

THE EFFECTIVENESS OF CHILD PARENT RELATIONSHIP
THERAPY (CPRT) FOR FATHERS

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High levels of quality father involvement in childhood are associated with children's socio-emotional, cognitive, and behavioral wellbeing. However, fathers can experience difficulty in building positive relationships with their kids due to work-life balance, lack of relational experience, and other life stressors. The purpose of this study was to assess the effectiveness of child-parent relationship therapy (CPRT) on fathers' parental empathy, parental stress, and child behavior problems. Though an abundance of literature exists to support the efficacy of CPRT, this was the first study to include a randomized controlled design with an all-male sample. This was also the first CPRT study to include both English and Spanish speaking fathers with intervention offered in both languages. Participants were 30 fathers (22 English, 8 Spanish; 53% Latino, 40% Caucasian, 7% Asian) with children between the ages of 3 and 10 (60% male, 40% female; 57% Latino/a, 37% Caucasian, 6% Asian). Fathers were randomly assigned to the experimental group (CPRT) ($n = 14$) or waitlist control group ($n = 16$). Results from 2 (Group) by 2 (Time) repeated measures ANOVAs did not yield statistically significant interaction effects on the dependent variables. However, results indicated a statistically significant main effect for time on each dependent variable with large effect sizes. Results of the paired samples *t*-test post hoc analyses indicated a statistically significant change over time for the experimental (CPRT) group and a non-statistically significant change over time for the control group on all dependent variables. Findings of this study support previous studies on the effectiveness of CPRT, but also indicate a need for future research to more accurately determine the effectiveness of CPRT for fathers compared to a waitlist control group.

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By

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THE EFFECTIVENESS OF CHILD PARENT RELATIONSHIP THERAPY (CPRT) FOR FATHERS

Introduction

According to McGill (2014) fathers now hold more egalitarian ideas of work and fatherhood and they spend more time with their children when compared to fathers in the 1990's. McGill highlighted that although fathers are spending more time with their children, they are not necessarily spending less time at work. Fathers report feeling pressure to be a primary breadwinner for the family while also spending ample time with their children to build relationships with them (Bryan, 2013; Guzzo, 2011). Similarly, a Pew Research survey found that 57% of respondents said that fatherhood is more difficult now than it was 20-30 years ago (Taylor, Parker, Livingston, Wang, & Dockterman, 2011). These findings are critical given research that shows that a negative father-child relationship is significantly correlated with adolescent alcohol and substance abuse (Goncya & van Dulmena, 2010), lower educational attainment (McLanahan, Tach, & Schneider, 2013), adolescent crime (Palmer & Gough, 2007), emotional and behavioral problems (Ramchandiet al., 2013), poor physical health (Carr & Springer, 2010), risky sexual behaviors (Manlove, Wildsmith, Ikramullah, Terry-Human, & Schelar, 2012), and suicidality (Aria et al., 2009). Thus, it is pivotal to identify culturally responsive interventions for fathers that help strengthen the father-child relationship. In response, this study focuses on examining the effectiveness of Child Parent Relationship Therapy (CPRT; Landreth & Bratton, 2020) on fathers' parental stress, parental empathy, and perceptions of children's behavioral problems.

Impact of the Father-Child Relationship on Children

Recent studies underscore the importance of the father-child relationship on children's holistic development. A body of literature shows that children in father-absent homes and children whose fathers abuse drugs or alcohol are at a greater risk for alcohol and drug abuse (Harcourt, Adler-Baeder, Erath, & Pettit, 2015; Mandara & Murray, 2006). Similarly, young men and women who have poor relationships with their fathers and do not perceive their fathers to be primary attachment figures are more likely to engage in risky sexual activity (Freeman and Almond, 2010) and more likely to struggle with suicidal ideation and attempts (De Luca, Wyman, and Warren, 2012; Saffer, Glenn, & David Klonsky, 2014). At a systemic level, Knoester, & Hayne (2005) found that neighborhoods in the United States with low numbers of fathers had high rates of teen violence. Whereas these studies have focused on studying the negative effects of a poor or absent father-child relationship, other researchers have focused on the effects that a positive father-child relationship has on children's development.

Research shows that high levels of quality father involvement in childhood are associated with social and emotional wellbeing (Adamsons & Johnson, 2013), behavioral adjustment (Ferreira et al., 2016), cognitive development (Pancsofar & Vernon-Feagans, 2006), and academic achievement (Adamsons & Johnson, 2013). Newland, Chen, and Coyl-Sherherd (2013) found that a secure father-child attachment was a statistically significant predictor of children's self-concept between the ages of 8 and 11. A similar study showed that paternal relationship factors were better statistically significant predictors of children's emotional symptoms than maternal factors (Michiels, Grietens, Onghena, & Kuppens, 2010). These findings were corroborated by Adamson and Johnson (2013) meta-analysis which showed that father involvement was strongly associated with child social and emotional wellbeing. In this meta-

analysis, the researchers noted that it was not the amount of contact fathers had with their children that led to positive outcomes, but rather the quality of the father-child relationship. After completing the analysis, the researchers reported a large mean effect size of .11 for relationship quality compared to a relatively small mean effect size of .02 for amount of contact (Adamson & Johnson, 2013).

Father involvement has also been shown to have positive effects on children's behavioral adjustment at multiple stages of development. Keizer, Lucassen, Jaddoe, & Tiemeier (2014) found a statistically significant negative correlation between father involvement and child attention and behavioral problems in a sample of toddlers. Adamson and Johnson (2013) also found a strong positive correlation between positive father-child relationships and behavioral adjustment in childhood. Also, children who have positive father-child experiences have higher levels of self-control and are less likely to act out in school (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008; Anthes, 2010). Along with the benefits to social, emotional, and behavioral development in children, a strong father-child relationship has been shown to support children's cognitive development as well (Bronte-Tinkew, Carrano, Horowitz, and Kinukawa, 2008; Pancsofar and Vernon-Feagans, 2006). Given these findings regarding the unique contributions of the father-child relationship to the holistic development of children, it is important that the father-child relationship be fostered and nurtured within families. Nevertheless, obstacles and difficulties exist that can make the development of this positive and growth-promoting relationship difficult.

Current Stressors for Fathers

Deater-Deckard (2004) defined parenting stress as "A set of processes that lead to aversive psychological and physiological reactions arising from attempts to adapt to the demands

of parenthood” (p. 6). These processes can arise from within the parent (e.g. personal health, job, competence, depression; Abidin, 2012) and from within the child (e.g. hyperactivity, demandingness, and mood; Abidin, 2012). When parenting stress arises, regardless of whether it is a process of the parent, the child, or both, it can cause further stress in the parent-child relationship. Apart from the average stressors of parenting, fathers face specific challenges that can add to the processes of parenting stress and negatively impact the parent-child relationship.

One such stressor that fathers report is the balance of time between work, housework, and quality time with their children. McGill (2014) used the words “traditional” and “nontraditional” to compare fathers in his research and found that fathers with “traditional attitudes” towards parenting spent more time at work and less time with their children than fathers with “nontraditional attitudes.” Even the language used in this study to differentiate between traditional and nontraditional fathers is an example of societal norms in fatherhood and how fathers’ roles in the family are changing. Parker and Wang (2013) found that the division of labor around the roles of fathers and mothers has converged drastically in recent years. For example, fathers in 2011 spent more than twice as much time per week doing housework (10 hours vs. 4 hours) and triple the amount of time per week with their children (7.5 hours vs. 2.5 hours) than fathers in 1965 (Parker & Wang, 2013). Recent research shows that fathers report feeling pressure to be a primary breadwinner for the family while also spending ample time to build relationships with their children (Taylor, Parker, Livingston, Wang, & Dockterman, 2011). Even though fathers feel the need and desire to spend more quality time with their children, they have not lost the societal or personal pressure to provide for their family economically. In fact, statistics indicate that providing economically for a family has become even harder for modern fathers than it was for fathers of past generations (Pew Research Center, 2014).

As a result of this role overload and societal and personal expectations, many fathers feel an increased level of parenting stress. Fathers who have difficulty coping with this stress tend to spend more time at work, whereas fathers who have found a way to balance their work and family roles report higher levels of positive attitudes, increased work performance, higher quality of life, satisfaction in their jobs, and greater community commitment (Evans, Carney, & Wilkinson, 2013). Fathers who have achieved a sense of work-life balance also report better father-child relationships, while fathers with high levels of work stress and work-family conflict report poor father-child relationships and low-quality interactions with their children (Lau, 2010; Goodman, Crouter, Lanza, & Cox, 2008).

Given the importance of the father-child relationship for healthy child development (Johnson, 2013; Michiels, Grietens, Onghena, & Kuppens, 2010), along with the recent statistics that show the struggles of fathers in America today (Taylor, Parker, Livingston, Wang, & Dockterman, 2011), it is important to provide services to fathers that can assist them in developing healthy relationships with their children. Research shows that parental stress and parental empathy have significant impacts on the quality of the parent-child relationship (Music, 2011; LeSure-Lester, 2000). Thus, child-parent relationship therapy, an evidence-based parenting program that has been shown to be effective in reducing parental stress (Ceballos & Bratton, 2010; Sheely & Bratton, 2010; Tew, Landreth, Joiner & Solt, 2002) and increasing parental empathy (Carnes-Holt & Bratton, 2014; Costas & Landreth, 1999; Glover & Landreth, 2000; Opiola & Bratton, 2017), presents itself as a viable intervention for fathers.

Child-Parent Relationship Therapy (CPRT)

Child-parent relationship therapy (Landreth & Bratton, 2020) is an evidence-based, manualized mental health intervention for children and their parents. Child-parent relationship

therapy (CPRT) is rooted in the theoretical constructs of child-centered play therapy (CCPT) and holds that the relationship between the parent and child is the agent of change and the foundation for children's overall wellbeing (Landreth & Bratton, 2020). CPRT utilizes a small group format that meets once a week for two hours for ten weeks. During the group meeting, parents are supported in their struggles by group facilitators, connect with other parents, and learn the basic child-centered ways of being and interacting with their children. By learning the CCPT skills and attitudes and incorporating them into their interactions with their children, parents become a therapeutic agent for their children. CPRT is a unique and developmentally appropriate intervention that can increase parental empathy and help parents to build a strong, supportive relationship with their children.

The first CPRT outcome study was published in 1995 with the methodological rigor and evidence-base continuing to grow over the last 23 years. To date, researchers have conducted over 40 studies using a control group design with over 1100 participants to examine the effects of CPRT on various populations (e.g. Bratton & Landreth, 1995; Carnes-Holt & Bratton, 2014; Cornett & Bratton, 2014; Kim, 2009; Opiola & Bratton, 2017). Of these 40 studies, 17 employed experimental designs (e.g. Carnes-Holt & Bratton, 2014; Cornett & Bratton, 2014; Opiola & Bratton, 2017) and 16 studies used quasi experimental designs (e.g. Jang, 2000; Kim, 2009). The vast majority of research conducted on CPRT yielded statistically significant results with medium to large treatment effects for both parents and children (Bratton et al., 2015). Two meta-analyses (Bratton, Ray, Rhine, & Jones, 2005; Lin & Bratton, 2015) support these results and add further credibility to the findings from individual CPRT studies.

CPRT research demonstrates its efficacy with a variety of populations and presenting issues. Some of the outcomes targeted include: increasing parental empathy, decreasing stress in

the parent-child relationship, and reducing children's behavior problems (Lin & Bratton, 2015). Some of the populations studied include: adopted/fostered children, sexually abused children, children with incarcerated fathers/mothers, and at-risk children of teenage parents. Over eight ethnic groups were represented in the studies along with families of various socioeconomic and cultural identities. However, only one previous research study focused specifically on fathers and was conducted in 1997 with incarcerated fathers (Landreth & Lobaugh, 1997). This study builds upon past research by incorporating the general population of fathers along with a randomized control design. This is also the first CPRT study to offer groups in both English and Spanish allowing for a more representative sample of the population and generalization of results.

