Child-Parent Relationship Therapy

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Child-Parent Relationship Therapy History

This paper is a clinical research review of Child-Parent Relationship Therapy (CPRT). Child-Parent Relationship Therapy (CPRT) is a 10-week group filial therapy program that teaches parents how to conduct child-centered play therapy (CCPT) sessions with their kids (Landreth et al., 2006). CPRT is conducted in small groups of 4-8 parents, who choose a focus child to work with throughout the program. Parents submit recordings of at-home play sessions and receive feedback from the therapist. CPRT studies evaluate the bond between the parent and child and the effectiveness of parents as agents of therapeutic change, as well as measuring parenting stress and the child's emotional and behavioral issues.

CPRT has been proven successful in helping children with externalizing behavior problems and reducing parenting stress (Carnes-Holt & Bratton, 2014; Swan et al, 2019; Garza et al, 2009; Socarras et al, 2015). CPRT is based on the premise that if you strengthen the parent-child relationship the child's wellbeing will also increase; therefore, it is the parent-child relationship that is the therapeutic change agent (Landreth & Bratton, 2006). Parents who have children who act out in aggressive manners including yelling, hitting, oppositional behaviors, self-destructive behaviors, and more are inclined to use CPRT as a way to fix their child. While not intuitive at first, many CPRT studies measure parental stress which is an indicator of therapeutic change and has a large impact on the parent-child relationship (Carnes-Holt & Bratton, 2014; Opiola and Bratton, 2018; Swan et. al, 2019). Overall, CPRT focuses on improving the parent-child relationship but also has a positive impact on parental stress and family functioning (Swan et al., 2019).

In this paper, we will first discuss CPRT's theoretical tenets including play therapy, child-centered therapy, and filial therapy. Second, we will discuss the history of CPRT. Third, we

will analyze the replicability and transportability of CPRT. Lastly, we will evaluate the mechanisms of change and economic evaluation of CPRT.

Theoretical Tenets

Child-Parent relationship therapy relies on the vast research and philosophy behind play therapy, child-centered therapy, and filial therapy. Overall, child-parent relationship therapists believe that parents are essential for therapeutic change in their children and that children need a strong bond with their parents in order to develop through emotional and behavioral developmental challenges. In this section below, we define play therapy, child-centered therapy, and filial therapy, and describe how each of these theoretical tenets contributes a philosophical perspective to the therapeutic relationship with parents and children and to the practices of CPRT.

The first theoretical tenet of CPRT is play therapy. Melanie Klein (1975) was the first psychoanalyst to utilize play with children in a therapeutic context and form the concept of how children communicate through play. Following Klein, Frederick Allen recognized the importance of a therapeutic relationship with children through play to allow the child to express their feelings (Gitelson et al., 1938). The work of Klein and Allen influenced our current understanding of a child's natural ability to communicate through play within the therapeutic relationship. Landreth (2012) the creator of CPRT describes play therapy as a dynamic relationship between child and therapist that provides a safe environment and relationship for children to explore their selves through play, their natural communication. By teaching parents the foundations of play therapy they can empathize and understand their child's struggles better. Landreth (2012) believes that it takes a lot of energy for children to sit still which squashes their natural creativity, however, through play children can discharge physical energy, relieve

frustrations, prepare for challenges, and act aggressively in socially acceptable ways. The rules of the playroom are only confined to a child's safety and relieve a child of social pressures to play and imagine in confined ways.

The second theoretical tenet of CPRT is the therapeutic relationship that is built on the theories of child-centered therapy. Carl Rogers (1939) research in person-centered therapy established a new way for therapists to view their clients. A person-centered therapist trusts that their client has the capacity to move towards positive growth (Rogers, 1939). A person-centered therapist who works with young children is referred to as a child-centered therapist. Therefore, according to Landreth (2012), the goal of child-centered therapists is to "relate to the child in ways that will release the child's inner-directional, constructive, forward-moving, creative, self-healing power" (p.37). For instance, a therapist using child-centered play therapy would avoid using judgemental words and instead reflect back on the action of the child. For example, instead of saying "you are a strong hitter" the therapist would say "you can hit just like that". This way of talking seems awkward at first, however, it avoids evaluating the child based on their strength and instead sends a message to them that the therapist is interested in the child's actions. This way of viewing children is essential for a child-parent relationship therapist to pass along to parents during CPRT groups.

The third theoretical tenet of CPRT is filial therapy, a treatment model for emotional difficulties in children under 20 who utilize parents as therapeutic change agents (Garza et al, 2007). According to Garza et al. (2007), in filial therapy, therapist's train parents to be therapeutic agents with their children through play therapy which, increases the parent-child attachment bond. Parents learn how to create a nonjudgmental, understanding, and accepting environment, which enhances the parent-child relationship, thus facilitating personal growth and

change for the family (Garza et al, 2007). Filial therapy emphasizes the importance of the parent-child relationship in its effectiveness due to the special knowledge and connection between children and their parents (Guerney, 1964). Guerney (1964) claims it is crucial to begin treatment before 20 years of age for emotional and behavioral difficulties because interventions later in life are less effective for problems beginning in childhood.

Landreth and Bratton (2006) integrated the philosophy of play therapy, child-centered therapy, and filial therapy to create CPRT. In CPRT parents learn how to conduct child-centered play sessions, including responsive listening, setting limits, recognizing and reflecting children's emotional needs, and building children's self-esteem. It is through these three theoretical tenets that CPRT is able to change the parent and child dyad.

History of Child-Parent Relationship Therapy

In 1909, Sigmund Freud published the classic case of *Little Hans*, in which he was the first to use play in a therapeutic setting (Strachey, 1955). Hans was a 6-year-old boy who was presented to Freud because of his phobias that translated to major temper tantrums and emotional outbursts. In the context of CPRT, play is described as a child using toys and expressing feelings through symbolism and metaphor. Freud only saw Hans briefly and asked Hans about his what he liked to play more than he played with Hans (Strachey, 1955). There was limited information on what the play consisted of. Freud collected most of the psychoanalysis information from accounts of the boy's behavior from his Father. Apart from this Freud did advise Han's father of ways to respond to Hans acting out which could be considered the first account of filial therapy. This is the first recorded case in which Freud explores play as a therapeutic concept (Strachey, 1955).

