a small town in South Africa and if it wasn't for this online training course, I probably would never have had the opportunity to learn and practise the play therapy skills I acquired during this online training. I do not know of any play therapists in our area.
**Sharing in the hangout.** Five of the participants (n=5, 68%) responded that the sharing and camaraderie within the group Hangout was very positive. The group dynamic of support and encouragement is a large part of the CPRT training and the online format was no exception. One participant said: “Enjoyed support and community with other moms in hangouts.” Another participant said: “Getting to know other parents and watch their play sessions during Hangouts.”

**User experience.** Three of the participants (n=3, 38%) indicated that the user experience was enjoyable and positive. This included comments related to the training being well-organized and well-planned; effective presentation of content; professional and easy to navigate website; and high quality of the training videos. One participant said: “Straightforward, terrific content and program, well planned in advanced and always on time, neat and easy to use and very clearly presented both verbally and in writing.”

**Single response.** The final response to the questions of positive elements related to participating in the online training format was unique to the individual completing the survey and was not thematic in nature. It was that it is financially beneficial (n=1, 13%).

**Negative Perceptions**

As mentioned previously, the responses to the following questions were aggregated to eliminate redundancy in the results: Please discuss the perceived drawbacks of an online format for parent training; and Please indicate what you liked least about the online format. These responses were coded thematically and are presented as the negative perceptions of an online format.
Technical difficulties. Three of the participants (n=3, 38%) indicated that internet connectivity and technical difficulties were drawbacks. Two of these participants were in South Africa, where there are noted bandwidth issues causing delays in the uploading and viewing of videos. One participant responded: “In RSA, some weeks it was a real challenge to watch the whole video end to end, as our bandwidth was limited and caused the video to buffer a lot.” Another participant said: “The internet connection, at times, was slow.”

Length of hangouts. Three of the participants (n=3, 38%) responded that they felt that the synchronous group Hangouts were too short each week. Each session was scheduled for 45 minutes each week so that the participants were able talk with the other moms and go over questions and concerns. One participant said: “I felt the time of 45 minutes for a group was too little and by wanting to ask more questions I felt a bit that I would be of bother to all, since time always went above.” Another participant said: “Group discussions were limited. Sharing of experiences with other moms limited sometimes due to length of hangouts.” Another participant said:

At one point I had emailed a question and was told to bring it up in the hangout, and because of time we just never talked about it. So I did feel that some weeks I would have liked to have more time to discuss things.

Virtual interaction. Three of the participants (n=3, 38%) indicated that the virtual interaction may have been less conducive to spontaneous conversation that could have taken place in a face-to-face setting, and that the online format felt less personal as compared to a face-to-face setting. More specifically that the online group format prevented one-on-one interaction with the therapist. One participant said: “It wasn’t as
personal as I would like, but it was because of the group setting.” Another participant said: “I believe it can sometimes be more effective in person so the energy of being present in the given moment applies or issues can more easily be addressed.”

Single responses. The remaining three responses to the perceived drawbacks of participating in an online training format were unique to the individual competing the survey and are not thematic. They were that an online format required self-discipline to complete the requirements on time (n=1, 13%), the content and videos could have been condensed (n=1, 13%), and that the examples used to illustrate a skill could have been from a participant rather than from the manual (n=1, 13%).

Suggested Improvements

There were thirteen unique responses from the eight participants in answer to the following question: Please suggest ways to improve the online format in the future. There were no thematic codes identified from this set of responses, as each response was unique to the individual. The suggestions were as follows:

1) to add more examples to the training videos, rather than reading directly from the manual.

2) to offer a different platform to which play session videos can be uploaded.

3) to group parents in the Hangouts according to the age of their child of focus.

4) to offer digital versions of worksheets and materials.

5) to create an online space for each participant, similar to a profile page.

6) to implement a ten minute weekly phone call to check in with each participant.

7) to shorten the training.
8) to provide a weekly content list at the beginning of the training so that participants know what is coming next.

9) to clarify when to begin play sessions.

10) to address who is to speak in the Hangout by name.

11) to clarify when to complete the supplemental material each week.

12) to create a separate discussion/comment section not specific to each week that remains available throughout the training.

13) to require participants to post at least one comment per week in the weekly discussion forum to encourage conversation and support.

One Word Description

There were seven unique responses to the following question from the eight participants: Please provide one word expressing your feelings about the parent training that you just completed. There were no thematic codes identified in this data set; however, there was one duplicate response. The words chosen by the participants were as follows:

1) gratitude

2) helpful

3) life-changing

4) successful

5) communication

6) inspired

7) amazing (n=2)
Future Online Training

The eight participants were asked the following question: Would you complete an online parent training again, as a result of your experiences in this study? In each case, the participant responded that they would complete another online training.

**Explanation.** As a follow up to the question regarding their likelihood to take another online parent training, each of the eight participants responded to the following question: Why or why not? There were seven unique responses from the participants that were thematically coded and represent their explanation for why they would participate in another online parent training. Many of these responses overlap from the positive perceptions of the online format.

**Personal benefit.** Five of the participants (n=5, 62%) responded that they gained great personal benefit for themselves, their parenting skills, and their family by participating in the training. One participant said: “I saw immediate benefits in my relationship with my kids. I learned skills that I otherwise would not have been exposed to that have improved my interactions with my kids on a daily basis.”

**Effective tools.** Half of the participants (n=4, 50%) indicated that they learned effective and helpful tools to assist them in their parenting and better their relationship with their children. One participant said: “I feel that I received benefit from being in this study. The tools taught were effective.”

**Interaction.** Three of the participants (n=3, 38%) indicated that they loved having the interaction with other participants during the training. The synchronous, group Hangouts and the forum on the study website allowed the participants to discuss and
talk with other moms throughout the training. One participant said: “The collaboration with other moms was nice.”

**Convenience.** Two of the participants (n=2, 25%) remarked that they loved the convenience of the online format and virtual training program. It was practical for many busy families to have the opportunity to participate at home. One participant said: “The online parent training format is very up-to-date with people's lives and schedules. There is little hassle or worry about making it to a session on time.”