Purpose of the Study

This study examined the effects of child-parent relationship therapy (CPRT) on fathers, their children, and the father-child relationship. Specifically, this study addressed three primary research questions: 1) do fathers who participate in CPRT report a decrease in child behavior problems compared to a waitlist control group? 2) do fathers who participate in CPRT report a decrease in parental stress compared to a waitlist control group? and 3) do fathers who participate in CPRT report an increase in parental empathy compared to a waitlist control group?

Methodology

I used a randomized control group design to examine the effects of CPRT on fathers. I conducted a G* Power a priori power analysis and determined that a minimum sample size of 34 participants was necessary to find a statistical difference between two groups over two times of measurement (pre and post-test). I based G* Power calculation on an alpha level of .05, moderate treatment effect size ($f = .25$), and minimum power at .80 (Cohen, 1988). To allow for attrition, I aimed to recruit 60 fathers for the study.

Participants

Fathers were recruited from a large metropolitan area in the southwest United States, through flyers and announcements made in local schools, churches, and community counseling clinics. Because the CPRT protocol has been translated into Spanish, I was able to include both English and Spanish speaking fathers to allow for a more representative sample of the population in the Southeast region where the study was conducted. Fathers were required to meet the following criteria in order to be eligible for the study: 1) Be above the age of 18; 2) have at least one child between the age of 3 and 10 for whom the father reported behavior or relationship concerns; 3) Identify as the primary male parental figure; 4) Be present and participating in the child's life for at least one year; and 4) Is not related to the child in some way other than as a parent. Fathers were considered ineligible to participate in the study if they were currently participating in another parenting program or if their child-of focus for the study was currently in counseling.

Over 60 fathers initially expressed interested in participating. However, due to their work schedules, time constraints, and difficulty in reaching participants via phone, only 44 participants agreed to participate. I recruited both English and Spanish speaking fathers from various locations. I used a block randomization technique to randomize fathers by location and language and used an online random assignment generator to randomly assign the 44 fathers into either the treatment group or the control group. Of the 44 fathers who agreed to participate, only 30 fathers completed both pre and post-testing. Most of the fathers who dropped from the study either did not complete pre-testing, or lost contact immediately after pre-testing and before the start of the intervention.

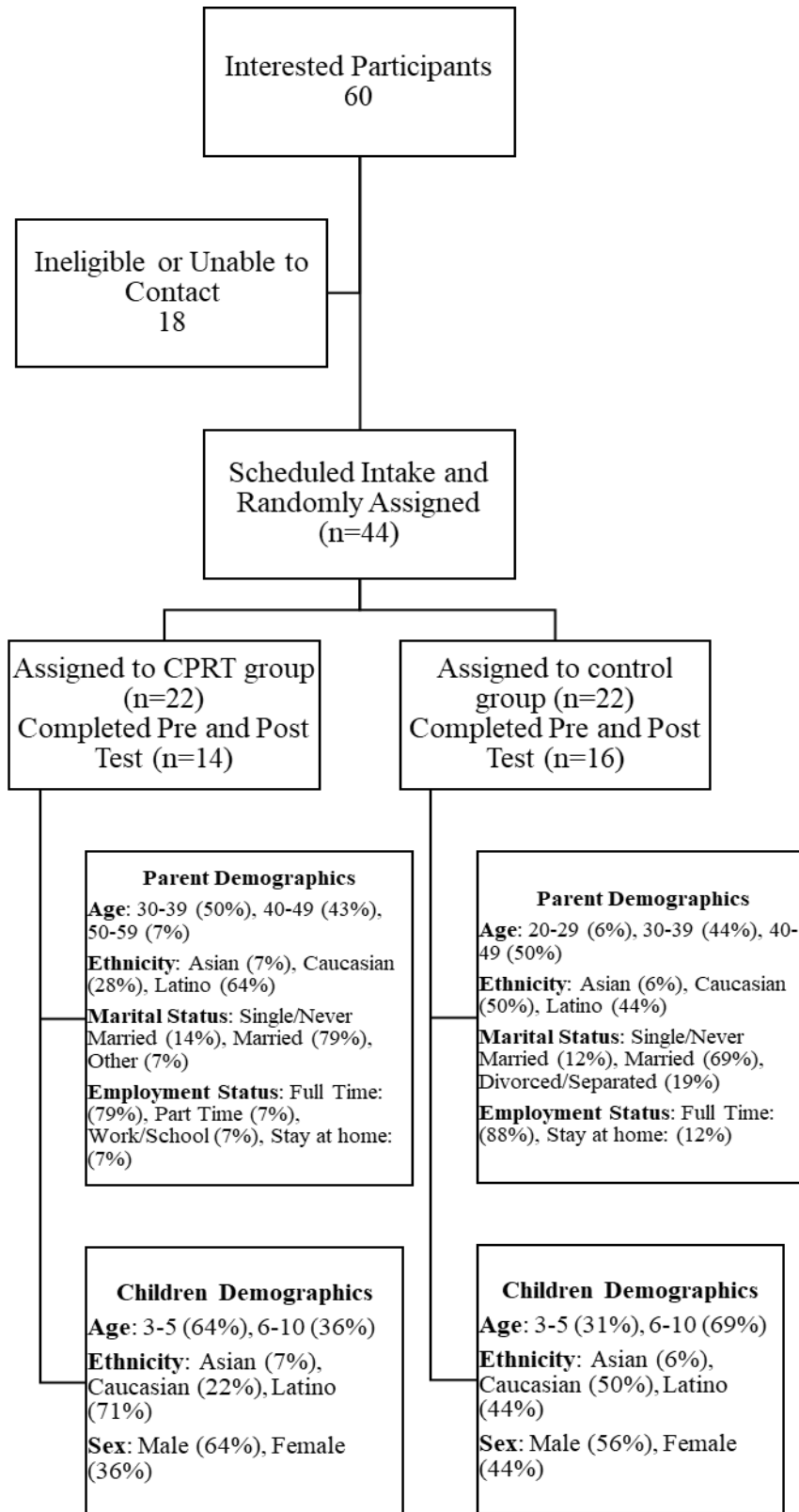


Figure 1. Participants flow chart.

The primary attrition rate occurred in the Spanish speaking population with 8 fathers (50%) of the Spanish speaking participants (4 Experimental and 4 Control) failing to complete post-testing. The final analysis included 14 fathers in the experimental group (4 Spanish and 10 English) and 16 fathers in the control group (4 Spanish and 12 English). Final total participants included 30 fathers (22 English, 8 Spanish; 53% Latino, 40% Caucasian, 7% Asian) with children between the ages of 3 and 10 (60% male, 40% female; 57% Latino/a, 37% Caucasian, 6% Asian). Further demographic and procedural information for fathers and children is presented in Figure 1.

Instrumentation

Child Behavior Checklist (CBCL)

It is a paper-based questionnaire completed by caregivers and is comprised of 99-113 Likert-scaled items that measure parents' perceptions of their child's behavioral, emotional, and social functioning (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001). The CBCL consists of three domains; Internalizing Problems, Externalizing Problems, and Total Problems (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001). The Total Problems domain was interpreted as a dependent variable in the study as this domain is a combination of the Internalizing and Externalizing domains. The CBCL has acceptable psychometrics with strong test-retest reliability and criterion-related validity (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001; Njoroge & Bernhart, 2011). According to Achenbach and Rescorla (2001), the mean score on both versions of the CBCL across all tests was $r = .90$. The authors also reported consistently revising and researching the assessment in order to maximize criterion-related validity. Due to the age range of participant's children, both the CBCL 1½ - 5 and the CBCL 6-18 versions of the CBCL were used in this study. Multiple studies have used both versions of the

assessment (e.g. Akoury Dirani, Sinno, Wheeler, Tamim, & Charafeddine, 2018; Plotkin, 2014). Also, in order to include both English and Spanish speaking participants in the study, I used both the English and Spanish versions of the CBCL, which have been shown to be consistent across multiple studies (Gross, Fogg, & Young, 2006; Viola, Garrido, & Rescorla, 2011).

Parenting Stress Index, 4th edition Short Form (PSI-4-SF)

The PSI-4 measures parents' perceptions of their stress related to the parent-child relationship, as well as attributes of the parent and child that contribute to stress for the parent. The assessment has a Parent Domain, a Child Domain, Life Stress scale, and a Total Stress score (Abidin, 2012). It is paper-based, self-administered assessment that consists of 109 Likert-scaled items on a scale of *strongly agree to strongly disagree*. The test-retest reliability coefficients for the PSI-4 are $r = .55-.82$ for the Child domain, $r = .96$ for the Parent domain, and $r = .65-.96$ for the Total Stress domain (Abidin, 2012). The PSI-4 also has strong internal consistency with coefficient alpha scores ranging from .75 - .98 for the Parent and Child domains and a Total Stress score coefficient alpha of .96 (Abidin, 2012). Solis and Abidin (1991) evaluated the Spanish version of the PSI and stated that alpha coefficients for test-retest reliability ranged from .58 - .92 for the parent domain, .58 - .88 for the child domain, and .94 for the total stress score. Researchers concluded that the Spanish version of the PSI shares similar reliability and validity with the original English version.

Today, the only version of the PSI-4 that is available in both English and Spanish is the PSI-4-SF, or short form. This is an abbreviated version of the original PSI-4 with only 36 questions, which are also found on the long form. The three domains were renamed to Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC), which combine to form the Total Stress score. Multiple studies have shown similar reliability and

consistency for the English PSI-4-SF compared to the original English PSI-4 (e.g. Harding, Murray, Shakespeare-Finch, & Frey, 2018; Mersky, Topitzes, Janczewski, & McNeil, 2015). Pérez-Padilla, Menéndez, and Lozano (2015) conducted a study to measure the reliability and consistency of the Spanish version of the PSI-4-SF. Results indicated a strong reliability and consistency for the Total Stress score, similar to the English version of the PSI-4-SF.

Adult-Adolescent Parenting Inventory, 2nd edition (AAPI-2.1)

The AAPI-2.1 was designed to assess parenting and child rearing attitudes of adolescents and adults and is useful in determining strengths and weaknesses in child-rearing (Bavolek & Keene, 2010). The AAPI-2.1 has two forms: Form A and Form B, which consist of 40 questions each and are traditionally offered as pre-test and post-test respectively. Both forms are paper-based, self-administered assessments and consist of Likert-scaled items on a scale of *Strongly Agree to Uncertain*. The AAPI-2.1 consists of 5 subscales called “constructs” including: Construct A - Expectations of Children, Construct B - Parental Empathy towards Children’s Needs, Construct C - Use of Corporal Punishment, Construct D - Parent-Child Family Roles, and Construct E - Children’s Power and Independence.

For the combined forms, internal reliability was calculated using Chronbach’s Alpha and resulted in strong reliability coefficients for each subscale ranging from .86 to .96 (Bavolek & Keene, 2010). Researchers conducted a factor analysis of the five constructs to determine construct related validity and reported strong evidence of the generalizability and validity of all five constructs (Bavolek & Keene, 2010). On their website, assessingparenting.com, the authors reported that the AAPI-2.1 has been developed and normed for both English and Spanish speaking families with appropriate scoring profiles and response interpretations. Though it is not explicitly stated, it appears that the norm tables provided in their publication (Bavolek & Keene,

2010) include both English and Spanish speaking families. A previous dissertation study used both the Spanish and English version of the AAPI-2.1 to examine the effects of postpartum adjustment on childrearing attitudes and found statistically significant results (Chiverton, 2008).

Procedures

I began the research process by partnering with local churches, schools, and community counseling clinics for advertising and the possible use of facilities to conduct CPRT groups. I made face-to-face announcements and/or provided flyers for the organizations to post and hand out to parents. Interested parents called the student investigator who conducted a preliminary phone interview with fathers to determine their eligibility and availability for the study. Fathers who agreed to participate in the study filled out the informed consent, family background form, CBCL, PSI-4-SF, and AAPI-2.1 during the in-person intake (see appendixes). These forms were given to participants in either English or Spanish, depending on participants' preferred language and choice of English or Spanish group.