Use of play in psychotherapy

In 1919 Melanie Klein (1975) published detailed descriptions of her use of play with children that closely resemble that of modern-day Psychoanalysis Play Therapist. Klein was working with kids conducting psychoanalysis trained by Freud and recognized the difference between an adult's and a child's ability to do free association. She began exploring using play as a way to allow the child to explore their dreams and act out events. Klein (1975) compared the free associations discovered in psychoanalysis with the metaphors encountered in children's play.

Through working with children, Klein (1975) discovered play protocols that allowed the children to free-associate with minimal interruptions. Klein used simple, small toys that are non-mechanical and human figures that do not depict occupation, as well as an individually locked playbox for each child. She believed the child's playbox was the equivalent of an adult's associations being kept between the client and analyst. In addition, Klein (1975) believed that psychoanalysis should not be conducted in the child's home because transference can only happen if the child feels that the play-room is something separate from home life. The selection of toys and the need for differential spaces are aspects that Landreth and Bratton (2006) outline in their CPRT protocol.

Therapeutic relationship with children

In the 1930's Dr. Frederick Allen (Gitelson et al., 1938) developed relationship play therapy and was the first to emphasize the value of the therapeutic relationship with children that utilized play as a medium to express feelings. Allen believed that the therapeutic relationship provided the child with a safe space to explore and act out emotionally intense play themes. The therapeutic relationship is different in that there is limited judgment or evaluation of the child. Allen explained that the child has to play an active role in building the therapeutic relationship

by expressing his feelings and his turmoil through play to the therapist (Gitelson et al., 1938). Allen gave examples of cases where the child projected their negative experiences and struggles onto the therapeutic relationship. In these cases, Allen was not interested in the content of the play but rather how the child can gain a different perspective of themselves through the therapeutic relationship (Gitelson et al., 1938).

Person-Centered Play Therapy

Person-centered therapy is a theoretical orientation created by Carl Rogers (Rogers, 1939). Rogers (1939) identifies four basic attributes of a person-centered therapist: objectivity, respect for the individual, understanding of the self, and psychological knowledge. It is through the person-centered lens that a therapist has unconditional positive regard for their client. This means a therapist sees a person as being fully capable of solving their own problems. Person-centered therapy sets the foundation for child-centered therapy.

Virginia Axline (1964), studied under Carl Rogers and took the theoretical tenets of person-centered therapy and applied them to play therapy. Axline (1964) was a key therapist in establishing nondirective play therapy, later known as CCPT. Non-directive play therapy is when a therapist allows the child to lead the play session and does not impede the child with their interpretation of the play. Previous psychologists would ask the child to engage in a certain activity or ask the child questions about the meaning of their play. Axline (1964) published a detailed case study about the use of nondirective play with a 6-year-old that details the intricacies of non-directive play. While being non-reactive seems like a simple task for a therapist, it is often not how adults interact with children and can take great effort to avoid judgments. For example, during the session, the boy handed Axline a toy, and Axline avoided giving praise by avoiding saying thank you in response. Instead, she reflects the boy's statement by saying "You want to

give me that, do you?" (Axline, 1964, p. 55). Axline, explains that the purpose of her response was to keep her communication open which in turn allowed the boy to add more thoughts and feelings if he wishes to do so. This is an example of a therapist respecting the child's ability to make choices in order to work through his own problems. This is an example of what a parent would learn while in a CPRT group session. Through her work, Axline created the 8 basic principles of nondirective play therapy, which are outlined in Landreth and Bratton's (2006) CPRT manual.

Foundation of Filial Therapy

Previous psychoanalysis, including Natalie Rogers Fuchs (1957), practiced non-directed play therapy with their own children however did not transfer the importance of filial therapy to other parents. It wasn't until the 1960s that Bernard and Louise Guerney founded filial therapy (Guerney, 1964). Guerney (1964) discovered that combating emotional problems later in life was less effective than if interventions started during child developmental years. Guerney (1964) argues that parents have special knowledge of their children and can make more long-lasting changes compared to therapists. Therefore, filial therapy is a more efficient way of making use of the limited time needed to make behavioral and emotional changes.

Establishment of Play Therapy

The Association for Play Therapy was established in 1982 by Charles Schaefer and Kevin O'Connor (Association for Play Therapy, 2021). Following the establishment, Landreth (1982) publishes a paper reflecting on what it means to practice play therapy. Landreth (1984) consults Carl Rogers on his views of facilitating groups, which lays the foundation for the group model of child-parent relationship therapy. In 1988, Garry Landreth established the center for play therapy, which holds the world's largest play therapy center (College of Education, 2021).

Establishment of Child-Parent Relationship Therapy

By the late 1990s, researchers understood the necessary shift from viewing children as tiny adults to entering the world of children through play therapy (Landreth, et al., 1999). The research focused on the effectiveness of child-centered play therapy in treating specific problems in children including externalizing behavior such as aggression (Wilson & Ray, 2018), attachment disruptions (Carnes-Holt & Bratton, 2014), and history of familial abuse (Tal, et al., 2018). In addition, the research examined the validity of child-parent relationship therapy on different populations and found it to be effective with: first nation people (Boyer, 2011), Hispanic parents (Garza et al., 2009), Israel families in Isreal (Kidron & Landreth, 2010), and military families (Jensen-Hart et al., 2012). In 2006, following 20 years of research on the child-parent interactional therapy model and building on Guerney's (1964) filial therapy model, Landreth and Bratton (2006) publish the training manual for child-parent relationship therapy. This is a comprehensive history of child-parent relationship therapy.

Replicability

The CPRT manual created by Bratton, Landreth, Kellam, and Blackard (2006) outlines the protocols for therapists to follow when teaching CCPT to parents. The book also includes handouts and worksheets for the parents. This manual was used in all of the studies cited in this paper. It was also translated to Spanish to increase accessibility to Spanish-speaking families. The structure of CPRT has allowed other researchers to closely follow its protocol allowing for reliable replicability of CPRT treatment.