**Access to content.** Two of the participants (n=2, 25%) responded that they loved that they can go back to re-watch the videos to refresh their skills. The login for each participant allows them access to the material and content even after the ten week program is over. One participant said:

I find when you don't constantly refresh yourself on the techniques, you gradually forget what you learned. If you don't constantly practice to be calm and neutral (or not ask and answer questions) you start to sink back to old habits during the tough times. Luckily we have notes (and videos) to go over again for future reference.

**Single responses.** The final two responses related to why they would complete an online parent training again were unique to the individual and not thematic in nature. They were that they loved the therapist (n=1, 13%), and they love the fact that they can begin play sessions with their other children (n=1, 13%).

**Summary**

The responses from the participants on the PPAS (Porter, 1954) indicate that participating in CPRT online does significantly increase levels of parental acceptance;
therefore, the null hypothesis is rejected. Further, parental perceptions of participating in an online parent training were mostly positive. Recommendations for changes to the format were helpful and appropriate. The implications and considerations of these results will be addressed in Chapter Five.
Chapter Five: Summary and Conclusions

Children’s mental health is of growing concern and attention in the field of therapy (Goldfine et al., 2008), as practitioners aim to better meet the needs of children and their families. Empirically supported treatments are critical and parent participation increases positive outcomes for children in therapy (Diamond & Josephson, 2005). CPRT has been proven to increase levels of parental acceptance, but had never been offered in an online format until this study. Integrating CPRT and an online format allows for more children and their families to be offered mental health treatment and effective therapeutic interventions.

This study was conducted with eight participants (n=8) who completed the ten week CPRT manualized treatment program, but in an online format rather than the traditional, face-to-face setting. The participants completed the PPAS (Porter, 1954) before and after the training and also completed a semi-structured brief survey post-treatment. This exploratory study aimed to answer the following questions:

1. To what extent does an online format of CPRT effect levels of parental acceptance of children?

2. What are the parental perceptions of the process of online parent training, including benefits and challenges?
Discussion

Research Question One

To address Research Question One, a correlated means t-test was conducted with the data collected from the PPAS (Porter, 1954). The findings indicated a significant increase in levels of parental acceptance after completing the CPRT online training. The total mean score, as well as the mean scores on two of the four subscales on the instrument, reflected statistically significant increases when comparing pre- and post-treatment responses.

Total mean score. The PPAS (Porter, 1954) is designed to measure levels of parental acceptance, regardless of the child’s behavior. Many parents, when answering questions that posed negative scenarios in the assessment, responded with corrective or critical answers pre-treatment. Answers were markedly more accepting and neutral when given the same scenario in the assessment post-treatment. This reflects a higher level of neutrality about their children’s behavior, likely emerging as a result of the CPRT training concepts that teach parents to respond rather than react and set limits when necessary while still reflecting the child’s feelings.

These results confirm the findings in other studies that report an increase in levels of parental acceptance after participating in CPRT (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002;
Yuen et al., 2002). Considering the mental health implications that have been reported relative to levels of parental acceptance and children’s psychological adjustment (Lee & Chyung, 2014; Giotsa & Touloumakos, 2014; Teichman & Kefir, 2000), the evidence that CPRT in an online format does have a positive influence on parental acceptance levels is noteworthy for practitioners.

**Subscales.** The two subscales that reflected a statistically significant increase in levels of parental acceptance, respect for the child’s feelings and their right to express them and recognition of the child’s need for independence and autonomy, were reflective of two of the major skills taught in the CPRT training.

Interestingly, Harris and Landreth (1997), as well as Tew and colleagues (2002), analyzed the subscales independently and reported that parents who participated in filial therapy “scored significantly higher than parents in the control condition on two subscales: respect for the child’s feelings and their right to express them, and the recognition for the child’s need for autonomy and independence” (VanFleet and Topham, 2015, p. 143). These are the two subscales that had statistically significant increases in this study as well, confirming the impact that CPRT has on parental acceptance levels.

**Respect for the child’s feelings.** This subscale, reflected in the parent’s ability to not become emotionally disturbed because the child expresses negative feelings and to realize that such feelings need to be expressed for the maintenance of good mental health, did show a statistically significant increase in mean scores. Reflective responding, which includes recognizing and reflecting the child’s feelings, is a foundational principle of play therapy.
This skill was taught and reinforced throughout the ten weeks, and is rooted in the CPRT training concept that any feeling is valid and accepted. Parents are encouraged to identify the child’s emotion and then tell the child what they believe they are expressing. Bratton et al. (2006) state: “Reflective responding is a way of following rather than leading. Reflect behaviors, thoughts, needs/wishes, and feelings without asking questions. This helps parents understand the child and helps the child feel understood” (p. 183). This element of the CPRT training likely led to an increase in awareness of the child’s feelings and sensitivity to recognizing that the child should be encouraged to express them, and was reflected in an increase mean score on that subscale.

**Child’s need for independence.** This subscale, reflected in the parent’s ability to allow and encourage the child to become increasingly independent and not resist the growth toward independence, showed statistically significant increases in scores. Encouragement, another foundational principle of play therapy, recognizes the child’s effort regardless of outcome. This skill was practiced extensively for ten weeks, and is rooted in the CPRT training concept that an adult should “never do for a child that which he can do for himself or herself” (Bratton et al., 2006, p. 216).

Encouragement is offered with phrases that focus on building self-esteem, self-confidence, and self-worth and are spoken without value judgments, such as “You did it” or “You figured it out.” This likely led to an increase in allowing the child to do things for himself or herself and to test his or her abilities, and was reflected in an increase mean score on that subscale.
Unconditional love. This subscale, reflected in the parent’s ability to offer support and love at all times - share his child’s joys and sorrows; support him in failures as well as successes, did not indicate a statistically significant increase, though it did reflect a positive change in score from pre- to post-training. One possible consideration is that ten week training program may not be long enough to cultivate a fundamental change in a parent’s approach to loving their child no matter what the circumstance. Testing the participants after a longer time period may show an additional increase in unconditional love toward the child, with continued practice of skills and principles gained from the CPRT online training program.