I conducted multiple rounds of recruitment and randomization over the course of 7 months in order to reach 30 total participants. To maintain experimental rigor while also accounting for location and language, I used a block randomization technique to randomize by location and language. To ensure equal numbers of participants in the treatment and control groups, and to achieve a minimum of 4 and maximum of 8 parents in each CPRT group, I required a minimum of 8 consenting participants in one location who all spoke the same language before I randomized. No couples or partners participated in the study. Thus, it was not necessary to randomize pairs of fathers. After completing the CPRT intervention within each block, I conducted post-assessments with all participants and began the CPRT intervention for the control group.

Before beginning treatment, all parents completed a background form, CBCL, PSI-4-SF, and AAPI-2.1 during their intake. Within one week of finishing the treatment phase within each block, parents from both the treatment group and control group completed the CBCL, PSI-4-SF and AAPI-2.1 again as post-assessment measures. For all assessments, I provided a quiet place, free of distractions, where I could administer the assessments and observe the participants.

Treatment Group (CPRT)

Participants assigned to the CPRT treatment group were placed into groups of 4-8 parents by primary spoken language and location. Following the CPRT treatment protocol (Landreth & Bratton, 2006), these groups met once a week for 2 hours for ten weeks. Days, times, and locations were decided according to the needs and availability of the participants, the clinics, and the therapist. I led one of the Spanish speaking groups with a level 1 CPRT certified parent educator as my coleader and translator. The other Spanish group was led by a level three certified CPRT therapist. Both group leaders have had at least three graduate level classes in play therapy and one graduate level class in Filial/CPRT. The facilitators followed the CPRT protocol (Bratton et al. 2006) throughout the study. All group sessions were recorded and a faculty supervisor with advanced training and experience in CPRT provided weekly supervision. The faculty supervisor also randomly viewed 20% of the recorded CPRT sessions using the CPRT Therapist Skills Checklist to determine treatment fidelity (See Appendix I).

Following the CPRT treatment manual (Bratton et al., 2006), the first three sessions, focused on foundational CCPT attitudes and skills. The *be with* attitudes include: *I am here, I hear you, I understand, I care* (Bratton et al., 2006; Landreth & Bratton, 2006). Sessions 4-6 focused on identifying and encouraging parental strengths, teaching limit setting, choice giving, and refining previously learned skills. After Session 3, parents began weekly 30-minute special

playtimes with their “child of focus” and parents recorded their special play times with their children for the purpose of supervision. For the first 45 minutes of each group after Session 3, facilitators checked-in with all parents on their play sessions, then at least 2 parents showed video of their play sessions and facilitators and group members provided feedback and support to those parents (Bratton et al., 2006). Sessions 7 and 8 focused on helping parents to build self-esteem in the child and learning the difference between praise and encouragement (Bratton, et al., 2006). The skills that parents learned in these sessions help them to play and interact with their children in ways that increase their internal loci of control, motivation, and evaluation, thus increasing their self-esteem and ability to regulate self (Bratton et al., 2006; Landreth & Bratton, 2006). Sessions 9 and 10 focused on summarizing and refining skills and attitudes learned in the group while parents showed their final recorded sessions for feedback and support (Bratton, et al., 2006).

Waitlist Control Group

All participants in the control group began the CPRT groups following their post-data collection. I followed the same CPRT treatment manual protocol (Bratton et al., 2006) with the control group and treatment was provided by the same group leaders.

Results

In order to evaluate the effectiveness of CPRT for fathers, I conducted 2 (Group) by 2 (Times) repeated measures ANOVAs on each dependent variable. The three dependent variables included the Total Problems score on the CBCL, the Total Stress score on the PSI-4-SF, and the Empathy score on the AAPI-2.1. I used the Statistical Package for the Social Sciences (SPSS) to check all assumptions, review the data, and conduct the three ANOVA analyses. The treatment group (CPRT/Waitlist control) served as the between-subjects variable and time (pretest/posttest)

served as the within-subjects variable. Prior to conducting the analyses, each dependent variable was examined to ensure the data met assumptions for a factorial ANOVA. The assumptions for normal distribution and homogeneity of variance were reasonably met for each analysis. Sphericity was assumed based on two points of measurement. The skewness and kurtosis for the continuous variables were within normal limits, positive or negative one and positive or negative three respectively. In order to determine statistically significant differences, I used a .05 alpha level. I calculated partial eta squared effect sizes (η_p^2) as a measure of practical significance to determine the strength of the differences between the two groups over time. I interpreted effect sizes according to the Cohen (1988) guidelines on interpreting practical significance. Cohen's guidelines are .01 equals a small effect, .06 equals a moderate effect; and .14 equals a large effect. I focused primarily on identifying an interaction effect between groups over time for each dependent variable, but also recorded main effects for time and group. I also ran paired samples t-tests as post-hoc analyses for statistically significant main effects. I used a .05 alpha level to determine statistical significance and calculated Cohen's *d* effect sizes for each. I used the Cohen (1988) guidelines of .2 equals a small effect, .5 equals a medium effect, and .8 equals a large effect. I conducted G*Power analysis to determine computed power for all post-hoc analyses based on an alpha level of .05, moderate treatment effect size of .5, and sample size within the analysis. Computed power equals .410 for sample sizes of 14, .438 for sample sizes of 15, and .465 for sample sizes of 16. The impacts of these low power levels are address in the discussion. Table 1 presents the pretest and posttest mean scores and standard deviations for the CPRT and control groups for the three dependent variables.

Table 1

Means and Standard Deviations on all Dependent Variables

		Experimental (CPRT) Group (n = 14)		Waitlist Control Group (n = 16)	
		M	SD	M	SD
CBCL Total Problems	Pre-test	54.286	6.426	55.563	9.872
	Post-test	48.000	6.164	51.688	11.435
PSI-4-SF Total Stress	Pre-test	77.857	21.640	88.400	16.724
	Post-test	67.000	17.146	83.200	17.989
AAPI-2.1 Empathy	Pre-test	6.210	1.847	5.940	2.175
	Post-test	7.071	1.979	7.312	1.815

Research Question 1: Child Behavior Problems

The first ANOVA analyzed the total problems scale on the CBCL to address the question, “What is the effect of CPRT on parental perception of child behavior problems compared to a waitlist control group?” Table 1 presents the mean scores and standard deviations for the pre and post CBCL Total Problem scores for both the experimental and waitlist control groups.

Results indicated that there was no statistically significant interaction effect between the two groups over two times of measurement $F(1,28) = .846, p = .366$ and showed a small effect size of $\eta_p^2 = .029$. Results also indicated no statistically significant main effect for group, $F(1,28) = .690, p = .413$ with a small effect size of partial $\eta_p^2 = .029$. However, results showed a statistically significant main effect for time, $F(1,28) = 15.02, p = .001$ with a large effect size of $\eta_p^2 = .349$.

In order to further explore the statistical significance for time, I ran paired samples t-tests to compare the difference between means at pre-test and post-test for each group on the CBCL

Total Problems scale. For the experimental (CPRT) group, there was a statistically significant decrease in Total Problem scores from pre-test ($M = 54.286$, $SD = 6.426$) to post-test ($M = 48.000$, $SD = 6.164$), $t(13) = 4.076$, $p = .001$ (two-tailed). I also calculated a Cohen's d effect size to determine the magnitude of the difference between the means. Results indicated a large effect size with Cohen's $d = .998$. The results for the control group did not show a statistically significant decrease from pre-test ($M = 55.563$, $SD = 9.872$) to post-test ($M = 51.688$, $SD = 11.435$), $t(15) = 1.895$, $p = .078$ (two-tailed). Results indicated a small effect size with Cohen's $d = .363$. A visual inspection of the graph in Figure 2. supports the statistically significant change over time reported by the CPRT group.

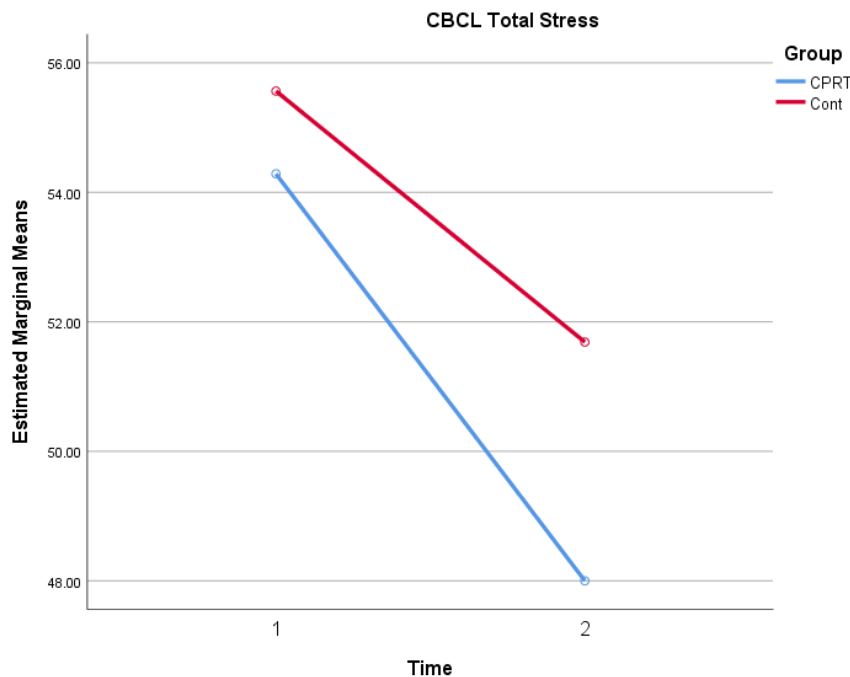


Figure 2. Means between groups over time on CBCL Total Problem Score.

Research Question 2: Parental Stress

The second ANOVA analyzed the total stress scale on the PSI-4-SF to address the question, “What is the effect of CPRT on parental stress compared to a waitlist control group?”

Table 1 presents the mean scores and standard deviations for the pre and post PSI-4-SF Total Stress scores for both the experimental and waitlist control groups. One participant in the control group did not complete the post assessment and that participant's scores were removed from this analysis resulting in a total of 14 in the experimental group and 15 in the control group.

Results indicated that there was no statistically significant interaction effect between the two groups over two times of measurement, $F(1,27) = .852, p = .364$ and showed a small effect size of $\eta_p^2 = .031$. Results indicated a statistically significant main effect for time, $F(1,27) = 6.868, p = .014$ with a large effect size of $\eta_p^2 = .203$. Results also showed a statistically significant main effect for group, $F(1,27) = 4.761, p = .038$ with a large effect size of partial $\eta_p^2 = .150$.

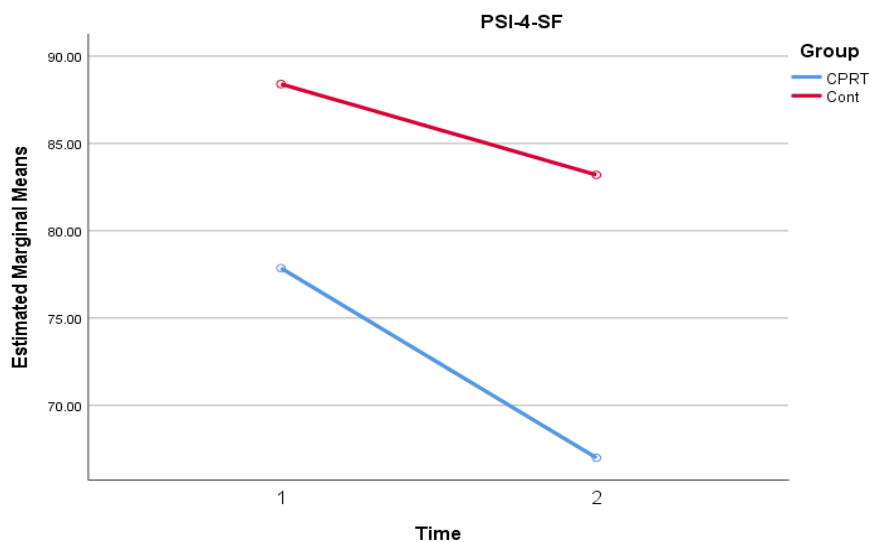


Figure 3. Means between groups over time on PSI-4-SF Total Stress Score.