Following Guerney's (1964) and Landreth's (1984) research, other researchers have focused on replicating CPRT with adoptive families. Unlike biological families, adoptive children face unique issues such as attachment disruptions, which cause unattuned and

unpredictable caregiving in addition to comorbidity in behavior problems (Carnes-Holt and Bratton, 2014). The goal of CPRT in these cases is to increase the parent-child relationship attachment through filial therapy that uses child-centered play therapy techniques. Carnes-Holt and Bratton (2014) explain that "a parent's ability to communicate empathy, understanding, and acceptance promotes an attuned parent-child relationship that is essential for developing secure attachments and future relationships" (p.129). Carnes-Holt and Bratton (2014) conducted a randomized control study including 61 adoptive families using CPRT. As per the CPRT protocol, Carnes-Holt and Bratton (2014) had parents learn and practice CPRT skills including "empathic listening, reflecting the child's feeling, reading nonverbal behaviors more accurately, reflecting the nonverbal and verbal content of the child's play, using encouragement, therapeutic limit setting, and using esteem-building responses" (p.332). The researchers facilitated an additional pre-session group prior to beginning the 10 weeks of CPRT. The pre-session allowed group members to share their adoptive stories and develop relationships with other group members before treatment. After the 10-week study period, they found a significant decrease in the children's externalizing behaviors including acting out, tantrums, oppositional behavior, and aggression (Carnes-Holt & Bratton, 2014).

The study examining the effects of CPRT on families with adopted children was replicated by Opiola and Bratton in 2018. They also conducted a randomized control group design to examine the effects of CPRT on families with adopted children. Opiola and Bratton (2018) closely followed Carnes-Holt and Bratton's (2014) research protocols which reflected the CPRT training manual protocols and included the pre-session to discuss adoption stories (Landreth & Bratton, 2006). Results from this study confirm the results from the original study

by Carnes-Holt and Bratton (2014) and provided strong evidence for the effectiveness of CPRT as a treatment intervention with adopted children.

Swan et. al (2019) conducted a pilot study on the effect of CPRT with parents of adoptive preadolescents. They used a single-group, repeated-measure research design to investigate the effects of CPRT. The study specifically referred to Carnes-Holt & Bratton (2014) and Opiola and Bratton's (2018) study protocols when describing their procedure. Swan et al (2019) paralleled previous results by showing an increase in parental empathy and a decrease in parenting stress and aggressive child behavior.

Furthermore, CPRT studies have been replicated with people of different ethnicities and racial backgrounds. Garza et al. (2009) studied CPRT on Hispanic parents and their children and found the results to be consistent in its efficacy as with other research studies on the effectiveness of CPRT. Garza et al. (2009) put in extra effort to make culturally appropriate adjustments of CPRT. For instance, they translated the CPRT handbook and worksheets into spanish, had native spanish speaking therapists, and held a pre-session to ask participants about how culture influences their parenting. In a different study, Boyer (2011) utilized CPRT in a case study to introduce a safe therapeutic environment for First Nations participants. Through self-report, the caregiver in the study confirmed the model's effectiveness in treating anger management and other emotional development issues in their child.

Three of these studies (Carnes-Holt & Bratton, 2014; Opiola and Bratton, 2018; Swan et. al, 2019) used the Child Behavior Checklist (CBCL) and the Parent Stress Index (PSI), and the Measurement of Empathy in Adult-Child Interaction (MEACI) as measurement tools when assessing pre and post-treatment outcomes. By using the same measurement tools, researchers can replicate the study and compare results across a larger body of data. All in all, the official

CPRT treatment manual by Landreth & Bratton (2006) has been replicated effectively with adoptive parents as well as parents from ethnically diverse backgrounds and has shown consistent results.

Transportability

Research on CPRT has also been utilized in multiple different practice settings, primary schools, and centers. In one study, CPRT was conducted at a school for children ages three to five which housed a Head Start program (Lindo et al. 2012). Researchers chose to study the Head Start Program participants because of its focus on children from underserved populations. The CPRT groups were conducted in the school that the participants attended. By bringing the group to a location that the participants have access to, the researchers were able to study children who were at risk for academic failure and their parents. This study also found strengthened parent-child relationships, and a reduction in parental stress, and behavioral problems in the child (Lindo et al. 2012).

In addition to school settings, other studies were conducted at centers, such as Tal et al.'s (2018) research on the effectiveness of CPRT with extra-familial abused children. Researchers used the center to recruit participants and provide treatment at a convenient location. Tal et al. (2018) added four sessions to the CPRT training to provide parents with a safe space to process their feelings and experiences after being exposed to their children's sexual abuse stories. The researchers found the objectives of CPRT were achieved, including decreased parental stress, parental secondary trauma, and child behavior problems (Tal et al., 2018).

Limitations

On the one hand, most studies followed Landreth and Bratton's (2006) CPRT protocol, however, the accessibility of resources may have had a strong effect on retention or recruitment

of participants. One limitation is CPRT focusing on only one child. This limited participants to families with one child or with access to childcare. In some studies (Ceballos & Bratton, 2010; Opiola & Bratton, 2018) child-care was provided on-site for families with multiple children who were not participating in the study; however, many studies did not provide child-care (Hicks & Baggerly, 2017; Tal et. al 2018; Taylor et. al 2011; Kidron & Landreth 2010). Another limitation is a family's access to CPRT approved toys and video recording equipment. Part of the CPRT 10-week training protocol is for parents to conduct and record at-home play sessions which are then watched by a therapist to provide feedback to the parents (Landreth & Bratton, 2006). This means that to fully participate in CPRT a family must have a recording device with ample storage and capacity to record a 30-minute play session. In addition, the parents must have a certain selection of toys. Depending on the location of the studies, access to childcare, access to recording devices, and specific toys, limited families were able to participate.

Furthermore, the studies cited in the research table outlined in the appendix did not pay close attention to the comorbidity of diagnosis or multiple problems in the families. None of the articles mentioned if the children or parents had any mental illness diagnosis. One study by Ceballos and Bratton (2010), mentioned the participant's experiences acculturation problems, however, parental acculturation was not measured as an outcome of the study. Not accounting for multiple problems within a family system does not account for real-life scenarios and could affect the transportability of CPRT to people's lived experiences. CPRT has promising research, but it does not account for a family's accessibility needs.

Mechanisms of Change

Two studies thoroughly examined the mechanisms that led to change in the parent-child relationship after CPRT was conducted. First, Socarras et al. (2015) utilized pre-intervention

interviews and post-intervention interviews in order to understand underlying themes and categories in how changes occurred between parents and children of African American families living in poverty. Second, Lindo et al. (2012) utilized the Parenting Stress Index (PSI) and the Child Behavior Checklist (CBC) in order to understand the mechanism for change in their participants from a Head Start preschool program.