Further, other studies have reported results of the PPAS (Porter, 1954) without calculating the Unconditional Love subscale while still acknowledging an increase in parental acceptance levels. Guerney and Gavin (1981) reported that they chose not to calculate the Unconditional Love sub scale because “the scale has a different format, requiring different directions, and was reported by Porter (1954) to correlate less well than the other scales with the total score” (p. 29). This seems to support the findings of this study that although there was a statistically significant increase in parental acceptance levels, the Unconditional Love subscale reflected an increase in scores that was not significant.

Appreciation for the child’s uniqueness. This subscale, reflected in the parent’s ability to allow the child to be different from every other child and feel all right about it, also did not indicate a statistically significant increase, although the mean score was higher after the training. Upon the author’s examination, some of the questions on the appreciation of the child’s unique makeup subscale lend themselves to very specific
responses by parents who have completed CPRT. For example, one question poses: “When my child is unable to do some things as well as others in the group, I:” One of the responses is: “Encourage him/her to keep trying.” This response, specifically highlighting the skills of encouragement and independence which are taught in CPRT, is not as neutrally scored as some of the other possible responses to this question on the scale. This encouraging response, while extremely reflective of CPRT principles, does not reflect the highest level of parental acceptance per the scoring rubric, resulting in a decrease in score on that subscale for many participants.

**Application**

The positive correlation between CPRT and an increase in levels of parental acceptance has been widely documented in the literature, albeit from studies with groups conducted in the traditional format rather than online (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002; Yuen et al., 2002). The impact of CPRT on parental acceptance levels may now extend beyond a face-to-face setting to an online format, where the same effect has been observed.

**Research Question Two**

To address Research Question Two, a brief, semi-structured post-treatment survey was conducted, yielding responses related to the participants’ perceptions about an online parent training program. Responses were examined and analyzed for themes. However, there was clearly overlap in the responses from two pairs of questions and for the sake of reducing redundancy in the discussion, those responses were aggregated
and reported together. Positive and negative perceptions of the online format were analyzed by combining questions one and three, and questions two and four:

1. Please discuss the perceived benefits of an online format for parent training.
2. Please discuss the perceived drawbacks of an online format for parent training.
3. Please indicate what you liked best about the online format.
4. Please indicate what you liked least about the online format.

Positive perceptions. The survey responses were thematically identified and coded to assess positive perceptions of the online training. Many of the responses overlapped in content and topic and were aggregated to provide a broad sense of benefits and positive perceptions.

Convenience. Convenience was the most commonly reported benefit, which took on many forms. Participants indicated that they liked the opportunity to work at their own pace during the training. Participants reported that they appreciated being able to participate from their home. They also indicated that not having to drive to an appointment and get there on time was a benefit. They liked that the online format did not take time away from their family. They also mentioned that they appreciated that they did not have to arrange for daycare or babysitters to participate.

Access to the training material was another commonly reported response. Participants indicated that they appreciated the ability to access the content at any time, when their schedules allowed. They liked that they could still participate and login even when they were traveling or on vacation. They remarked that it benefitted them that they were able to watch the training videos and print materials twenty-four hours a day, so that living in different time zones around the world did not affect the training schedule.
They also appreciated that the online format allowed them access to the materials and videos consistently, so that they could complete the required assignments throughout the week at their own pace.

One of the reported benefits of online counseling consistent in the literature is that of accessibility. Speyer and Zack (2003) state: “Online counselling offers convenience and remote access, serving clients with limited mobility, time restrictions, or anyone seeking help who is reluctant to see a counsellor in person. It makes keeping appointments at a specific time and place unnecessary” (p. 11). The responses from the participants in this study seem to support what exists in the literature.

Many barriers have been reported regarding seeking and entering into treatment in a clinical setting (Corrigan, 2004; Richards et al., 2014). Among those barriers are distance and time. This appears to be well-supported by the survey responses in this study. Further, Anderson and her colleagues (2000) indicated that online therapeutic interventions reduce or eliminate most of the commonly noted barriers and resistance to treatment, which was also supported by the results of this study. Families, and mothers specifically, seem to be aware of the limited time together and wary of adding another responsibility or obligation. All of the reported convenience benefits from the participants in this study relate to wanting training to increase their parenting skills and communication, but an unwillingness to add another item to their already hectic schedules to achieve that goal.

**Sharing in the hangouts.** The synchronous, group Hangouts each week was another commonly reported response, for several reasons. Participants appreciated the sharing between the other participants that took place during the Hangouts. Participants
reported that the interaction with other moms was helpful and beneficial. They also acknowledged that it created a sense of community within the participants and added a unique dynamic to the training.

The positive impact of the group component of CPRT has been well-documented in the literature. Landreth and Bratton (2006) speak of a mother who participated in CPRT that said:

Dr. Landreth could sit there and tell us all day that there are other parents like us who are struggling, to try to make us feel better, but knowing that there are other people we can see, hear, and touch makes a big difference. It helped me so much to hear you all describe your problems and struggles with your children. (p. 19)

This group element, converted into the Hangouts in the online format, still proved to be a very significant and important benefit to the training, based on the participants’ responses to the survey questions. This further confirms and supports existing literature that providing a place where participants can interact, support, and encourage each other is “unique and vital to the success of CPRT” (Landreth & Bratton, 2006, p. 17).

**User experience.** User experience was another commonly reported theme, again with many forms. Participants reported appreciating the well-organized and well-planned study as a whole. They liked the presentation of the material and the content. They commented on the user-interface and easy-to-navigate study website. Participants also appreciated the high quality of the training videos.

Donald Norman (2002) speaks about user-centered system design when creating websites and webpages:
Think of the user’s point of view. Assume that every possible mishap will happen, so protect against it. Make actions reversible. Try to make them less costly. Make the results of each action apparent. Make it possible to determine the system state readily, easily, and accurately, and in a form consistent with the person’s goals, intentions, and expectations. (p. 140)

The author’s goal, when designing the user interface of the study website with the web designer, was to make it easy to use and intuitive for study participants. The author understood that if it was difficult to navigate, understand, or use the participants would be less likely to gain the full benefits of the study. Technology and usability barriers would have confounded the outcome, and made it difficult to assess the relationship between the CPRT training and the data gathered on the assessments.