In order to further explore the statistical significance for time, I ran paired samples t-tests to compare the difference between means at pre-test and post-test for each group on the PSI-4-SF Total Stress scale. For the experimental (CPRT) group, there was a statistically significant decrease in Total Stress scores from pre-test ($M = 77.857, SD = 21.640$) to post-test ($M = 67.000, SD = 17.146$), $t(13) = 2.272, p = .041$ (two-tailed). I also calculated a Cohen's d effect size to

determine the magnitude of the difference between the means. Results indicated a medium effect size with Cohen's $d = .556$. The results for the control group did not show a statistically significant decrease from pre-test ($M = 88.400, SD = 16.724$) to post-test ($M = 83.200, SD = 17.989$), $t(14) = 1.335, p = .203$ (two-tailed). Results indicated a small effect size with Cohen's $d = .299$. A visual inspection of the graph in Figure 3. supports the statistically significant change over time reported by the CPRT group.

Research Question 3: Parental Empathy

The final ANOVA analyzed the Empathy subscale on the AAPI-2.1 to address the question, "What is the effect of CPRT on the parental empathy compared to a waitlist control group?" Table 1 presents the mean scores and standard deviations for the pre and post AAPI-2.1 Empathy subscale scores for both the experimental and waitlist control groups.

Results indicated that there was no statistically significant interaction effect between the two groups over two times of measurement $F(1,28) = .462, p = .502$ and showed a very small effect size of $\eta_p^2 = .016$. Results also indicated no statistically significant main effect for group, $F(1,28) = .001, p = .977$ with a small effect size of partial $\eta_p^2 < .001$. However, results did indicate a statistically significant main effect for time, $F(1,28) = 8.576, p = .007$ with a large effect size of $\eta_p^2 = .234$.

In order to further explore the statistical significance for time, I ran paired samples t-tests to compare the difference between means at pre-test and post-test for each group on the AAPI-2.1 Empathy Subscale. For the experimental (CPRT) group, there was a statistically significant increase in Empathy Subscale scores from pre-test ($M = 6.214, SD = 1.847$) to post-test ($M = 7.071, SD = 1.979$), $t(13) = -2.482, p = .028$ (two-tailed). I also calculated a Cohen's d effect size to determine the magnitude of the difference between the means. Results indicated a small-

medium effect size with Cohen's $d = .448$. The results for the control group did not show a statistically significant increase from pre-test ($M = 5.938, SD 2.175$) to post-test ($M = 7.313, SD = 1.815$), $t(15) = -2.133, p = .05$ (two-tailed). Results indicated a medium effect size with Cohen's $d = .686$. A visual inspection of the graph in Figure 4. supports the statistically significant change over time reported by the CPRT group. Though the mean difference for the control group is greater than the mean difference of the experimental group, the standard deviations of the control group scores were such that statistical significance was not reached on the post hoc analysis.

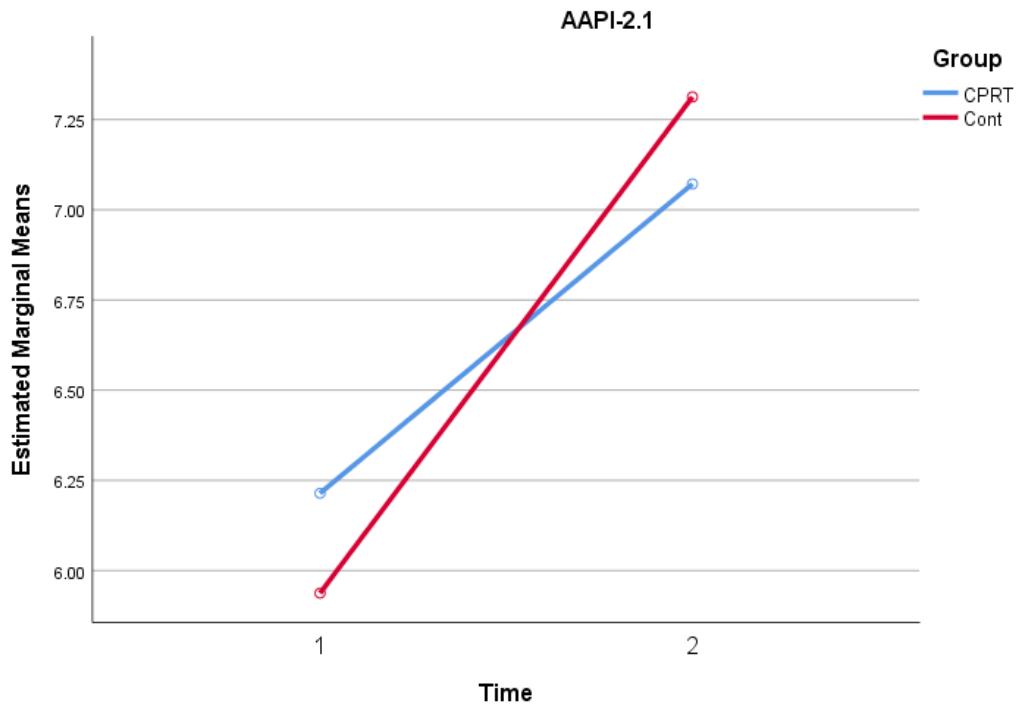


Figure 4. Means between groups over time on AAPI-2.1 Empathy Subscale.

Discussion

The purpose of this study was to measure the effectiveness of child-parent relationship therapy for fathers compared to a waitlist control group. Specifically, I aimed to measure the effect of the CPRT program on child behavior problems, parental stress, and parental empathy. A

secondary purpose of this study was to increase the volume of literature and research support for parenting programs that may be effective for fathers. CPRT is an effective evidence-based program for parents (Lin & Bratton, 2015), but approximately 80% of the participants in CPRT research to date are mothers (Bratton et al., 2015) and only one study has been conducted on its effectiveness for fathers exclusively (Landreth & Lobaugh, 1997). This was the first randomized controlled study on the effectiveness of CPRT for fathers and is also the first study to include both English and Spanish CPRT groups.

The results of the present study indicate that there were no statistically significant differences between the groups over time on the dependent variables and the effect sizes associated with these results were small. However, each analysis yielded statistically significant differences for time with various levels of practical significance, which required further exploration. Post hoc analysis showed that the CPRT group demonstrated statistically significant improvement across the three dependent variables, whereas the control group did not. However, by not reaching the necessary number of participants designated by the G*Power analysis, the statistical significance findings must be interpreted in light of the lack of power and increased possibility of type 2 error on all analyses. Due to the lack of power, the effect sizes may provide more accurate information for the interpretation of the results. A more specific discussion on the findings for each dependent variable is included in the following sections.

Child Behavior Problems

Results of the ANOVA analysis for the CBCL indicated no statistically significant interaction effect with a small effect size. However, a visual inspection of the standard deviations in Table 1. is taken into account when interpreting this result. The experimental group showed consistent deviation over time, while the control group standard deviations varied dramatically.

In fact, the variance in the control group scores at pretest were close to not meeting the assumption of homogeneity at $p = .051$ and the variance in the control group scores at posttest did not meet the assumption for the homogeneity at $p = .043$. This violation in the assumption of homogeneity of variances inhibits an accurate result pertaining to an interaction effect between groups over time.

Results did indicate a statistically significant main effect for time. When controlling for group assignment, fathers scored statistically significantly better at posttest than at pretest. The magnitude of this difference over time is shown in the partial eta squared effect size of $\eta_p^2 = .349$, which indicates a large practical significance across time. The post hoc analysis indicated that the CPRT group reported a statistically significant decrease in child behavior problems, while the control group did not. With low power for the post-hoc analysis, the Cohen's d effect sizes play an important role in the interpretation of the results. The large effect size of .998 for the experimental group compared to the small effect size of .363 for the control group shows a more significant change over time for the experimental group. A visual inspection of the means in Table 1. shows a greater decrease in the total problem score for the experimental group (6.286) than for the control group (3.875).

With a statistically significant change over time and a large effect size in the post hoc analysis, CPRT showed promising results as an effective program for fathers in reducing child-behavior problems. However, due to the lack of an interaction effect when compared to a waitlist control group, more research is necessary to support this finding. A larger sample size and a more homogenous data set would increase the power of this analysis and provide more information on the effectiveness of this program for fathers and child behavior problems.

CPRT may impact child-behavior problems, not only by building stronger father-child relationships, but also by teaching fathers how to appropriately limit and discipline their children through the relationship that they build throughout the program (Landreth & Bratton, 2020). Sessions 1-3 of the CPRT program focus on helping fathers to learn a specific “way of being” with their children that communicates attitudes of, “I See you, I hear you, I understand, and I care” (Bratton, et al., 2006, p.7). Fathers learn to listen to how their children communicate through play in order to better understand and grow closer to their children. Fathers also learn how to reflect and respond to their children in ways that help their children to feel understood and to better understand themselves. Sessions 4-7 focus on limit setting and choice giving, which directly impact children’s behaviors and decision making. Rather than an authoritarian approach, which can be met with resistant, or a laissez-faire parenting style, which can lead to unruly and immature behaviors, the CPRT program teaches fathers how to address child-behavior problems in a way that decreases child’s resistance and increases the child’s sense of responsibility and self-control (Landreth & Bratton, 2020). Past research has shown CPRT to be an effective approach for decreasing child-behavior problems (Ceballos & Bratton, 2010; Lin & Bratton, 2015; Opiola & Bratton, 2017). With a statistically significant main effect for time and a substantial decrease in mean scores for the CPRT group, this study supports the findings of previous CPRT research.

Parental Stress

Results of the ANOVA for the PSI-4-SF showed statistical significance for the main effects of group and time independently, but not for the interaction effect. The statistically significant main effect for time is important to note in that all fathers reported a decrease in parental stress over time. Similar to the CBCL scores, Table 1 shows that the mean difference

from pretest to posttest for fathers in the experimental group (10.857) is twice as large as the mean difference for fathers in the control group (5.200). Post hoc analysis of the change over time indicated that the experimental (CPRT) group reported a statistically significant decrease in parental stress, while the control group did not. The medium effect size of .556 for the experimental group compared to the small effect size of .299 for the control group shows a more significant change over time for the experimental group. Results indicate that CPRT may be an effective approach to reducing parental stress for fathers. However, the lack of an interaction effect in this study necessitates further research to examine how this change over time compares to a waitlist control group.

There are multiple components of CPRT that can have positive impacts on parental stress and may explain the change seen in this study. The group format of CPRT is one aspect of the program that can help parents to connect with one another and let go of feelings of isolation in their parenting struggles. Parents bond with other parents in the group and learn, not only that it is okay to struggle sometimes, but also that others are struggling as well (Landreth & Bratton, 2020). This could lead to a decrease in feelings of shame and doubt, which are significant contributors to stress. The CPRT group also serves as a process group for parents where they can discuss the issues they are facing at home and experience the acceptance, genuineness, and unconditional positive regard of the other parents and the group facilitator (Opiola & Bratton, 2017). In this study, many fathers took full advantage of the opportunity to express their struggles and concerns to each other.

Another aspect of the CPRT program that may impact parental stress is the weekly playtimes parents have with their children (Bratton et al., 2006). Fathers in this study verbally reported how meaningful these playtimes were, both for themselves and for their children. Many

children memorized the times that their fathers had planned to play with them and asked regularly throughout the week for more play times. These playful and positive experiences, combined with the supportive group format, may contribute to the decrease in parental stress seen in this study. The statistically significant decrease in parental stress indicated in the post hoc analysis of the CPRT group, along with the medium effect size, support the findings of previous research (e.g. Ceballos & Bratton, 2010; Opiola & Bratton, 2017; Sheely & Bratton, 2010; Tew, Landreth, Joiner & Solt, 2002) and show that CPRT may be an effective approach for decreasing parental stress for fathers. However, with no statistically significant interaction effect found in this study, more randomized controlled trials with larger sample sizes are needed to further support this claim.