First, Socarras et al. (2015) conducted a qualitative study on CPRT with African American parents living in poverty to hear about their experiences using the short and intensive 4-week model with their preschool-aged children. Using this study, Socarras et al. (2015) analyzed barriers to receiving counseling, changes in parent's perceptions of parenting, child's play, and the CPRT group process. In order to achieve a deeper understanding of parent's experiences, Socarras et al. (2015) utilized a constructivist theoretical perspective which creates more interactions between researchers and participants so that researchers receive a more in-depth understanding of the participants' lived experience of the model and fully encapsulate the participant's perspectives. The researchers' questions for the study were on studying the parent's barriers to participation, their opinions on participating with counseling services, the parent's perspectives on changes in their parent-child relationship, and what the parents wanted vs received in help with their parenting (Socarras et al, 2015). Therefore, the specific mechanisms of change that the researchers were looking for were the parent's processes that contributed to the parent's utilization and acceptance of CPRT. They achieved this through line-by-line coding of interview data from which themes and categories were constructed (Socarras et al, 2015). In the end, the researchers found that parents took away at the very least one CPRT technique that they wanted to continue with their children, which allowed the parents to focus more on their relationship with the child than disciplining the child. Parents also

experienced an increase in empathy and the ability to focus on the child's emotions (Socarras et al, 2015). The participants had originally come in asking for their cultural views to be respected and expressed family stressors that affected their parenting, including how to be consistent and more effective with discipline. There was also a significantly low dropout rate compared to other studies because of the researcher's focus on understanding parent's cultural views (Socarras et al, 2015). In the end, the mechanisms in CPRT that led to change for the participant parents were having their cultural values respected, having their original questions before the intervention valued and answered, as well as receiving social support from the group sessions as is evident from line by line coding analysis for themes from pre-interview and post-interview data. As for the children, a decrease in parental stress allowed the child to be heard and understood which in turn reduced externalizing behaviors and oppositional behaviors (Socarras et al, 2015).

Secondly, Lindo et al. (2012) conducted a study on the effectiveness of CPRT with parents of preschool children at risk of school failure in a Head Start program who are part of underserved populations. Specifically, the researchers were looking to understand how CPRT affects parenting stress, children's internalizing and externalizing behaviors, parent's perceptions of the process and outcome of CPRT, as well as a child's academic performance and the parent-child relationship. In order to measure outcomes from the intervention, Lindo et al. (2012) utilized the PSI and the CBCL. This study looked at multiple factors throughout the process of parents utilizing CPRT in their relationship with their child as mechanisms of change. They looked to achieve this by using the qualitative method of a mixed-methods approach to gain richer insight into the data and attain alternate insights as well (Lindo et al, 2012). In the end, they found that the majority of the parents experienced decreased parenting stress on the PSI and a decrease in problematic internalizing and externalizing behaviors on the CBCL. Parents also

reported an overall improvement in the parent-child relationship, the impact on the child's behavior in general, and improvements in their own approaches to parenting and interactions with the group and other people (Lindo et al, 2012). Therefore, the researchers posited that the mechanisms for change in CPRT rely on decreasing parenting stress in order to decrease problematic internalizing and externalizing behaviors in children.

Economic Evaluation

While most qualitative studies did not directly analyze cost-effectiveness, compared to other health practitioners and other family therapy models, CPRT is more cost-effective. According to a study by Crane and Christenson (2012), after one year of psychotherapy began, clients who received family therapy were observed to have reduced health care usage by 21.5%. This is compared to a 10% reduction in those who participated in individual therapy (Crane & Christenson, 2012). These results are promising in how much a family could save in medical costs long term, however, this study focused on higher users of medical services and has not been replicated. Nonetheless, services provided by MFTs are shown to be less expensive than services provided by other professionals such as medical doctors or clinical psychologists (Crane & Christenson, 2012).

According to the Washington State Institute for Public Policy (WSIPP) the average cost of CPRT is $901 in 2015 for the 10-week program. Compared to other brief family therapy models CPRT is more cost-effective. For example, Brief Strategic Family Therapy, widely considered a brief model, cost on average $2,595 in 2015 for an average of 12-16 sessions (WSIPP, 2020). Both brief strategic family therapy and CPRT measure disruptive behavior as an outcome measurement and target the parent-child relationship. Parent-child interaction therapy

for children with disruptive behavior cost on average $2,993 in 2017 for 14 therapeutic hours. CPRT offers the most therapeutic hours (20) and is the least expensive out of these three models.

For a therapist to conduct the CPRT model with clients they must be certified in CPRT. In order to achieve a CPRT certification, a therapist must be certified in CCPT, attend a formal university course on CPRT, complete the CPRT certification exam, and obtain supervised clinical CPRT experience (College of Education, 2021). The cost to be certified in CCPT is the bulk of expenses to be a child-parent relationship therapist. Therefore, it is much easier for a child-centered play therapist to become certified in CPRT than those not certified in CCPT.

Researchers in CPRT have tested the effectiveness of a shortened CPRT group in order to reduce costs even further. CPRT is designed to be flexible enough for parents and children from underserved communities or communities living in poverty to benefit from the model through social service organizations or schools. For example, Socarras et al. (2015), who studied the effectiveness of CPRT with African American parents and children living in poverty, adjusted down the length of the intervention to 4 weeks from 10 weeks in order to work with the parent's schedules and abilities. They experienced a lower than average dropout rate for the model in part because of the adjustment (Socarras et al, 2015). This is an example of how CPRT can be adjusted to accommodate low-income families.