Considering so many of the responses on the survey related to the user experience, it appears to align with the data that indicates that functionality and format are important to participants and worth considering when designing an online training. The author’s vision for the study website was one that blended usability with pleasing aesthetics. The participants’ survey data confirmed that this was achieved.

**Negative perceptions.** The survey responses overlapped in content and topic and were aggregated to provide and broad sense of negative perceptions and drawbacks of the online format. The responses to questions two and four were thematically identified and coded to assess the negative perceptions of the training.

**Technical difficulties.** Technical issues was a commonly reported drawback, but it was only reported by the two participants from South Africa and the one participant
who had a slow internet connection. The other five participants did not mention technical issues in their negative perceptions of the online format.

The Republic of South Africa has data caps in place, and throttles bandwidth to home internet users (Chetty, Banks, Bernheim Brush, Donner & Grinter, 2012). As a result of the bandwidth regulations, the two South African participants mentioned that the loading and uploading times for the videos, both the training videos and the play session videos, were extremely long. The long loading times sometimes prevented them from watching the training in video in one sitting, which they reported as a drawback.

The other participant who mentioned internet difficulties and technical issues reported that the internet connection was slow. The author noticed that in the Hangouts, this participant’s group dialogue was delayed due to the connectivity of her internet. One of the requirements of the training, per the inclusion criteria, was high speed internet. The author is not sure if the participant was not truthful about her internet connection, or if there were other issues causing the slow relay of live video feed. Regardless, it is obvious that technical issues can be a source of frustration for participants in an online format.

**Length of hangouts.** Participants reported that the length of the Hangouts were too short each week as a negative perception of the online CPRT format. They acknowledged that it limited sharing and interaction, limited questions that could be asked and answered, and that they would have liked to have had more time to discuss and talk about concerns, issues, or the material.
In a traditional, face-to-face setting the group meeting for CPRT is a once a week requirement. It is at that meeting that the weekly material is covered, the skills are discussed and practiced, and the parents are able to support and encourage each other. It typically lasts ninety minutes. This structure was modified for the online format, and it impacted the Hangouts for several reasons.

First, due to the number of participants and their varied schedules, there were three groups that met in the Hangouts. In order to ensure consistency and eliminate a confounding variable, the teaching and training portion of the weekly material was pre-recorded. The author was aware that if she conducted a live training with three different groups, there may be inconsistency from group to group. In an effort to reduce this bias, each participant watched the exact same training video, regardless of which Hangout group they were in. Due to the fact that participants watched the training portion on their own time and independently, this component was eliminated from the group time.

Second, each week’s training video ranged from forty to eighty minutes long, depending on what content was covered. This training is quite time intensive; a thirty minute play session each week, approximately an hour of training video to watch, and a forty-five minute group Hangout. With this in mind, the author felt it necessary to put a time limit on the Hangout so that it was less time intensive for the participants. This meant that there was less time to openly talk about issues from that week, the play session, or in general.

Finally, the weekly play session videos are also reviewed during the Hangout. Each week, a participant uploaded a play session video to receive feedback from the therapist and the other participants. While it was only partially viewed and feedback was
limited, it still required a large portion of the Hangout time each week, limiting open discussion.

**Virtual interaction.** Participants indicated that the virtual group setting was a negative perception. Some of the participants indicated that not being able to participate in spontaneous, in-the-moment conversation that would have been possible in a traditional, face-to-face setting was disappointing. Due to the structure of the Hangout, participants seemed less likely to just comment or add to the conversation; the participants appeared to wait for the author to serve as a moderator in the online interaction, rather than just jumping in and asking questions or responding to other participants’ discussion.

In fact, in one of the comments regarding ways to improve the online format in the future, a participant said:

> It helped a lot when you said: "E, will you please share..." instead of "Can you all please share?" It was hard to anticipate who is going to start talking first and then we ended up staring at each other.

The lack of natural flow of conversation in the Hangouts seemed to slightly influence the perception of the participants of the online format, even though all of the participants indicated that they would participate in another online parent training as a result of their experience in this study.

This aligns with a previously conducted study revealing that students had “slightly more positive perceptions about the instructor and overall course quality” when the training was conducted face-to-face as compared to an online delivery of the training, even though “the two methods of delivery were reported to produce no difference in
several measures of learning outcomes” (Johnson, Aragon, Shaik, & Pama-Rivas, 2000, p. 29).

Conclusions

Upon assessing the quantitative and qualitative data gathered from the assessments, it is clear that CPRT does positively impact levels of parental acceptance. Further, most of the perceptions of the process of an online format and the participants’ experience were positive. There are other less broad and more specific conclusions that can be drawn from the results of this study, based on the author’s experience and the supporting literature:

Timing. There were several mitigating factors that the author believes influenced aspects of the study. First, the recruitment phase began in the last week in April. The first half of May is when all of the participants were required to meet inclusion criteria, sign the informed consent document, and prepare to begin the study. This happened to occur simultaneously with the academic calendar’s last few weeks of school for their children.

Many potential participants who expressed initial interest or those who fully qualified and were admitted into the study informed the author at a later date that the end of the school year was too hectic and busy for them to devote the time required to enroll in the study. The author realizes now that the recruitment phase would have been better suited for early April, so as not to conflict with the academic calendar. Further, it appears as though the timing of the recruitment significantly impacts the likelihood that a potential participant will complete the requirements and enroll in the study.
Additionally, the timing of the study was also a concern in hindsight. Several potential participants chose not to participate even after meeting inclusion criteria because the study spanned the entire summer, from the first week of June until the second week in August. Vacations, traveling, and summertime plans made the timing of this study challenging for parents of young children.

**Attrition.** Other online counseling studies with therapist interaction report an average of twenty percent attrition rates (AL-Asadi et al., 2014; Andrews et al., 2010). Although the author intended to account for a twenty percent attrition rate by recruiting more than necessary, this study reported a forty-seven percent attrition rate. The author believes this is due to several factors.

First, CPRT is a ten week training program. Once again, related to the timing, June 1 was the scheduled start date, requiring participants to login and complete pre-training week requirements. After the ten week protocol, the study finished up its last week on August 8. This spanned the entire summer, and family vacations and trips are usually planned at this time. Several participants who initially began the training got behind and missed weeks when on vacation and were not able to complete the training. Several participants were also lost due to not meeting compliance criteria related to traveling or vacations.