Parental Empathy

Results of the ANOVA analysis for the AAPI-2.1 indicated a statistically significant main effect for time with a large effect size of $\eta_p^2 = .234$. When controlling for group assignment, fathers reported a statistically significant increase in parental empathy over time. Post hoc analysis of the main effect for time indicated that the CPRT group reported a statistically significant increase in empathy while the control group did not. However, due to the lack of power in the post-hoc analysis, an examination of the effect sizes may yield a more accurate interpretation of the results. The medium effect size of .686 for the control group compared to the small-medium effect size of .448 for the control group shows a slightly more significant change over time for the control group, which can be seen in Figure 4. Though the control group showed a greater mean difference than the CPRT group, they did not report a statistically significant increase in empathy. This result is most likely due to the lack of power and the standard deviation in the control group pretests.

Though many factors may be contributing to these results, they must be interpreted with caution for multiple reasons. Both the English and Spanish versions of this assessment were used and it is not clear if the Spanish version has been properly normed and validated. Also, the AAPI-2 is not commonly used in CPRT research making it difficult to compare the results of this study to others. Many CPRT studies use the Measurement of Empathy in Adult-Child Interactions (MEACI) to measure change in empathy over time. This is an objective measure that requires blinded observers to rate the level of empathy observed in a parent-child interaction. The MEACI has yielded positive results in many CPRT study and shows the effectiveness of CPRT on increasing parent's empathic interactions with their children (Carnes-Holt & Bratton, 2014; Costas & Landreth, 1999; Glover & Landreth, 2000; Opiola & Bratton, 2017). In contrast, the AAPI-2.1 is a subjective assessment that bases the measurement of empathy more on the parent's attitudes and beliefs than on interactions and behaviors. Thus, the variation in definition and measurement between the MEACI and the AAPI-2.1 may explain the more robust interaction effects found in previous studies compared to this one. Nevertheless, examining the CPRT group alone in the post-hoc analysis shows a statistically significant change over time with a small-medium effect size. These results support the findings of previous research on the effectiveness of CPRT on parental empathy, but also highlight the need for future research to include a larger sample size and more homogenous data.

An empathic understanding of children is a key component in developing a stronger relationship with them and encouraging their optimal development. Studies show that children who experienced quality interactions and emotional support from their fathers also demonstrated more emotional stability, higher academic achievement, and stronger behavioral adjustment throughout childhood (Adamson & Johnson, 2013; Bavolek & Keene, 2010; Michiels, Grietens,

Onghena, & Kuppens, 2010; Newland, Chen, & Coyl-Sherherd, 2013; Stern, Borelli, & Smiley, 2015). Thus, it is important that fathers experience empathic interactions with and understandings of their children. CPRT aims to increase the empathic understanding of parents for their children through its psychoeducational and attitudinal components. It also helps to increase the opportunity for empathic interaction through the one-on-one play times that are required throughout the group (Opiola & Bratton, 2017). These play times are opportunities for parents to express and experience empathy with their children. The play times also serve as a form of practice for parents as they learn to interact empathically with their children on a regular basis outside of the play sessions as well.

The results of the post hoc analysis align with previous research on the effectiveness of CPRT for increasing parental empathy (Carnes-Holt & Bratton, 2014; Costas & Landreth, 1999; Glover & Landreth, 2000; Opiola & Bratton, 2017). However, with the lack of an interaction effect in this study, more randomized control research with a larger sample size is necessary in order to compare the effectiveness of CPRT on parental empathy to a waitlist control group.

Limitations and Recommendations

Multiple limitations exist within the current study which may have affected its outcome, including: sample size and the use of parent-report assessments. Sample size was a difficult and continuous process throughout the study. Over 60 fathers were recruited to participate in the study, which met the requirements for the study and was well beyond the necessary number of participants based on the g-power analysis. However, due to ineligibility, dropout, and inability to contact recruited participants, the overall number of fathers included in the study dropped to just 30, which is below the g-power requirement. Thus, all results from the present study must be interpreted with care, and the most significant limitation to the study is sample size.

Limitations also exist regarding the assessments chosen for this study. The CBCL, PSI-4-SF, and AAPI-2.1 are all subjective assessments, which measure the parents' perceptions of child-behaviors problems, stress, and empathy respectively. These measurements are focused solely on the parent's perspective and may not capture the full reality of the relationship. Survey assessments cannot control for response bias or impression management, which may have had a significant impact on the results of this study. The change over time reported by the control group is not representative of previous CPRT research (Lin & Bratton, 2015) and raises the questions as to whether or not the fathers scored more defensively at pretest while also wanting to show improvement at posttest.

Also, 2 of the 3 assessments had limited data on published norms and psychometrics. The AAPI 2.1 has a published set of norms for the English version and the developers claim that it is translated, normed, and validated in Spanish as well. However, it is not clear if the Spanish norm tables and validation studies have been published. Similarly, for the PSI-4-SF, the publishers did not provide specific data, but they noted on their website that it had similar psychometrics to the original PSI-4, and that it had been validated by various studies, which I found and included in the review of literature.

The results of this study support the premise that CPRT could be an effective treatment modality for fathers, but also indicate that more research with larger sample sizes is necessary. CPRT is an evidence-based and empirically supported parenting program for all parents. According to SAMHSA's NREPP (2017), CPRT has been recognized as effective for family cohesion and disruptive behavior disorders and symptoms as well as promising for internalizing problems in children. Although mothers make up the vast majority of participants in CPRT research (Bratton et al., 2016), many CPRT studies have included fathers and their findings

support the effectiveness of CPRT for all parents (Bratton & Landreth, 1995; Carnes-Holt & Bratton, 2014; Chau & Landreth, 1997; Cornett & Bratton, 2014; Costas & Landreth, 1999; Landreth & Lobaugh, 1998; Opiola & Bratton, 2017). The purpose of this study was to increase the body of evidence on the effectiveness of CPRT for fathers and, though the study did not find a statistically significant interaction effect, it did result in statistically significant post hoc analyses which support findings in previous research as well as a need for similar studies with larger samples.

Conclusion

Research shows that high levels of quality father involvement in childhood are associated with optimal childhood development (Adamsons & Johnson, 2013; Ferreira et al., 2016). On the contrary, absent fathers and poor father-child relationships are significantly correlated with negative outcomes such as adolescent alcohol and substance abuse (Goncya & van Dulmena, 2010; Mandara & Murray, 2006), lower academic achievement (McLanahan, Tach, & Schneider, 2013), and emotional/behavioral problems (Ramchandiet al., 2013). Despite the importance of the father-child relationship, statistics show that fathers feel less experienced and more stressed about their parenting roles now than fathers did in the past (Evans, Carney, & Wilkinson, 2013). In response, this study sought to examine the effects of the child-parent relationship therapy on reducing parental stress and child misbehaviors and on increasing parental empathy. In CPRT, parents learn to develop genuine, empathic, and unconditionally accepting relationships with their children. Given the importance of the father-child relationship for child-development, CPRT presents itself as a viable option for helping fathers to build these types of relationships with their children.

Though the lack of power in this study increased the possibility of a type 2 error, the statistical and practical significance of the interaction effects showed that there was no substantial difference between the experimental group and the control group over two points of time. However, the statistical and practical significance of the post hoc analyses indicated that CPRT may be effective for fathers in increasing parental empathy and decreasing parental stress and child behavior problems, but more stringent research with a larger sample size is necessary.

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APPENDIX A
EXTENDED LITERATURE REVIEW

Importance of the Father-Child Relationship

Societal views of fatherhood have changed drastically in the past few decades and societal expectations of fathers have increased. In a study of over 1,000 fathers, McGill (2014) found that fathers now hold more egalitarian ideas of work and fatherhood and they spend more time with their children when compared to fathers in the 90's. However, the same study found that fathers who are spending more time with their children are not necessarily spending less time at work. Fathers report feeling pressure, not only to be a primary breadwinner for the family, but also to spend ample time with their children and build relationships with them (Bryan, 2013; Guzzo, 2011). A Pew Research survey found that 57% of respondents said that fatherhood is more difficult now than it was 20-30 years ago, but 47% of fathers believe that they are doing a better job than their own fathers (Taylor, Parker, Livingston, Wang, & Dockterman, 2011). Recent research studies focusing on exploring the importance of the father-child relationship may explain why societal views on fatherhood have changed.

Research shows that high levels of quality father involvement in childhood are associated with social and emotional wellbeing (Adamsons & Johnson, 2013), behavioral adjustment (Ferreira et al., 2016), cognitive development (Pancsofar & Vernon-Feagans, 2006), self-control, and academic achievement (Adamsons & Johnson, 2013). On the contrary, absent fathers and poor father-child relationships are significantly correlated with adolescent alcohol and substance abuse (Goncya & van Dulmena, 2010; Mandara & Murray, 2006), lower educational attainment (McLanahan, Tach, & Schneider, 2013), adolescent crime (Palmer & Gough, 2007), emotional and behavioral problems (Ramchandiet al., 2013), poor physical health (Carr & Springer, 2010), risky sexual behaviors (Manlove, Wildsmith, Ikramullah, Terry-Human, & Schelar, 2012), and suicidality (Aria et al., 2009). It is possible that this current research on fathers has shed light on

the importance of fathers' involvement in children's lives and has contributed to the societal shift towards strengthening father-child relationships. It seems that fatherhood is being more valued in today's society while simultaneously becoming more complex.

The parent-child relationship is one of the most important and impactful relationships that children will have in their developing years (Guernsey, 1964), and fathers serve a unique and critical role in this process. In this section, I will first highlight the benefits of a positive father-child relationship on multiple aspects of child development and wellbeing followed by an exploration of the negative consequences of a poor father-child relationship.

Impact of a Positive Father-Child Relationship

The results of many recent studies support the conclusion that the father-child relationship is highly correlated to a child's social and emotional development. Newland, Chen, and Coyl-Sherherd (2013) studied 274 father-child dyads from the U.S. and Taiwan and found that a secure father-child attachment was a statistically significant predictor of children's self-concept between the ages of 8 and 11. These results support similar findings that further solidify the relationship between father involvement and child psychosocial adjustment. A study of 552 children showed that paternal relationship factors were better statistically significant predictors of children's emotional symptoms than maternal factors (Michiels, Grietens, Onghena, & Kuppens, 2010). In a longitudinal study of forty-four families, Grossman et al. (2002) found that children whose fathers were more sensitive, cooperative, and accepting during toddler play had stronger relationships with their children at age 6, 10, and 16. Researchers also reported that children maintained stronger emotional stability throughout the study.

In a recent meta-analysis of over 50 studies involving over 17,000 fathers, Adamson and Johnson (2013) found that father involvement was strongly associated with child social

wellbeing with a large mean effect size of .15. Researchers also reported a statistically significant mean effect size of .03 for the impact of father involvement on psychological and emotional outcomes. However, the researchers noted that it was not necessarily the amount of contact fathers had with their children that led to positive outcomes, but rather the quality of the father-child relationship. Many of the studies included in the meta-analysis compared the quality of the father-child relationship to the amount of contact in the relationship on various dependent variables. After completing the analysis, the researchers reported a large mean effect size of .11 for relationship quality compared to a relatively small mean effect size of .02 for amount of contact. Thus, though amount of time spent did have a statistically significant mean effect size, it was the quality of the relationship between fathers and children that had the stronger effect on positive social and emotional outcomes.

Positive father-child relationships have also been shown to affect various aspects of children's cognitive development. Bronte-Tinkew, Carrano, Horowitz, and Kinukawa (2008) studied infant cognitive development and found a statistically significant positive correlation between father involvement and infant cognitive outcomes (babbling and exploring objects with a purpose). The same study also found a statistically significant negative correlation between positive father-child interactions and cognitive delays in childhood. Pancsofar and Vernon-Feagans (2006) found that fathers' language output to children in the first two years of life made a unique contribution to their children's language development beyond what mothers' language output could explain. These findings support the idea that the father-child relationship has a unique way of helping children to develop in ways that a mother-child relationship does not. Similarly, children whose fathers are actively involved in their lives, read more books to them, and engage them in discussion about books tend to have higher literacy skills and positive

cognitive outcomes, regardless of how often mothers read to them (Saracho, 2007; Garfield & Isacco, 2006). In addition to the impact of the relationship on cognitive development, some of the strongest research support for the positive impact of the father-child relationship on the academic achievement of children.