Another example of CPRT with low SES families is seen in Lindo et al. (2012) study that focused on participants from a Head Start program that specifically provided education to children from underserved populations. In this case, CPRT was successful in helping parents be involved in their child's education. Longitudinal studies are needed to evaluate the long-term effects of parent involvement. Furthermore, Swan et al. (2019) studied the effectiveness of CPRT on parents of adopted children, and went through extra measures to accommodate the needs of

families. For instance, they provided childcare when collecting data from parents. They also provided three different locations for parents to participate in group sessions. However, information was not provided on if parents were compensated for transportation for the group sessions, as the study was taken in a large metropolitan city (Swan et al. 2019). Also, parent's schedules and ability to participate were mitigated by the fact that parents were recruited to participate in the study based on how involved they already were with the school due to their child's behavior issues (Swan et al. 2019). Lastly, Tal et al. (2018) conducted a quantitative study on parents of children who were sexually abused by a perpetrator outside of the family. All group sessions and data collection occurred at a center that provides assistance to children who are victims of sexual assault in which the parents participating were already receiving other services (Tal et al, 2018). Overall, most studies did not provide in-depth information around cost-effectiveness, however, they did provide information about mitigating impediments to participating because of parent's schedules. They also occurred where parents usually frequented with their children, to begin with. Additionally, childcare was not always provided, which resulted in many parents with multiple young children not being able to participate in the study. These limitations including child care, transportation, location of services, and out-of-pocket expenses reflect the limitations of CPRT participants outside of research conditions. Even with these limitations, CPRT is a cost-effective family therapy intervention.

Conclusion

CPRT is essentially built on theoretical tenets from play therapy, child-centered therapy and filial therapy. Play therapy posits that a child's natural communication is their play and is also where a child forms their perception of themselves, so intervening in a child's play can be a setting for therapeutic change (Landreth, 2012). Child-centered therapy adapts Carl Roger's

person-centered therapy tenets for children and promotes the idea that children have the capability for positive growth (Rogers, 1939; Garza et al., 2007). Filial therapy theorizes that parents can be agents for therapeutic change because of the special bond between the parent and child. This is a bond that is difficult for a therapist to completely imitate, thus increasing parents' empathy and focus on the child's emotional self can create the basis for positive emotional development in the child (Garza et al., 2007). Therefore, the history of CPRT began on developments in play therapy and psychotherapy with children, notably Carl Rogers and Virginia Axline in their work on person-centered therapy, Natalie Rogers Fuchs Bernard and Louise Guerney in their work on Filial therapy, which led to the development of Child-Parent Relationship Therapy by Garry Landreth and Sue Bratton (Strachey, 1995; Rogers, 1939; Bernard & Guerney, 1964; Landreth et al., 2006).

CPRT has been effectively replicated with multiple populations, including First Nations, Hispanic, African American, adoptive and non-biological parents as well as children who survived extra-familial sexual abuse (Carnes-Holt & Bratton, 2014; Landreth & Bratton, 2006; Swan et al, 2019; Garza et al, 2009; Socarras et al, 2015). The results of the model are also consistent in different settings, most of which were at home, in schools, or through organization-specific centers (Lindo et al, 2012; Tal et al, 2018). However, the limitations in replication and transportability are in the fact that only one child can be the focus of the intervention at a time and childcare was not always provided to the parents for other young children which could skew the results in favor of parents with fewer children. Also, a significant time commitment was required of parents during the study. The mechanisms of change that studies looked at were barriers to participation and parent's perceptions of the process and outcome (Socarras et al, 2015; Lindo et al, 2012). Lastly, there is a need for economic

evaluations of the model because no cost-effectiveness was analyzed, nor was information provided on compensation to the parents for participating in the study. However, researchers removed impediments to participation such as decreasing the length of group sessions and keeping the setting of group sessions at accessible locations where parents already frequented. CPRT is usually recommended when a child presents with emotional difficulties and academic performance issues and most parents are recruited from social service organizations and schools for the intervention. Overall, studies show that CPRT improves the bond between parent and child, as well as reducing parenting stress, and children's externalizing behaviors.

References

Association for Play Therapy. (2021, May 24th). *About APT*. A4PT. https://www.a4pt.org/

Axline, V. (1964). *Dibs in search of self.* Random House Publishers.

Boyer, W. (2011). Using child parent relationship therapy (CPRT) with our First Nations people. *International Journal of Play Therapy, 20*(1), 38-49. https://doi.org/10.1037/a0022650

Carnes-Holt, K. & Bratton, S. (2014). The efficacy of child-parent relationship therapy for adopted children with attachment disruptions. *Journal of Counseling and Development. 92*, 328-337. DOI: https://doi.org/10.1002/j.1556-6676.2014.00160.x

College of Education (2021, May 24th). *Center-play-therapy.* College of education center for play therapy. https://cpt.unt.edu/center-play-therapy

Crane, R. and Christenson, J. (2012). A summary report of the cost-effectiveness of the profession and practice of marriage and family therapy. *Contemporary Family Therapy, 34*, 204–216.

Fuchs, N. (1957). Play therapy at home. *Merrill-Palmer Quarterly* (1954-1958), 3(2), 89-95. Retrieved April 19, 2021, from http://www.jstor.org/stable/23080665

Garza, Y., Kinsworthy, S., & Watts, E. R. (2009). Child-parent relationship training as experienced by Hispanic parents: A phenomenological study. *International Journal of Play Therapy, 18*(4), 217-228. https://doi.org/10.1037/a0017055

Garza, Y., Watts, E. R., Kinsworthy, S. (2007). Filial Therapy: A process for developing strong parent-child relationships. *The family journal: Counseling and Therapy for Couples and Families*, 15(3), 277-281, DOI: 10.1177/1066480707301374

Gitelson, M., Ross, H., Homberger, E., Allen, F., Blanchard, P., Gerard, M., & Lowrey, L. G. (1938). Section on "Play therapy" 1938. *American Journal of Orthopsychiatry,* 8(3), 499-524. https://doi.org/10.1111/j.1939-0025.1938.tb06399.x

Guerney, B. (1964). Filial therapy: Description and rationale. *Journal of Consulting Psychology,* 28(4), 304-310. https://doi.org/10.1037/h0041340

Jensen-Hart, J. S., Christensen, J., Dutka, L., & Leishman, C. J. (2012). Child parent relationship training (CPRT): Enhancing the parent-child relationships for military families. *Advances in Social Work, 13*(1), 51-66.

Kidron, M., & Landreth, G. (2010). Intensive child parent relationship therapy with Israeli parents in Israel. *International Journal of Play Therapy,* 19(2), 64-78. https://doi.org/10.1037/a0017516

Klein, M. (1988). *Envy and gratitude, and other works, 1946-1963*. Vintage.

Landreth, G. (2012). *Play therapy: the art of the relationship.* Routledge.