Second, CPRT requires a large time commitment and personal investment. Not only is ten weeks a long time to participate in a training, but it requires watching weekly training videos, conducting weekly play sessions, attending weekly group meetings, completing weekly homework, and weekly practice of the skills.
Landreth and Bratton (2006) discuss revisions to the 10-week model, acknowledging that in certain circumstances and with certain populations a condensed format may be more suitable or appropriate. They mention that CPRT has been conducted once a week for ten weeks as the traditional model, twice weekly or five weeks, 12 sessions in 14 days, four consecutive Saturdays, and one weekend comprised of two hours Friday night and seven hours on Saturday, each with statistically significant results, attesting “to the robustness of the ten-session CPRT model” (p. 445).

The investment required in CPRT makes it effective, but it also can be discouraging for people who could not commit to all of those requirements for ten weeks. Several participants who did not complete the training expressed that they were initially unaware of the lengthy time commitment and had to withdraw from the study as a result. A condensed version may be warranted to lessen the time commitment that is currently required or parents as the online format of CPRT is refined and replicated.

Third, the author believes that the nature of conducting a parent training at no cost to the participants lends itself to high attrition rates. Studies in economics, marketing, and business reveal that when people do not have to pay for something, they value it less (Sawyer, 2014). Therefore, as the participants in this study were receiving a $1250 training at no cost, this may partially explain the high levels of attrition, as they did not have a monetary investment in continuing and completing the training.

Considering there were no statistically significant differences in pre-training scores between those who completed and did not complete the training, parental
acceptance levels are not likely to have impacted attrition rates. It seems likely, then, that the timing of recruitment and the training, the personal and time commitments required, and the no cost training are all considerations for acquiring and retaining participants in an online format of CPRT.

**Hangouts.** As the literature reveals, CPRT is unique and effective in part due to the group component. Landreth and Bratton (2006) note that:

> parents often have strong reactions to their children and feelings about themselves and their family members that they need to process in order to be fully present and emotionally available to learn what is being taught in the CPRT training sessions. (p. 17)

In the modified online format, this group interaction took place in the Google Hangouts. It is interesting to note that the Hangouts were mentioned as one of the perceived benefits and positive perceptions of the online training format, even though the length of the Hangouts was reported as a perceived drawback. In light of both the reported appreciation for the group time and the desire for greater length of time to share, the Hangouts appear to be a significant element in the training, as supported by previous literature, and should be expanded to allow for more sharing and interaction.

In a traditional CPRT format, the entire weekly meeting is conducted at one time for approximately 90 minutes. This 90 minutes includes the weekly training and practice of new skills, review of the special playtime video to allow for support and feedback, group discussion, and peer interaction and encouragement. When the online format was developed, the weekly training video was prerecorded to ensure consistency and eliminate confounding variables in the presentation of the content.
Most of the training videos were between 45 and 60 minutes in length. To maintain integrity to the traditional format of CPRT, the author allocated 45 minutes for the Google Hangout so that there was not a greater time commitment each week than normally required of the participants had they been in a face-to-face setting. Even though the 90 minute meeting in the traditional format would include the same elements as the online format, the face-to-face meeting would include spontaneous and consistent interaction of participants through examples, role playing, questions, and feedback for twice the time allotted in the 45 minute Hangout. This extra time was obviously missed in the online format, as reported in the survey responses.

**Participants.** Although CPRT has been conducted effectively with diverse populations and groups (Bratton et al., 2005), there appears to be no mention of what type of person might be well-suited for this particular training. Further, since there have been no studies on the efficacy of CPRT in an online format, additional investigation into the types of participants who are a good fit for this approach is warranted.

Based on demographic data collected in this study, and the author’s analysis of participants who completed CPRT in this study, it appears that those who are likely to complete the online CPRT training have the following characteristics in common:

- Married
- Stay-at-home moms or moms with flexible work schedules
- Academically oriented
- Socially and community focused
- Achievement minded
- Competent using a computer, the internet, and social media
Recognizing these characteristics can inform recruitment messages and very specifically target those who might be the most likely to engage and complete the online format of CPRT.

It is also worth noting that all of the participants who completed the study were White. This warrants further investigation into motivations for participating in an online parent training and potential barriers to prevent interest or completion. Technological requirements may be one such consideration, as families with lower socioeconomic statuses may not possess the computer, video, and technical components required for this type of study. Several interested participants did not qualify due to their lack of technical equipment or their inability to buy the required toys for the special playtimes; this seems correlated with a financial implication, and could help to better screen potential participants.

**Limitations**

Several limitations are noted in this study. First, the volunteer sample of parents were not randomly chosen out of the population. This lessens the generalizability of the results. However, the author screened the parents who volunteered to ensure that they met inclusion and eligibility criteria, thus reducing unnecessary bias in the sample.

Second, the quantitative component of this study analyzed data yielded solely from the PPAS (Porter, 1954), measuring reported levels of parental acceptance. As such, the data collected is only as reliable as the instrument itself. However, studies have demonstrated a split-half reliability coefficient of at least .80 (Porter, 1954), and internal consistency at the .001 level of probability (Burchinal et al., 1957).
Third, both the quantitative assessment and the qualitative survey are self-report. Therefore, the validity of the data is contingent on honest and accurate responses from the parents; if they respond more favorably than truthfully, the integrity of the study is undermined. However, the participants were ensured confidentiality, and were strongly encouraged to respond honestly.

Fourth, the post-treatment survey to collect qualitative data about the perception and process of online parent training is not a published instrument, nor has it been tested for reliability or validity. The survey was developed to help inform the author about positive and negative elements related to conducting CPRT in an online format, but may not garner all possible feelings, beliefs, or thoughts from participants.

Finally, a ten week intervention offers a brief glimpse into the measured effect of the treatment, but does not provide insight into the lasting effects or the maintenance of treatment gains over time. Further, the effects are also reflective of circumstances and conditions existing throughout that ten week period outside of the author’s control. The acknowledgement is made that a longitudinal study would allow for greater insight about the effect of the treatment.