Martin, Ryan, and Brooks-Gunn (2010) found that father supportiveness had a significant impact on children's school readiness when mothers scored at or below the mean on a supportiveness scale. These results imply that fathers not only make a unique contribution to their children's school readiness, but also serve as a protective factor for children who do not have supportive relationships with mothers. Along with school readiness, research shows that children with involved fathers have higher levels of literacy and reading achievement (Howard, Burke Lefever, Borkowski, & Whitman, 2006). Newland, Chen, and Coyl-Shepherd (2013) found that children who experienced secure attachment with their fathers had higher academic self-concepts and fewer social, emotional, and behavioral problems at school. The results of these studies support that a positive father-child relationship can help children be more prepared for school, feel more confident in their academic abilities, and perform better overall.

Father involvement has also been shown to have positive behavioral effects on children at all stages of development. Keizer, Lucassen, Jaddoe, & Tiemeier (2014) studied a sample of 1,523 toddlers and found a statistically significant negative correlation between father involvement and child attention and behavioral problems. The meta-analysis conducted by Adamson and Johnson (2013) also showed a strong positive correlation between positive father-child relationships and behavioral adjustment in childhood. Children who have positive father-child experiences have higher levels of self-control and are less likely to act out in school (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008; Anthes, 2010). Carlson (2006) surveyed

2,733 adolescents and found that teens who reported experiencing emotional support and interaction from their fathers reported significantly fewer behavioral problems than teens who did not feel close to their fathers. A positive father-child relationship has also been connected to a decrease in more severe behavioral issues such as: risky sexual behaviors, delinquency, and substance abuse (Bronte-Tinkew, Moore, & Carrano, 2006; Green et al., 2014).

Lastly, researchers have found that the level of empathy in a positive father-child relationship has significant effects on child development. Parental empathy can be defined as the ability of parents to be aware of and understand the needs and feelings of their children while creating an environment that is conducive to their children's emotional, intellectual, and physical wellbeing (Bavolek & Keene, 2010). Tong et al. (2012) found that parental empathy was significantly correlated with the development of empathy in children. Parental empathy has also been associated with lower rates of interpersonal aggression and higher levels of behavior compliance in children (LeSure-Lester, 2000). In regards to the impact of parental empathy on the parent-child relationship, Stern, Borelli, and Smiley (2015) found that parental empathy was positively related to child attachment security and child's perception of emotional closeness to parents. Thus, when considering the impact of the father-child relationship on child development, it is important to examine the level of empathy in the relationship and the effect that paternal empathy has on the social, emotional, and behavioral wellbeing of the child.

Thus, research support for the impact of a positive father-child relationship on child development is strong and abundant. High levels of empathy and quality father involvement in childhood are associated with child social and emotional wellbeing, behavioral adjustment, cognitive development, and academic achievement (Adamsons & Johnson, 2013). However, a poor or non-existent father-child relationship can lead to negative outcomes in these areas and

others. Having a poor father-child relationship not only prevents children from inheriting the benefits mentioned above, it also hinders children in their ability to develop to their full potential.

Consequences of a Poor Father-Child Relationship

The presence of a father in a child's home is a significant protective factor against emotional and behavioral issues throughout childhood. Children who grow up in father absent homes and have weak father-child bonds are more likely to experience depression and anxiety (Oldehinkel et al., 2008), stress and abuse (Turner, Finkelhor, Hamby, & Shattuck, 2013), and externalizing behavior problems and aggression (Mokrue, Chen, & Elias, 2012; Osborne & McLanahan, 2007). The quality of the father-child relationship affects the emotional and behavioral development of children from birth through young adulthood. Ramchandi et al. (2013) found that disengaged or remote interactions with fathers in infancy was a statistically significant predictor of child externalizing behavior problems as early as age 1. In another study involving 441 college students, researchers found that a poor paternal bond in childhood was predictive of depression in the young adult population (Patock-Peckham & Morgan-Lopez, 2007). In a way, the positive effects of a healthy father-child relationship mentioned in previous sections are negatively correlated with the effects of a poor father-child relationship. Just as a strong father-child bond is predictive of self-esteem and self-control (Newland, Chen, and Coyl-Sherherd, 2013; Sarkadi et al., 2008), a poor father-child bond is predictive of depression and externalizing behavior problems (Oldehinkel et al., 2008; Mokrue, Chen, & Elias, 2012). Furthermore, depression and externalizing behavior problems in childhood and adolescence are closely connected to alcohol and substance abuse later on in life Patock-Peckham & Morgan-Lopez, 2007).

Children in father-absent homes and children whose fathers abuse drugs or alcohol are at a greater risk for alcohol and drug abuse (Harcourt, Adler-Baeder, Erath, & Pettit, 2015; Mandara & Murray, 2006). Children who experience early divorce or live with never married mothers have significantly greater marijuana use than children in two-biological parent households (Mandara, Rogers, & Zinbarg, 2011). Similarly, after examining data from the National Longitudinal Study of Adolescent Health, Goncy & van Dulmena (2010) found that shared communication and emotional closeness to fathers had a unique impact beyond maternal involvement on adolescent alcohol use, alcohol related problems, and risky behavior co-occurring with alcohol. In another study of 296 at-risk adolescents, researchers found that children who had weaker bonds with their fathers in terms of admiration and emulation were at a higher risk for drug use and smoking (Brook, Brook, Rubenstone, Zhang, & Gerochi, 2006). Thus, the presence of fathers and the relationships between fathers and their children are statistically significant predictors of alcohol and substance abuse rates in children and adolescents.

Closely related to alcohol and substance abuse is the issue of violence and crime. Knoester, & Hayne (2005) found that neighborhoods in the United States with low numbers of fathers had high rates of teen violence. Another study of 835 juvenile male offenders arrested for gun carrying, drug trafficking, and co-occurring behaviors found that father absence was the only common disadvantage shared by the children (Allen & Lo, 2012). Children from father absent homes were found to be 279% more likely to carry guns and deal drugs compared to their peers who grew up with a father in the home (Allen & Lo, 2012). Multiple studies found that children who had poor communication and low social interaction with their fathers exhibited higher rates of delinquent behaviors than other children (Keijsers, Frijns, Branje, & Meeus, 2009; Coley and

Medeiros, 2007). Finally, In an effort to summarize the impact of a poor father-child relationship on crime and violent behavior, Bronte-Tinkew, Moore, & Carrano, (2006) examined data from the 1997 National Longitudinal Study of Youth and found that: a) a more negative father-child relationship is predictive of a an increased risk of engagement in risky behaviors, b) having a father with an authoritarian parenting style is associated with adolescent delinquency and substance abuse, and c) permissive parenting is predictive of risky behavior when the father-child relationship is negative. The risky behaviors mentioned in the study primarily included risky sexual behaviors of young teens and many other studies have supported this finding as well.

Ellis, Schlomer, Tilley, and Butler (2012) studied 101 sister pairs and found that girls who reported low quality relationships with their fathers were more likely to engage in risky sexual behaviors at a young age. The researchers concluded that a quality father-child relationship was a protective factor against risky sexual activity in young women. In a similar study, Freeman and Almond (2010) found that young men and women who have poor relationships with their fathers and do not perceive their fathers to be primary attachment figures are more likely to engage in risky sexual activity. Many recent studies show similar findings regarding an earlier onset of sexual activity and risky sexual behaviors positively correlated with an inability to bond with fathers and poor father-child relationships (Jordahl & Lohman, 2009; Coley, Votruba-Drzal, & Schindler, 2009; Burn, 2008). Thus, risky sexual behaviors, earlier onset of sexual activity, and teen pregnancy are all common consequences associated with a poor father-child relationship.

Another risky behavior associated with a poor father-child relationship is suicidality. Though there are many factors that impact suicidality, research has shown that the father-child

relationship is a statistically significant predictor of adolescent suicidality. In a study of 172 adolescents in acute psychiatric care, researchers found that children with a history of suicide attempts were more likely to report low paternal care than children with only suicidal ideation (Saffer, Glenn, & David Klonsky, 2014). Results indicate that a positive father-child relationship may have been the difference between suicide attempts and suicidal ideation. De Luca, Wyman, and Warren (2012) studied over 1,500 Latina high school students and found that lower levels of perceived father support was predictive of suicidal ideation and behavior. In a similar study of over 1,200 first year college students, Aria et al. (2009) found that father-child conflict as an independent risk factor was a statistically significant predictor of suicidal ideation within a multivariate analysis.

The consequences of a lack of father involvement and poor father-child relationships go beyond the psychosocial and behavioral maladjustment of children to impact even their physical health and development. Alio et al. (2011) studied over 1.3 million children in Florida and found that a lack of father involvement was linked to earlier births, lower birth weights, and a four-fold increase in infant mortality in the first 28 days of life. The results of their study show, not only the importance of the father child-relationship, but also how important father involvement is during pregnancy and infancy. During infancy, high-quality interactions between father and child are predictive of better overall health for the infant, emphasizing not only father involvement, but quality time and positive interactions (Carr & Springer, 2010). Wake, Nicholson, Hardy, and Smith (2007) found correlations between children's BMI category and their fathers' behaviors and styles of parenting. Fathers with disengaged or permissive parenting styles and behaviors were more likely to have children who scored in the overweight or obese BMI category. The parenting style of mothers was not correlated with their children's BMI. The findings of this

article suggest that the parenting styles of fathers are more predictive of children's physical health than the parenting styles of mothers; further emphasizing the importance of the father-child relationship.

Lastly, the consequence of a child growing up in a home devoid of parental empathy can have lasting negative effects on the child's social, emotional, and behavioral wellbeing. Fathers who lack sufficient levels of empathy for their children often struggle to understand their children's needs, thus causing fathers to feel overwhelmed and frustrated at the demands of their children (Bavolek & Keene, 2010). The needs of the children then begin to conflict with the needs of the fathers, who may tend to place their own needs before their children's. Children who grow up in empathy deficient environments often fail to develop empathy for others as they are forced to meet their own needs and learn to focus only on themselves (Bavolek & Keene, 2010; Music, 2011; National Scientific Council on the Developing Child, 2012). Thus, when fathers fail to develop empathic relationships with their children, the children may be stunted in their ability to develop empathy and the amount of stress and conflict in the parent-child relationship may increase.

Thus, as copious amounts of research support the positive impacts of a quality father-child relationship, an equally large body of research suggests that the absence of a positive father-child relationship can have long-lasting, negative effects on children's overall development and wellbeing. It is possible that this current research on fathers has contributed to the current societal shift towards strengthening father-child relationships and pushing fathers to spend more time with their families. Though fatherhood is becoming more valued in today's society, it has also become more complex and this shift in parenting roles for fathers is often associated with increased stress and difficulty.

Current Stressors for Fathers

Deater-Deckard (2004) defined parenting stress as “A set of processes that lead to aversive psychological and physiological reactions arising from attempts to adapt to the demands of parenthood” (p. 6). These processes can arise from within the parent (e.g. personal health, job, competence, depression, etc; Abidin, 2012) and from within the child (e.g. hyperactivity, demandingness, and mood; Abidin, 2012). When parenting stress arises, regardless of whether it is a process of the parent, the child, or both, it can cause further stress in the parent-child relationship. Apart from the average stressors of parenting, fathers in America face specific challenges that can add to the processes of parenting stress and negatively impact the parent-child relationship.

Work-Life Balance

Thanks to research on child development and parent-child relationships, fathers in America are more aware now than in any other time period of how important it is to have a strong relationship with their children. Fathers in previous generations may not have known the importance of the father-child relationship and society did not encourage fathers to develop close and empathic relationships with their children in the way it does now (McGill, 2014). A Pew Research survey found that 57% of respondents said that fatherhood is more difficult now than it was 20-30 years ago, but 47% of fathers believe that they are doing a better job than their own fathers (Taylor, Parker, Livingston, Wang, & Dockterman, 2011). A possible explanation for this statistic is that current fathers were raised without significant relationships with their fathers and may lack an example or template by which to develop a healthy relationship with their own children (Taylor et al., 2011). The 47% of fathers who believe that they are doing better reflects modern fathers' confidence in their ability to change the meaning of fatherhood.