Landreth, G., Baggerly, J., & Tyndall-Lind, A. (1999). Beyond adapting adult counseling skills for use with children: The paradigm shift to child-centered play therapy. *Journal of Individual Psychology*, 55(3), 272.

Landreth, G., & Verhalen, M. (1982). Who is this person they call a counselor who has a playroom? *The School Counselor*, 29(5), 359-361. http://www.jstor.org/stable/23900950

Landreth, G. L. (1984). Encountering Carl Rogers: His views on facilitating groups. *Personnel & Guidance Journal*, *62*(6), 323-325. https://doi-org.antioch.idm.oclc.org/10.1111/j.2164-4918.1984.tb00215.x

Landreth, G. (1993). Child-centered play therapy. *Elementary School Guidance & Counseling,* 28(1), 17-29. http://www.jstor.org/stable/42869126

Landreth, G. L., & Bratton, S. C. (2006). *Child parent relationship therapy (CPRT): A ten session filial therapy model.* Routledge.

Lee, K. R., & Ray, D. C. (2020). Child-centered play therapy parent services: A Q-methodological investigation. *International Journal of Play Therapy, 29*(3), 131-143. https://doi.org/10.1037/pla0000120

Lindo, N., Akay, S., Sullivan, J., & Meany-Walen, K. (2012). Child parent relationship therapy: Exploring parents' perceptions of intervention, process, and effectiveness. *International Journal of Humanities and Social Sciences,* 2(1), 51-61.

Opiola, K. K. & Bratton, S. C. (2018). The efficacy of child parent relationship therapy for adoptive families: a replication study. *Journal of Counseling and Development 96*, 155-166. https://doi.org/10.1002/jcad.12189

Ray, D. E. E. C. (2019). The child and the counselor: relational humanism in the playroom and beyond. *The Journal of Humanistic Counseling, 58*(1), 68–82. https://doi.org/10.1002/johc.12090

Rogers, C. (1939). *The Clinical Treatment of the Problem Child.* Houghton Mifflin.

Socarras, K., Smith-Adcock, S., & Shin, S. M. (2015). A qualitative study of an intensive filial intervention using Child-Parent Relationship Therapy (CPRT). *The Family Journal,* 23(4), 381–391. https://doi.org/10.1177/1066480715601681

Strachey, J. (1955). *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* Volume X (1909): Two Case Histories ('Little Hans' and the 'Rat Man'). i-vi. The Hogarth Press and the Institute of Psycho-analysis, London.

Swan, A. M., Bratton, S. C., Ceballos, P., Laird, A. (2019). Effect of CPRT with adoptive parents of preadolescents: A pilot study. *International Journal of Play Therapy, 28*(2), 107-122. http://dx.doi.org/10.1037/pla0000095

Tal, R., Tal, K., & Green, O. (2018). Child-parent relationship therapy with extra-familial abused children. *Journal of Child Sexual Abuse, 27*(4), 386-401. https://doi.org/10.1080/10538712.2018.1451420

Washington State Institute for Public Policy (June, 2020). Child-Parent relationship therapy. *Washington State Institute for Public Policy.* http://www.wsipp.wa.gov/BenefitCost/Program/826

Wilson, B. J., & Ray, D. (2018). Child-centered play therapy: aggression, empathy, and self-regulation. *Journal of Counseling & Development, 96*(4), 399–409. https://doi.org/10.1002/jcad.12222

Appendix A

Study Citation	Controlled assignment of treatment conditions through randomized clinical trials (RCT)	Contamination of major independent variables	Close supervision and training of the therapists	Adherence to treatment protocols	# of outcome measures used	Were appropriate statistical analyses conducted?	Were non-reactive dependent variables like incarceration, hospitalization, etc. used in the study?	diverse sample?	special efforts made to recruit/retain subjects and particularly difficult subjects?	attention given to comorbidity and multiple problem subjects and/or families?	long term follow up of one year or more?	Was there therapist-investigator non-equivalence?	Personal assessment: strengths and weaknesses	how conclusions can be useful (or not)
Kidron, M., & Landreth, G. (2010). Intensive Child Parent Relationship Therapy With Israeli Parents in Israel. International Journal of Play Therapy, 19(2), 64-78. doi:10.1037 /A0017516	No, parents who could not participate because of job constraints or lack of child care volunteered to be a part of the nontreatment comparison group.	Yes, Miki Kidron (author) rated 12 pre- and posttest videotapes	No, the authors do not mention training of the therapist	No, researchers did not mention measuring treatment adherence and they modified CPRT to be a 5-week training model	Yes	Yes	No	Yes	No, lack of childcare prevented parents from participating	No, The sample allowed parents to only select one child who needed their help and attention the most. Multiple kids were not allowed to participate	Yes, 1 year follow up	No, Kidron rate 12 out of 54 tapes and Kidron recruited participants	Strength: Study focused on Isreali families and considered the cultural implications of the treatment model. Weaknesses: Shortened CPRT from 10 to 5 sessions. Did not indicate anything about who the therapist's are and their backgrounds. Lack of training of therapist could play a role in treatment outcomes	Useful in regards to the use of CPRT with Isreali families, however, sample size was small (16 families). Not useful in describing what aspects of CPRT were effective. Not useful for replicability of the study
Carnes-Holt, K. & Bratton, S. (2014). The efficacy of child-parent relationship therapy for adopted children with attachment disruptions. Journal of Counseling and Development. 92, (328-337). DOI: 10.1002 /j.1556-6676.2014.00160.x	Yes	No, Interrater reliability was established using recorded parent–child play sessions independent of the present study.	Yes	Yes	2	Yes	No	No, 88.5% of parents reported European American ethnicity while children's ethnicity as 47% European American, 15% Latino, 9% Black American, and 18% other.	Yes, study focused on adoptive families. Child care was provided on site	Yes, the parent reported attachment-related concerns, such as ongoing difficulties to establish a mutually satisfying parent–child relationship, and concerns about his or her adoptive child's behavior;	No follow up	No, the first author had heavy involvement in carrying out the intervention and the research	Strength: Study displayed great effort in ensuring the reliability of the therapists and researchers rating the tapes. Weakness: Population was US southwest countries, non-diverse population.	Conclusion is useful in analysing CPRT effectiveness. Study ensured strict protocol to the CPRT manual with well trained professionals. However, authors heavy contribution could have tainted these results