There are also two significant limitations evident in this study, both related to the sample. This study was conducted with a small sample size (n=8), which affected both power and generalizability.

**Power.** An a priori power analysis revealed that this study would require thirty-four participants to attain a medium effect size (.15), a power of .80, and alpha of .05. Due to the factors of timing, required commitment, and stringent inclusion criteria, many potential participants were not admitted into the study. Of the twenty-two who were
admitted, seven did not complete the pre-training requirements and were not granted access to the first week’s material. Of the remaining fifteen, seven more withdrew or did not meet compliance criteria during the ten weeks, leaving eight who completed the training.

As a result of the study being underpowered, there is a greater chance of a large effect size (Gelman & Weakliem, 2009), which makes it more difficult to determine whether CPRT truly had the effect that the data revealed. Therefore, only preliminary conclusions should be drawn from this investigative study, even though the outcomes were positive.

**Generalizability.** The sample size (n=8) was not only small, but also not representative of the world's population regrading race and ethnicity. All eight of the participants in this study were white females, which does not accurately reflect the race nor gender distribution in the world. Further, seven of the eight participants reported as Non-Hispanic, and only one reported as Hispanic, also not reflective of world-wide ethnic distribution. Although there were international participants, including a Norwegian and two South Africans, there was a disproportionate amount of Caucasians in relation to other races in this study.

As a result of the bias in the sample, it is difficult to assess whether these results would be observed with other racial and ethnic groups, or with fathers. Kukull and Ganguli (2012) state, “fair samples must provide valid estimates of the population characteristics being studied” (p. 1887). Therefore, although the sample in this study does provide a valid representation of the population characteristics of parents of young
children around the world, it is not necessarily reflective of outcomes that would be replicated with other races, ethnicities, or fathers.

**Implications for Practice**

Based on existing literature, and the results of this study, it is evident that parental involvement in children’s mental health and therapeutic interventions is crucial. It is no longer enough to treat just the child’s behavior concerns or just provide training for the parent. A unified approach to treatment, working on the relationship and communication between the parent and the child, is the future of children’s mental health.

An important implication is that practitioners must be trained in and aware of effective and empirically supported treatment options for children and their families. This study revealed that families would not have had access to play therapy if it had not been offered in an online format. Far too many young families are not given the support and treatment that they need due to access, distance, cost, and other barriers. In order to best serve clients, therapists will need to seek appropriate training for the populations with whom they work, specifically in the area of children’s mental health.

A related implication is that those who are interested in providing online parent training to parents of young children must have a sufficient background and competency in technology. It is not enough to just be trained in the therapeutic intervention; the ability to interface the existing training with the technological platforms and capabilities is crucial. Further, practitioners must also be able to provide troubleshooting assistance to participants related to required technologies, such as videos, the study website, and
Hangouts. Finally, practitioners must be aware of the time required to pre-record training videos, and have the necessary production and editing equipment to create the videos.

An additional implication is that practitioners must consider the benefit and breadth of service that offering online versions of proven face-to-face treatments would provide for clients. This study confirmed what already exists in the literature: parents of young children are reluctant to schedule appointments into their calendars, hesitant to drive somewhere outside of the home with children in tow, and resistant to sacrificing more time with the family to fulfill an obligation. Even when they desire to benefit from therapy, they elect not to as the perceived cost is too great. Practitioners, even with their reservations about online therapy, must consider the opportunity cost of offering services virtually for children and their families.

Another implication is that institutions and universities offering graduate courses and training in play and filial therapies might begin integrating technology and virtual elements into standard curriculum. As the world becomes more virtually connected through computers, internet, and software, it is critical for the counseling field to merge existing theoretical models with upcoming technical capabilities to remain relevant and helpful. This study indicates that the future of play therapy may lie not in a conference room at a therapist’s office but in homes where parents can partake in treatment from their living rooms on their laptops.

A final implication is that parents of young children responded overwhelmingly positively to an online training format, and the online format was proven effective in increasing levels of parental acceptance. This opens up vast and expansive opportunities to reach children and their families with mental health treatment options.
Virtual parent training groups, based on the results of this study, can positively influence the dynamic of the child-parent relationship. These groups can easily be organized, facilitated, and managed by licensed therapists who are willing and able to do so.

**Recommendations for Further Study**

Due to the small and biased sample size, it would be prudent to replicate this study with a larger and more representative sample. Considering this investigative study recruited volunteers who met inclusion criteria, it is difficult to know what may have influenced only Caucasian participants to enroll. Looking further into motivation or hindrances to participating in an online parent training may yield insight into how to specifically target minorities in recruitment messages.

A few of the participants in this study indicated that they believed some of the weeks’ materials could have been combined, and that the training could have been condensed into a shorter time frame. Considering the high attrition rates in this study, it would be salient to try an eight week format to see if that increases initial interest in the study or prevents high rates of attrition.

The post-treatment perception survey was written and pilot tested for richness of data. However, while it yielded appropriate responses, it became clear that two pairs of questions prompted duplicate or similar responses and could be combined. Questions one and three on the survey, both asking about positive perceptions, can be combined in future studies. Questions two and four, inquiring about negative perceptions, can be combined as well. This will reduce the redundancy in coding, while still providing appropriate and rich responses.
This study revealed positive treatment outcomes in levels of parental acceptance as a result of participating in CPRT. This pre- and post-treatment assessment model provides a valid assessment at point in time gains related to the training. However, this does not offer insight into the longevity of positive gains found. It would be helpful to conduct a follow up assessment of the PPAS (Porter, 1954) six months post-treatment to measure the longitudinal effects of CPRT in an online format. An additional question about whether or not the child and parent have continued play sessions might offer insight into whether measured outcomes are related to the continual practice of the learned skills.

Several other studies reported that gains in parental acceptance levels remained at a two-month (Johnson-Clark, 1996), six-month, and three-year (Sensue, 1981) follow-up assessment. It would be prudent to assess whether similar findings would be replicated with participants who participated in an online format of CPRT, rather than the traditional, face-to-face model.