Current research on fatherhood is an example of societal norms in fatherhood and how fathers' roles in the family are changing. McGill (2014) used the words "traditional" and "nontraditional" to compare fathers in his research and found that fathers with "traditional attitudes" towards parenting spent more time at work and less time with their children than fathers with "nontraditional attitudes." This wording is seen throughout research on fathers and the data supports a vast difference between modern fathers and fathers of past generations. In comparing data from studies conducted in 1965 and 2011, Parker and Wang (2013) found that the division of labor around the roles of fathers and mothers has converged drastically in recent years. Fathers in 2011 spent more than twice as much time per week doing housework (10 hours vs. 4 hours) and triple the amount of time per week with their children (7.5 hours vs. 2.5 hours) than fathers in 1965 (Parker & Wang, 2013). Across the world, modern fathers have attempted to make spending time with family more of a priority in their lives (Craig, Powell, & Smyth, 2014; Parker & Wang, 2013; U.S. Census Bureau, 2010; National Center for Fathering, 2009). However, as fathers begin to realize the importance of the father-child relationship and attempt to spend more time with their families, societal pressure to provide for the family economically remains a heavy burden that interferes with their new roles and expectations.

Fathers report feeling pressure, not only to be a primary breadwinner for the family, but also to spend ample time with their children and build relationships with them (Taylor, Parker, Livingston, Wang, & Dockterman, 2011). Even though fathers feel the need and desire to spend more time with their children, they have not lost the societal or personal pressure to provide for their family economically. In fact, statistics indicate that providing economically for a family has become even harder for modern fathers than it was for fathers of past generations (Pew Research Center, 2014). A Pew Research survey of 50 million Millennials found that, though they are

more educated than past generations, they also have higher levels of student loans and a job market coming out of the Great Recession of 2007-2009. 52% of millennials said that they do not have enough money right now and 14% said that they would never have enough money (Pew Research Center, 2014). Thus, modern fathers feel the need to work more in order to pay off loans and provide for their families in a difficult economic environment, even though they place a higher priority on their roles as fathers.

As a result of this role overload and societal and personal expectations, many fathers feel an increased level of parenting stress. Fathers who have difficulty coping with this stress tend to spend more time at work, whereas fathers who have found a way to balance their work and family roles report higher levels of positive attitudes, increased work performance, higher quality of life, satisfaction in their jobs, and greater community commitment (Evans, Carney, & Wilkinson, 2013). Fathers who have achieved a sense of work-life balance also report better father-child relationships, while fathers with high levels of work stress and work-family conflict report poor father-child relationships and low-quality interactions with their children (Lau, 2010; Goodman, Crouter, Lanza, & Cox, 2008). Work-family balance and its positive impacts are difficult for fathers to achieve in the modern workplace. Nearly one in five fathers has reported missing four or more significant events in their children's lives due to a conflict with work and 50% of working fathers find it difficult to balance work and childcare responsibilities (Parker and Wang, 2013). This data seems to indicate that modern fathers are struggling to balance the pressure of providing for their families with their desire to spend time and build relationship with them.

Divorce, Separation, and Visitation

Possibly one of the most difficult obstacles for fathers in America to overcome is the system of custody and visitation of children when parents divorce or never marry. Statistics show that 50% of marriages end in divorce, 41% of children in America are born to never-married parents (Martin, et al., 2013), and 66% of parents who are unmarried at the time of their child's birth remain unmarried and separated (Waller & Dwyer, 2014). In 2014, 23.6% of all children in the United States (17.4 million) lived in father absent homes, whereas only 3.9% (2.8 million) lived in single father homes (U.S. Census Bureau, 2015). Though there are many factors involved in these statistics, the data implies that mothers are more likely to receive custody of children than fathers, whether divorced or never married. Similarly, visitation laws appear to be unbalanced and not conducive to the development of strong, positive relationships. One common form of parental visitation with children includes one night during the week and every other weekend. One out of three non-custodial fathers only get to visit their children 1-3 times per week, and some of these visits tend to be at night after a full day of work for the father and school for the children (Stykes, 2012). Also, non-resident fathers tend to work full time in order to support themselves and provide child support while custodial mothers are more likely to work part-time relying on the child-support payments of fathers and allowing for more time with their children (Grall, 2013). A recent study of 3,197 fathers found that resident fathers had consistently higher levels of involvement than separated/divorced and nonresident fathers (Goldberg, 2015). Thus, non-resident fathers attempting to build relationships with their children may struggle more than resident fathers, not only due to the limited amount of time they are allowed to spend with their children, but also due to the pressure of making enough money to support themselves and their children independently.

Given the importance of the father-child relationship for healthy child development (Johnson, 2013; Michiels, Grietens, Onghena, & Kuppens, 2010), along with the recent statistics that show the struggles of fathers in America today (Taylor, Parker, Livingston, Wang, & Dockterman, 2011), it is important to provide services to fathers that can assist them in developing healthy relationships with their children. Research shows that parental stress and parental empathy have significant impacts on the quality of the parent-child relationship (Music, 2011; LeSure-Lester, 2000). Thus, child-parent relationship therapy, an evidence-based parenting program that has been shown to be effective in reducing parental stress (Ceballos & Bratton, 2010) and increasing parental empathy (Opiola & Bratton, 2017) presents itself as a viable intervention for fathers.

Child-Parent Relationship Therapy (CPRT)

Child-parent relationship therapy (CPRT) (Landreth & Bratton, 2020) is an evidence-based, manualized mental health intervention for children and their parents. CPRT is rooted in the theoretical constructs of child-centered play therapy (CCPT) and holds that the relationship between the parent and child is the agent of change and the foundation for children's overall wellbeing. CPRT utilizes a small group format that meets once a week for two hours for ten weeks. During the group meeting, parents are supported in their struggles by group facilitators, connect with other parents, and learn some of the basic child-centered ways of being and interacting with their children. By learning the CCPT skills and attitudes and incorporating them into their interactions with their children, parents become a therapeutic agent for their children. CPRT is a unique and developmentally appropriate intervention that can increase parental empathy and help parents to build a strong, supportive relationship with their children.

History and Development

CPRT is a ten-week model of filial therapy, which is also grounded in CCPT and was originally developed by Bernard Guerney in the early 1960's (L. Guerney & Ryan, 2013). Guerney developed a training model that would allow parents to become therapeutic agents for their children by teaching them some of the same skills and attitudes that he used with children in child-centered play therapy (B. Guerney, 1964). Lousie Guerney, Bernard's wife, joined her husband in developing filial therapy in the 1960's and has been researching and refining it ever since (L. Guerney & Ryan, 2013).

Child-centered play therapy (CCPT) is a developmentally appropriate adaptation of Carl Roger's theory of counseling developed by Virginia Axline in 1947. Similar to Roger's theory on adult counseling, Axline believed that children have an innate ability to strive towards fulfilling their positive potential when they are in a nurturing and supportive relationship (Axline, 1947). The belief in CCPT is that play is children's language and toys are their words (Landreth, 2012). Thus, play therapists provide an environment for children in which they are free to play and express themselves in various ways. In CCPT, a child and a therapist enter a room filled with a plethora of toys and materials with which the child is free to play. The therapist builds a relationship with the child based on empathy, unconditional positive regard, and congruence (Landreth, 2012). The therapist trusts that providing this type of relationship will activate the child's innate striving for positive growth (Ray, 2011; Landreth, 2012).

The Guerneys were both practicing child-centered play therapists who adhered to these guidelines, but recognized the potential for a more family-based approach to working with children. The overarching idea behind their development of filial therapy was that, if children develop best in empathic and unconditional relationships, like ones fostered in CCPT, and if the

relationship between parent and child is the most important relationship that children will have in their developing years, then therapists should teach parents the skills and attitudes of CCPT. The Guerneys believed that by taking on a therapeutic role, parents could learn how to relate and respond to their children in healthier ways. B. Guerney (1964) stated that “every bit of success the parent achieves in filling the prescribed role should have an effect many times more powerful than that of a therapist doing the same thing” (p. 307).

When the Guerneys first developed filial therapy (B. Guerney, 1964), there was very little format or structure to the approach. Groups of parents met for an unspecified length of time and the group might meet weekly for over a year depending on the needs and availability of the parents (B. Guerney, 1964). Over time, however, the Guerneys discovered that keeping parents involved in group therapy for an extended length of time could be quite difficult. They continued to develop and refine the group to include specific goals that could be met in as few as 20 sessions (L. Guerney & Ryan, 2013). Other practitioners soon discovered this model and began to adapt it to include filial therapy for single families and individuals instead of the group format (VanFleet, 2013).

Garry Landreth discovered the Guerney’s model of filial therapy in the 1970’s and began working to further modify and structure it. In his book, *The Art of the Relationship*, Landreth outlined a 10-session group filial therapy training format (Landreth, 1991, 2002). Landreth believed that if he could reduce the time and financial commitment of parents to filial therapy, he could significantly increase parent participation and treatment success. Landreth and Bratton (2006) formalized the 10-session training model and called it child parent relationship therapy (CPRT), which is also the title of the book in which they published it. Bratton, Landreth, Kellam, and Blackard (2006) manualized the CPRT protocol not only to provide researchers and

clinicians a tool for ensuring treatment integrity, but also to give parents a brief, tangible explanation of CPRT without having to read the book. Landreth and Bratton (2020) maintain that, though the structure and model of CPRT is different from the original Guerney's model, the theoretical foundations and underlying philosophies are the same.

Theoretical Assumptions

CPRT is founded on the same theoretical principles as CCPT and person-centered therapy along with certain aspects of child development and attachment. In person-centered theory, Rogers (1951) believed that all people have within themselves an innate drive towards positive growth and optimal functioning. CCPT simply takes this person-centered belief and applies it to children. In a similar way, CPRT focuses not on a child's problematic behaviors, but on the person of the child and on strengthening that innate drive to achieve a positive potential. Another important component to person-centered theory is the belief that, given the proper environment, people have within themselves the ability to solve their own problems (Landreth, 2012). In CCPT the child is free to play out feelings as they emerge and either "learns to control them, or abandon them" (Axline, 1947, p. 16). Similarly, in CPRT, parents are required to have these child-led play sessions in which the child is free to explore and express themselves.

From a developmental standpoint, children do not typically verbalize their feelings and needs, rather, children use play as a way to experience and explore their world and to express themselves. The parent-child play sessions in CPRT provide children with opportunities to explore and express themselves and provide their parents opportunities to enter into the world of their children and attune to them (Landreth & Bratton, 2020). The play sessions are led by the children which not only allows them to be in control of their world, but also allows them to communicate and work through their problems in their own ways (Landreth & Bratton, 2020).

Experiencing this sense of self-control and mastery and expressing what they feel they need to express would not be possible if children were being directed by parents. These play sessions also serve to create relational experiences between the parent and child and allow parents and children to simply enjoy being with each other and spending time together (Bratton, Opiola, Dafoe, 2015). However, this child-led play is only one piece of the environment that is necessary to encourage a optimal child's growth. The most meaningful and growth-producing factor for the child is the therapeutic relationship.

A fundamental component to person centered, CCPT, and CPRT is the belief that when children experience a relationship characterized by genuineness, empathy, and unconditional positive regard, the self-actualizing tendency is activated and they can move towards their positive potential (Axline, 1969; Landreth, 2012; Landreth & Bratton, 2006). In person centered and CCPT, this therapeutic relationship is developed with the therapist. In CPRT, facilitators teach parents how to develop this relationship with their children (Landreth & Bratton, 2020). CPRT facilitators also develop this therapeutic relationship with parents in their group, both to increase movement towards a positive potential for the parents and to model for the parents what a therapeutic relationship looks and feels like. In CPRT, the therapeutic relationship that is built between a parent and child during their special play times is “the vehicle for the process of change” (Landreth & Bratton, 2006, p. 11).