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Swan, A. M., Bratton, S. C., Ceballos, P., & Laird, A. (2019). Effect of CPRT With Adoptive Parents of Preadolescents: A Pilot Study. International Journal of Play Therapy, 28(2), 107-122. doi: 10.1037 /PLA0000095	No, single-group, repeated-measures research design	No, however, All raters identified as European American, heterosexual, and female.	Yes	Yes, 10-week CPRT protocol was followed and adapted for preadolescents and included a presession.	2, Measurement of Empathy in Adult–Child Interactions Scale (MEACIS), Child behavior checklist (CBCL)	No, calculations looked acurate however in the results the researchers said there was "significant evidence" when the numerical evidence was weak	No	Not really, Parents= European American (6), Asian (3), Hispanic (1), and Black American (1). Preadolescent children= Hispanic (5), European American (3), and Black American (1). Equal male/female. 9 heterosexual, 2 LGBTQ	No, interested participants had to call the researchers themselves.	No, all families had a adopted child or multiple adopted children. No families had biological and adopted. No information about parental stress outside of adoption was provided.	No follow up	Yes	Strength: Adherence to CPRT protocol and reliability of researchers. Showed significant strength in increasing parental empathy. Weakness: Minimal change in child behavior. No data collected about child's perception. Considering they are pre-adolescence some data could have been collected to show their perception of the parental relationship	This seemed to be a successful pilot study however, more research on larger sample sizes is needed in order to generalize their findings.
Ceballos, P., Lin, Y., Bratton, S. C., & Lindo, N. (2019) Effects of Parenting Programs on Latina Mothers' Parental Stress and Their Children's Internalizing Behavioral Problems, *Journal of Child and Adolescent Counseling*, 5 (1), 73-88, DOI: 10.1080 /23727810.2018.1556983	Yes, (RCT between compare CPRT and STEP) no control group	No, the CPRT leader closely followed the published CPRT treatment protocol. Therapy group leaders were all fluent spanish speakers and conducted sessions in spanish	No, facilitators were Spanish-speaking, bilingual Latina mental health professionals with extensive training in the respective however, no supervision or mid treatment evaluation was mentioned protocols.	Yes, however, CPRT groups were conducted in Spanish and used Spanish-translated parent materials.	2, Spanish Version of the Child Behavior Checklist, and Spanish Version of the Parental Stress Index (one source of measurement to assess each outcome construct)	Yes	No	Yes, the study focused on Latina Mothers and offered services in Spanish to accomodate language barriers.	Yes, inclusion criteria included: parents rated their children in the clinical or borderline range on the internalizing behavior problem scale of the Child Behavior Checklist;	No, other conditions were not discussed	No follow up	No potential conflicts of interest were reported by the authors.	Strength: Focus on Latina Families and adaptability of resources to spanish Weakness: Researchers did not mee the required sample size based on the priori power analysis result and 9 parents dropped out leaving 21 parents for the data analysis.	Given the high drop out rate of STEP participants. No conclusion should be made from this study. However, cultural implications of CPRT and STEP were discussed and of value

Study Citation	Controlled assignment of treatment conditions through randomized clinical trials (RCT)	Contamination of major independent variables	Close supervision and training of the therapists	Adherence to treatment protocols	# of outcome measures used	Were appropriate statistical analyses conducted?	Were non-reactive dependent variables like incarceration, hospitalization, etc. used in the study?	diverse sample?	special efforts made to recruit/retain subjects and particularly difficult subjects?	attention given to comorbidity and multiple problem subjects and/or families?	long term follow up of one year or more?	Was there therapist-investigator non-equivalence?	Personal assessment: strengths and weaknesses	how conclusions can be useful (or not)
Ceballos, P. L., & Bratton, S. C. (2010). Empowering Latino families: Effects of a culturally responsive intervention for low-income immigrant Latino parents on children's behaviors and parental stress. *Psychology in the Schools*, 47 (8), 761–775. https://doi-org.antioch.idm.oclc.org/10.1002/pits.20502	Yes, RCT a total of 48 parents completed posttesting, 24 in the experimental group and 24 in the control group.	No, authors reported no contamination issues	Yes, All groups were led in Spanish by a bilingual Latina immigrant doctoral-level counseling student experienced in providing CPRT. All CPRT sessions were videotaped and supervised by an expert in the CPRT protocol.	No, leader remained flexible with session agendas to allot time for group members to engage in conversations regarding culturally relevant issues	2 - Spanish version of the Parent Stress Index (PSI) and Child Behavior Checklist (CBCL) Spanish Version	Yes	No	Yes, 83% of participants were Mexicans, and 17% were South or Central American. Stats matched the population in the area-southwestern USA	Yes, participating children needed to have borderline to clinical levels of child behavior concerns based on ratings on the CBCL and low-income, and Spanish as their first language. Parents chose to fill out forms or get interviewed the same questions to accomodate for low reading abilities. All materials including toys and video for recording were free and childcare was provded on site for free	yes, researches sought out families with children that were high risk of school failure and parents having aculturation difficulties	No follow up	Yes	Strength, researchers put great effort into adapting CPRT to fit the population. This study shows the posibility of this model's use on the latino population. Weakness: many resources are needed to implement this into real life settings	Conclusions are limited to the generalizability to the Latino population.
Tal R., Tal, K., & Green, O. (2018) Child-Parent Relationship Therapy with Extra-Familial Abused Children, *Journal of Child Sexual Abuse*, 27(4), 386-402, DOI: 10.1080/10538712.2018.1451420	No, researchers reported that random sampling was not feasible. Conducted tests during a waiting period before treatment.	No	No, All groups were led by the same facilitator but no report of supervision	No, facilitator added four more sessions to the adjust the model for parents of victims of ESA,	3, parenting stress inventory (PSI), Child Behavior Checklist (CBCL), Compassion Fatigue Self-Test (CFST)	Yes	No	No, parental level of education varried. Race/ethnicity and other factors were not reported	No	No, Researches did report what major life stressors families experienced a year prior to the study	No follow up	Yes, The authors declare that they have no conflicts of interest.	Strength: Large sample size (51) and focusing on a particular parent child stressor. Weakness: non diverse sample, limited information on the training of CPRT facilitators	Study found interesting results based on the age of the child participating