Conclusion

It is clearly evident that children are at the center of a shift in treatment approaches regarding mental health issues. Parents are now encouraged to participate in therapy and outcomes are more positive with familial involvement. Further, parents of young children are likely to prefer and embrace virtual therapy, providing greater breadth of services to a population who is consistently underserved. Online therapy for children and their families also reduces barriers that are commonly cited as obstacles to seeking and continuing treatment.
Landreth and Bratton (2006) discussed the paucity of trained filial therapists both nationally and abroad and the resulting effect for families who need or want treatment:

The number of mental health professional and agencies that provide filial therapy training is minimal because the majority of existing play therapists have not been trained in filial therapy. Therefore, this highly effective procedure for improving the mental health of families is not readily available to the majority of parents.

Entire regions of the United States and other countries do not have the services of a filial therapist. Indeed, some entire nations may not have a single filial therapist. (p. 448)

This study suggests that an online format of an existing treatment empirically supported in the literature is effective. It is the author’s hope that further research is conducted on the administration of traditional face-to-face therapies using an online format so that the mental health needs of children and their parents are better addressed. It is also the author’s desire that CPRT will become more widely available to serve the mental health needs of families around the world as more filial therapists are trained and begin to conduct training online. Children, their parents, and society at large will be the better for it.
References


United States Public Health Service. (2002). *Closing the gap: A national blueprint to improve the health of persons with mental retardation*. Washington, DC:
Department of Health and Human Services.


*Dissertations Abstracts International, B, 39*(11), 5597.


Appendices

Appendix A: Pre-Notice Email to Potential Participants

Hello to The Kid Counselor Family,

As many of you know, I am currently a doctoral student working on my dissertation at the University of South Florida. I wanted to let you know that in several days, I will be sending out an email with information about my research project and how you might participate in my study.

As a play therapist and mom, I know the importance of having access to effective and helpful training, techniques and skills related to parenting. However, there are often barriers to participating in parent trainings related to distance, time, cost, accessibility, embarrassment, or other factors. Therefore, I am exploring the outcomes of conducting a play therapy based parent training (Child Parent Relationship Therapy) in an online format. I will be investigating whether the program affects acceptance, as well as inquiring about the process and perceptions of an online training model.

This email is to prepare you for the upcoming email, so that you are looking for it and know what to expect. This study is the first of its kind, offering a proven face to face, play therapy training in an online format. It will inform play therapists and parents alike about the outcomes and possible benefits of participating in a parent training virtually.

Thank you in advance for considering participating in my research. My research can only be successful with the help of parents and their children.

This study has been approved by the Institutional Review Board at the University of South Florida, #20874.

We will talk again soon,
Brenna

Brenna Hicks
Doctoral Candidate, University of South Florida
727.238.5437
Appendix B: Initial Study Email

Hi again to The Kid Counselor Family!

As I mentioned in my last email, I am working on a research project exploring the outcomes of a parent training offered in an online format for my dissertation. Many parents do not have access to a play therapy based parenting program, even though they would consider completing the training if it were available.

I am asking you to consider participating in an online format of Child Parent Relationship Therapy, the same training that I offered to parents at my practice. This play therapy based program is proven effective in increasing communication, decreasing child behavior problems, decreasing parental stress, and strengthening the child-parent relationship. Further, this ten week training at my practice is valued at $1250, which would be offered at no cost to you during this research project.

Further information about the process of the online training, as well as a brief questionnaire to ensure that you qualify, are provided at the link below. Please visit the site and fill in the required information. Thank you in advance for considering participating in my study; I need your participation to complete this important research.

This study has been approved by the Institutional Review Board at the University of South Florida, #20874.

If you have any questions, or would like to speak with me further, you can contact me at 727.238.5437.

Thank you!
Brenna

Brenna Hicks
Doctoral Candidate, University of South Florida
Appendix C: Follow-Up Email

Hello The Kid Counselor Family!

One week ago, I sent an email with information and a link to participate in my doctoral research project to complete my dissertation. I do not keep track of who has or has not responded for confidentiality purposes, so if you have already completed the questionnaire, please disregard this reminder.

Thank you so much to all of you who have volunteered and completed the questionnaire to see if you fully qualify for the study. I am so grateful and excited about all of the parents who are interested in the play therapy based training in an online format. The results that emerge from the study will be very helpful to therapists and families.

I am writing this email as a final reminder to click the link below to find out more information about the study, as well as the brief questionnaire to ensure that you qualify for the study. All you are required to do is fill in the required information, and you will be informed if you meet the criteria to take part in the research project.

This study has been approved by the Institutional Review Board at the University of South Florida, #20874.

If you have any questions, or would like to speak with me further, you can contact me at 727.238.5437.

Thank you!
Brenna

Brenna Hicks
Doctoral Candidate, University of South Florida
Appendix D: Facebook Recruitment of Participants

Hello The Kid Counselor Fans!

As many of you know, I am currently a doctoral student working on my dissertation at the University of South Florida. I am working on a research project exploring the outcomes of a parent training offered in an online format. Many parents do not have access to a play therapy based parenting program, even though they would consider completing the training if it were available.

I am asking you to consider participating in an online format of Child Parent Relationship Therapy, the same training that I offered to parents at my practice. This play therapy based program is proven effective in increasing communication, decreasing child behavior problems, decreasing parental stress, and strengthening the child-parent relationship. Further, this ten week training at my practice is valued at $1250, which would be offered at no cost to you during this research project.

Further information about the process of the online training, as well as a brief questionnaire to ensure that you qualify, are provided at the link below. Please visit the site and fill in the required information. Thank you in advance for considering participating in my study; I need your participation to complete this important research.

This study has been approved by the Institutional Review Board at the University of South Florida, #20874.

If you have any questions, or would like to speak with me further, you can contact me at 727.238.5437.

Thank you!
Brenna

Brenna Hicks
Doctoral Candidate, University of South Florida
Appendix E: Informed consent

Informed Consent to Participate in Research
Information to Consider Before Taking Part in this Research Study

IRB Study # ______________

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called:
The Efficacy of Child Parent Relationship Therapy when Conducted in an Online Format on Levels of Parental Acceptance.

The person who is in charge of this research study is Brenna Hicks. This person is called the Principal Investigator. She is a doctoral candidate, and the chair on her committee is Herbert Exum.