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Taylor, D. D., Purswell, K., Lindo, N., Jayne, K., & Fernando, D. (2011). The Impact of Child Parent Relationship Therapy on Child Behavior and Parent-Child Relationships. International Journal of Play Therapy, 20(3), 124-137. doi: 10.1037/A0024469	No, only 3 participants	Yes, principle investigator and graduate student conducted CPRT sessions. Power differential could be involved.	Yes, graduate counseling students worked under the supervision of a faculty advisor.	Yes, The leaders adhered to the full CPRT protocol	2, PSI and CBCL	No, limited information was shown. Researchers also used qualitative data when calculating results	No	No, all White participants (only 3 parents)	No, however, play kit was provided to borrow if needed	No, parents had to choose a single child to focus on.	No follow up	No, The group leaders' participation on the research team could haveaffected the data analysis because of researcher bias.	Strength: Evidence showed positive results. Study allowed for feedback about what aspects the parents found most helpful. Information seemed useful for future researchers. Weakness: Small sample size (3) does not allow for generalizability. Only participating with 1 parent of divorced parents limits the effectiveness reliability of CPRT on child behavior	Not useful, sample size (3) is too small to generalize

Study Citation	Controlled assignment of treatment conditions through randomized clinical trials (RCT)	Contamination of major independent variables	Close supervision and training of the therapists	Adherence to treatment protocols	# of outcome measures used	Were appropriate statistical analyses conducted?	Were non-reactive dependent variables like incarceration, hospitalization, etc. used in the study?	diverse sample?	special efforts made to recruit/retain subjects and particularly difficult subjects?	attention given to comorbidity and multiple problem subjects and/or families?	long term follow up of one year or more?	Was there therapist-investigator non-equivalence?	Personal assessment: strengths and weaknesses	how conclusions can be useful (or not)
Opiola, K. K., & Bratton, S. C. (2018). The efficacy of child parent relationship therapy for adoptive families: A replication study. *Journal of Counseling & Development*, 96(2), 155–166. https://doi-org.antioch.idm.oclc.org/10.1002/jcad.12189	Yes, compare CPRT with treatment as usual (TAU) or an active control condition to overcome the limitations inherent to no-treatment wait-list control groups.	Yes, CPRT facilitators were five advanced doctoral counseling students and one counseling faculty member (second author). Eight doctoral-level counseling students, independent of the present study and with advanced training in play therapy and CPRT, scored the videos.	Yes, researchers were trained and tested on rating reliability.	No, All CPRT sessions were recorded for the purpose of weekly supervision and to ensure reliability. However, TAU was provided by counselors who were 1st-year doctoral students with a master's degree in counseling, whereas the CPRT counselors had more clinical experience.	3, PSI-4 total stress, CBCL total problems, and MEACI total empathy	Yes	No	No, Sample was mostly caucasion and mostly heterosexual couples	Minimal effort, child care was provided while parents completed assessments to accomodate for multi child house hold	No, Parents had to choose a single child to focus on. Most participants had more than one child.	No follow up	No, second author provided supervision throughout treatment and conducted CPRT to one of the groups. To control for bias, the first author met with cofacilitators and an expert in CPRT for weekly supervision to ensure adherence to CPRT protocol, explore biases that might interfere with treatment delivery and outcomes, and minimize the chance for prejudicing the findings.	Strength: 49 parents representing 30 families is a adequate sample size. Reserchers took careful consideration to account for bias. Weakness: Sample is limited in diversity and does not account for the effects on multiple children. Especially considering many families had more than one adopted child.	Study accounted for many aspects that could influence the controlled variables. Study seems reliable to generalize conclusion. Limitations are to the specific demographic popuplcation (Caucasian, middle class, southwest US metropolitin city). Results showed improvement in child behavior and reduction of parental stress after CPRt
Hicks, B., & Baggerly, J. (2017). The Effectiveness of Child Parent Relationship Therapy in an Online Format. *International Journal of Play Therapy*, 26(3), 138-150. doi: 10.1037/PLA0000033	No, A convenience sample was sought from parents who had an online connection to the first author's website and social media channels.	No	Yes, all therapist were master level graduates with a LMFT. Each had to watch a weekly training video on CPRT	Yes, all therapist were master level graduates with a LMFT. Each had to watch the weekly training video on CPRT and assure that the content was following the CPRT manual. Parents online progress was monitored. Each parent watched the same recorded video	1 - Porter Parental Acceptance Scale (PPAS)	No, priori power analysis revealed that this study would require 34 participants to attain a medium effect size (.15), however only 8 participants completed the study	No	No, All eight of the participants in this study were White females	No, Participants had to have access to internet, computer with camera, ability to navigate uploading videos to youtube and access to specific CPRT toys	No, Researchers did not mention this.	No follow up	Yes, the online platform allowed for prerecorded training videos.	Strength, researchers attempted to recruit a diverse population because the online format allowed them to do so. Pre recorded videos could of had the ability to reach an even larger number of parents. Weakness: Parents needed to have a lot of resources to participate!	No, The small sample size and high attrition rate. Useful information to conduct a future study. Not conclusive for the efficacy of CPRT in an online format

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Morrison Bennet, M. O., Bratton, S. (2011) The effects of child teacher relationship training on the children of focus: A pilot study. *International Journal of Play Therapy, 20 (4), 193-207.*	No, participants selected from one school but random drawing for control or active groups	Yes, Utilizing teachers who were involved in the training as the source of child data	Yes, all therapist were doctoral students with extensive training and supervised experience in play therapy, filial therapy, and CPRT methodology	No, Sue Bratton supervised sessions to ensure treatment protocols were followed however, 2 1/2 days of intensive training (14 hr of instruction) followed by 7 weekly 1-hr group training and supervision meetings	2, Child Behavior Checklist, Caregiver-teacher Report Form	Yes	Yes, Students attended the same Head Start school	Yes, Majority of teachers and children identified as Hispanic	No, researchers used one school as subjects	No, researchers did not mention specific problems	No follow up	No, researchers did not mention who conducted the analysis.	Strengths: showed inprovements in externalizing behavior Weakness: could not measure internalizing behavior, children only received 7 play sessions, benefits might not be long lasing	Useful in showing promising results for CPRT with teachers. More research is needed to know the long term effects of treatment and training