The research will be conducted online at http://brennahicks.com/study
Purpose of the study

The purpose of this study is to:

- Investigate the effects of Child Parent Relationship Therapy (CPRT) on levels of parental acceptance.
- Explore the perceptions of the process of an online parent training.
- Complete a dissertation research project, in accordance with doctoral curriculum.

Study Procedures

If you take part in this study, you will be asked to:

1. Watch 10 weekly training videos and complete the weekly activities from the Parent Handbook, lasting approximately one hour.
2. Meet in Google Hangouts for 10 weekly synchronous, group sessions lasting approximately 45 minutes.
3. Conduct 7 weekly special play times with your child of focus lasting 30 minutes that are video-recorded.
4. Upload at least one video-recorded session to YouTube for review and feedback from the PI and peer group.
5. Complete a pre- and post-test assessment and a post-treatment survey.

Total Number of Participants

About 42 individuals will take part in this study at USF.

Alternatives

You do not have to participate in this research study.

Benefits

The potential benefits of participating in this research study include:

1. Increased levels of parental acceptance of your child.
2. Decreased levels of child behavior problems.
3. Decreased levels of parental stress.
Risks or Discomfort

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Compensation

You will receive no payment or other compensation for taking part in this study.

Cost

There will be no costs to you as a result of being in this study.

Privacy and Confidentiality

We will keep your study records private and confidential. Certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator, study coordinator, and all other research staff.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- Any agency of the federal, state, or local government that regulates this research. This includes the Food and Drug Administration (FDA), Florida Department of Health, and the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is
any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

**New information about the study**

During the course of this study, we may find more information that could be important to you. This includes information that, once learned, might cause you to change your mind about being in the study. We will notify you as soon as possible if such information becomes available.

**You can get the answers to your questions, concerns, or complaints**

If you have any questions, concerns or complaints about this study, or experience an adverse event or unanticipated problem, call Brenna Hicks at 727.238.5437.

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638.
Consent to Take Part in this Research Study

and Authorization to Collect, Use and Share Your Information

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

I freely give my consent to take part in this study and authorize that my information as agreed above, be collected/disclosed in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

____________________________  __________________________
Signature of Person Taking Part in Study                  Date

____________________________
Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I hereby certify that when this person signs this form, to the best of my knowledge, he/she understands:

• What the study is about;
• What procedures/interventions/investigational drugs or devices will be used;
• What the potential benefits might be; and
• What the known risks might be.

I can confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in the appropriate language. Additionally, this subject reads well enough to understand this document or, if not, this person is able to hear and understand when the form is read to him or her. This subject does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give legally effective informed consent. This subject is not under any type of anesthesia or analgesic that may cloud their judgment or make it hard to understand what is being explained and, therefore, can be considered competent to give informed consent.

____________________________  __________________________
Signature of Person Obtaining Informed Consent / Research Authorization                  Date

____________________________
Printed Name of Person Obtaining Informed Consent / Research Authorization
Appendix F: Informed Consent Email

Hello!

Thank you so much for your interest in participating in this research project! You and your child are an integral component to this study, and you are almost done with the qualification process.

There is one final step to fully qualify for the study, which involves reading and signing the informed consent document. When you completed the questionnaire to ensure that you met the requirements of the study, you were automatically directed to the page with the informed consent document and electronic signature.

However, in case you were not able to complete it, the link to access the informed consent document and electronically sign the form is below. Please be aware that your consent and signature are required to participate in the study.

A copy of the informed consent document is also attached to this email for your records and review.

If you have any questions, concerns, or comments about this study or the informed consent document, you can contact me at 727.238.5437.

Sincerely,
Brenna

Brenna Hicks
Doctoral Candidate, University of South Florida
Appendix G: Acceptance into the Study Email

Hello again!

Thank you so much for volunteering to participate in the online parent training. It is my pleasure to inform you that you have fully qualified for the study, and have been accepted into the research project.

Your unique User ID and password to gain access to the study website are:

User ID: ______________
Password: _____________

Once you login to the secure area of the site, you will see a dashboard with everything you need to begin the training.

If you have any questions or difficulties logging into the site, or require assistance during the training, you may contact me at 727.238.5437.

Once again, I welcome you to the study and appreciate your willingness to participate in this research.

Sincerely,
Brenna

Brenna Hicks
Doctoral Candidate, University of South Florida
Appendix H: Exclusion from the Study Email

Hello again!

Thank you so much for volunteering to participate in the online parent training. Unfortunately, you do not meet all of the requirements for the study, and therefore do not fully qualify for the research project.

Once again, I greatly appreciate your interest in the study and for your time and consideration.

Please know that I will email you when a future opportunity for an online parent training arises.

Sincerely,
Brenna

Brenna Hicks
Doctoral Candidate, University of South Florida
727.238.5437
Appendix I: Perception Survey

Thank you for taking this post-treatment survey to provide insight into your thoughts and perspectives about the process of an online training format. Please answer honestly and openly, with assurance that your responses are confidential.

1. Please discuss the perceived benefits of an online format for parent training.

2. Please discuss the perceived drawbacks of an online format for parent training.

3. Please indicate what you liked best about the online format.

4. Please indicate what you liked least about the online format.

5. Please suggest ways to improve the online format in the future.

6. Please provide one word expressing your feelings about the parent training that you just completed.

7. a) Would you complete an online parent training again, as a result of your experiences in this study? b) Why or why not?

8. Are there any additional comments you would like to share about the training, the online format, your experiences, etc?

Thank you for your time!
Appendix J: Approval Letter

March 9, 2015

Brenna Hicks, M.A., L.M.H.C.
Educational and Psychological Studies
4202 E. Fowler Avenue, EDU105
Tampa, FL 33620

RE: Expedited Approval for Initial Review
IRB#: Pro00020874
Title: The Efficacy of Child Parent Relationship Therapy when Conducted in an Online Format on Levels of Parental Acceptance.


Dear Ms. Hicks:

On 3/9/2015, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
dissertation.pdf

Consent/Assent Document(s)*:
informed consent 2015.docx.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review...
category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

[Signature]

Kristen Salomon, Ph.D., Vice Chairperson
USF Institutional Review Board