According to Axline (1969), the role of the therapist in CCPT, in order to develop a therapeutic relationship, is to: (a) develop a warm, friendly relationship with the child; (b) accept the child unconditionally, without wishing the child were different in some way; (c) establish a feeling of permissiveness in the relationship so that the child feels free to express self; (d) attune to and reflect the child's feelings to create within the child a feeling of being understood; (e)

respect the child's innate ability to solve his or her own problems; (f) avoid directing the child's actions or conversation; rather, allow the child to lead the way; (g) recognize the gradual nature of the child's process and thus be patient with the process; and (h) establish only those limits that are necessary to anchor the child's play therapy experience to the real world (pp. 73-74). These principles are taught to parents through CPRT (Landreth & Bratton, 2020).

Overview of Structure, Format, and Content

CPRT uses a small group format of 5-8 parents that typically runs for 2 hours once a week for ten weeks. CPRT groups are a combination of support, education, and supervision for parents, making it different from other parent training programs that tend to be more focused on education (Landreth and Bratton, 2020). In addition to group meetings, parents are required to record and bring to the group weekly 30-minute child-led play sessions with their child of focus to receive supervision from the facilitator and feedback from other parents in the group (Landreth & Bratton, 2020). The child-led play sessions and the subsequent supervision are arguably the most important components of CPRT.

Like many support groups, the initial objective in CPRT is to create an environment of safety and support to enable parents to share their own parenting struggles and connect with other parents in the group (Landreth & Bratton, 2020). When parents realize that they are not the only ones struggling in their parenting roles, they are more willing to learn and accept feedback. According to Landreth and Bratton (2020) it is important for CPRT facilitators to teach parents basic information about child development along with the skills and attitudes of CCPT. Some of the skills taught to parents include: reflective listening, following the child's lead, limit setting, choice giving, and various ways of responding to children (Landreth & Bratton, 2020). The attitudes that parents are taught are called the "be with" attitudes (Bratton, et al., 2006, p.7)

including: I am here, I hear you, I understand, and I care. When parents are able to combine the “be with” attitudes with the CCPT skills in the child-led play sessions, they are building the therapeutic relationship, which is the true agent of change for both the child and the parent (Landreth & Bratton, 2020). The supervision and feedback components allow the parents to further develop their skills and recognize their areas of growth to further the therapeutic relationship with their children.

Before parents begin the child-led play sessions, they learn about the skills, see them in action, and practice them through role plays with other parents in the group throughout the first 3 sessions (Bratton, et al., 2006). When parents bring back their sessions for feedback, facilitators encourage all parents in the group to focus on what the parents are doing correctly (Ceballos & Bratton, 2010). CPRT is a strength-based approach, not only for children, but for parents as well. CPRT facilitators will point out what parents are doing well and encourage them to continue developing those skills. As parents further hone their skills and become more comfortable with receiving feedback, facilitators will teach more sophisticated skills, such as choice giving and encouragement, and give more direct feedback (Bratton et al., 2006). Throughout the process, parents are growing closer to each other and experiencing a therapeutic relationship (unconditional positive regard, empathy, and congruence) between themselves and other members of the group. Experiencing the therapeutic relationship not only allows parents to reach for their potential as parents, but also models for them how to develop a therapeutic relationship with their children to help them reach their potential as well.

Empirical Support

The first CPRT outcome study was published in 1995 with methodological rigor and the evidence-base growing over the last 24 years. To date, researchers have conducted 40 studies

using a control group design with over 1100 participants to examine the effects of CPRT on various populations (e.g. Bratton & Landreth, 1995; Carnes-Holt & Bratton, 2014; Ceballos & Bratton, 2010; Chau & Landreth, 1997; Cornett & Bratton, 2014; Costas & Landreth, 1999; Glover & Landreth, 2000; Jang, 2000; Kim, 2009; Landreth & Lobaugh, 1998; Opiola & Bratton, 2017). Of these 40 studies, 17 employed experimental designs (e.g. Bratton & Landreth, 1995; Carnes-Holt & Bratton, 2014; Ceballos & Bratton, 2010; Chau & Landreth, 1997; Cornett & Bratton, 2014; Costas & Landreth, 1999; Glover & Landreth, 2000; Landreth & Lobaugh, 1998; Opiola & Bratton, 2017) and 16 studies used quasiexperimental designs (e.g. Jang, 2000; Kim, 2009). The vast majority of research conducted on CPRT yielded statistically significant results with medium to large treatment effects for both parents and children (Bratton et al., 2015). Some of the outcomes targeted included: increasing parental empathy, decreasing stress in the parent-child relationship, and reducing children's behavior problems (Lin & Bratton, 2015). Some of the populations studied include: adopted/fostered children, sexually abused children, children with incarcerated fathers/mothers, at-risk children of teenage parents, and more. Over eight ethnic groups were represented in the studies along with families of various socioeconomic and cultural identities.

Of the 40 published outcome studies, only one examined the effectiveness of CPRT with fathers. Landreth and Lobaugh (1997) assigned 32 incarcerated fathers to the CPRT treatment group or the waitlist control group with children ages 3-7. Fathers completed their play times with their child-of-focus during weekly visitation times, but were not allowed to record their sessions due to prison rules. Thus, supervision and feedback on father skills were based upon father report during the CPRT group meeting. As supervision is one of the most important components of the CPRT process, this was a significant limitation to the study. Nevertheless,

researchers reported statistically significant improvements in child behavior problems ($p = .004$), child self-esteem ($p < .001$), parental stress ($p = .004$), and parental acceptance ($p < .001$) in the CPRT group compared to waitlist control. This study builds upon past research by incorporating the general population of fathers along with a randomized control design. This is also the first CPRT study to offer groups in both English and Spanish allowing for a more representative sample of the population and generalization of results.

Researchers have also found CPRT to be an effective treatment for parents of ethnically diverse backgrounds including: Korean, Chinese, Israeli, Latino(a), and Native American (Kim, 2009; Chau & Landreth, 1997; Kidron & Landreth, 2010; Ceballos & Bratton, 2010; Glover & Landreth, 2000). As a large percentage of the population in the area of the proposed study identifies as Latino(a), I aimed to include this population in the study. Ceballos and Bratton (2010) conducted a randomized control trial to determine the effectiveness of CPRT for Latino(a) immigrants on child behaviors problems and parent-child relationship stress. All groups were conducted in Spanish and all assessments were completed in Spanish. Researchers found that parents who participated in the CPRT groups reported a statistically significant decrease in child behavior problems ($p < .001$) and parent-child relationship stress ($p < .001$) compared to the waitlist control group. Thus, previous research with similar methodologies supports the inclusion of Spanish speaking fathers in the proposed study.

In summary, the evidence base for CPRT with various issues and populations is strong and well documented. According to SAMHSA's NREPP (2017), CPRT has been rated as effective for family cohesion and disruptive behavior disorders and symptoms as well as promising for internalizing problems in children. Although researchers have not yet conducted studies on the effects of CPRT with the general population of fathers, current findings on the

effects of CPRT with a variety of populations suggest that this treatment intervention may be effective for this population.

APPENDIX B
EXTENDED METHODOLOGY

Purpose of the Study

The purpose of the study was to examine the effects of child-parent relationship therapy (CPRT) on fathers, their children, and the father-child relationship. Particularly, the study was designed to determine whether or not participating in CPRT can decrease father stress and child behavior problems and increase parental empathy.

Definition of Terms

For the purpose of this study, I operationally defined the following terms.

- *Child behavior problems.* Child behavior problems refers to the internalizing and externalizing behaviors of children that are problematic or not conducive to healthy development. Internalizing problems consist of emotional reactions, anxiety, depression, sleep problems, and somatic complaints. Externalizing problems include attention problems, hyperactivity, aggression, defiance, and affective problems. For the purpose of this study, I operationally defined child behavior problems as the overall score on the Total Problems scale on the Child Behavioral Checklist ages 1 ½-5 and 6-18 (CBCL; Achenbach & Rescorla, 2000, 2001).
- *Child-of-focus.* During the CPRT treatment, fathers will choose one child between the ages of 3 and 10 with whom they will have special play times and practice their new parenting skills. This child is referred to as the “child-of-focus.” All play sessions will be conducted with this child and all assessments will be filled out in regards to this child.
- *Father.* A male parental figure who is present and participating in a child’s life and is not related to the child in some way other than as a parent (e.g. grandparent, uncle, cousin, etc.). Fathers can be married, single, divorced, never married, step-fathers, or adoptive fathers and can have sole, partial, or no custody of their child, as long as they maintain regular contact.

- *Parental empathy.* Empathy has many definitions, but in order to maintain consistency within the study, I will define parental empathy in conjunction with the assessment that I use to measure parental empathy. Bavolek and Keene (2010) the developers of the Adult-Adolescent Parenting Inventory, define parental empathy as a parent's ability to understand and value children's needs, allow children to display normal developmental behaviors, nurture children and encourage positive growth, communicate with children, and recognize children's feelings.

- *Parental stress.* Parental stress is defined as the amount of stress a parent experiences in relation to the parent-child relationship, parental characteristics, and child characteristics. For the purpose of this study, I operationally defined stress in the parent-child relationship as the Total Stress score of the three domains on the Parent Stress Index, 4th edition short form (PSI-4, Abidin, 2012).

Research Questions

This study contained three research questions:

1. What is the effect of CPRT on parental perception of child behavior problems compared to a waitlist control group?
2. What is the effect of CPRT on parental stress compared to a waitlist control group?
3. What is the effect of CPRT on the parental empathy compared to a waitlist control group?

Participants

Fathers were required to meet the following criteria in order to be eligible for the study:

- Be above the age of 18
- Have at least one child between the age of 3 and 10
- Identify as the primary male parental figure

- Be present and participating in the child's life for at least one year and
- Is not related to the child in some way other than as a parent

Fathers were also ineligible to participate in the study if they were currently participating in another parenting program or if their child-of focus for the study was currently in counseling.

Though I did not use a score related criteria on the dependent variables for inclusion, I did require that fathers list specific concerns that they had for their child of focus. If a father did not have concerns, they were considered ineligible for the study. Fathers were recruited from a large metropolitan area in the southwest United States through flyers and announcements made in local schools, churches, and community counseling clinics. Participants included both English and Spanish speaking fathers as there is a high Latino population in the DFW metroplex and the CPRT protocol has been translated into Spanish.

I conducted a G* Power a priori power analysis to determined that a minimum sample size of 34 participants was necessary to find a statistical difference between two groups over two times of measurement (pre and post-test). I based G* Power calculation on an alpha level of .05, moderate treatment effect size ($f = .25$), and minimum power at .80 (Cohen, 1988). To allow for attrition, I aimed to recruit 60 fathers for the study. After advertising for the study through local churches, counseling clinics, and schools, fathers who were interested in participation called me for more information. Over 60 fathers initially expressed interested in participating. However, due to their work schedules, time constraints, and difficulty in reaching participants via phone, only 44 fathers agreed to participate and scheduled intakes. Of the 44 fathers who agreed to participate, only 30 fathers completed both pre and post-testing. Most of the fathers who dropped from the study either did not complete pre-testing, or lost contact immediately after pre-testing and before the start of the intervention. The primary attrition rate occurred in the Spanish

speaking population with 8 fathers (50%) of the Spanish speaking participants (4 Experimental and 4 Control) failing to complete post-testing. The final analysis included 14 fathers in the experimental group (4 Spanish and 10 English) and 16 fathers in the control group (4 Spanish and 12 English).

Table B.1

Demographic Information for Fathers in the Experimental Group (n=14) and Control Group (n = 16)

Demographic Variables		Experimental Group	Control Group
Age	20-29		1
	30-39	7	7
	40-49	6	8
	50-59	1	
Mean Age		41.21	37.81
Ethnicity	Asian	1	1
	Caucasian	4	8
	Hispanic/Latino	9	7
	Other		
Marital Status	Never Married/Single	2	2
	Currently Married	11	11
	Divorced/Separated		3
	Widowed		
	Other	1	
Employment Status	Full-time	11	14
	Part-time	1	
	Work/School	1	
	unemployed		
	Stay at home dad	1	2

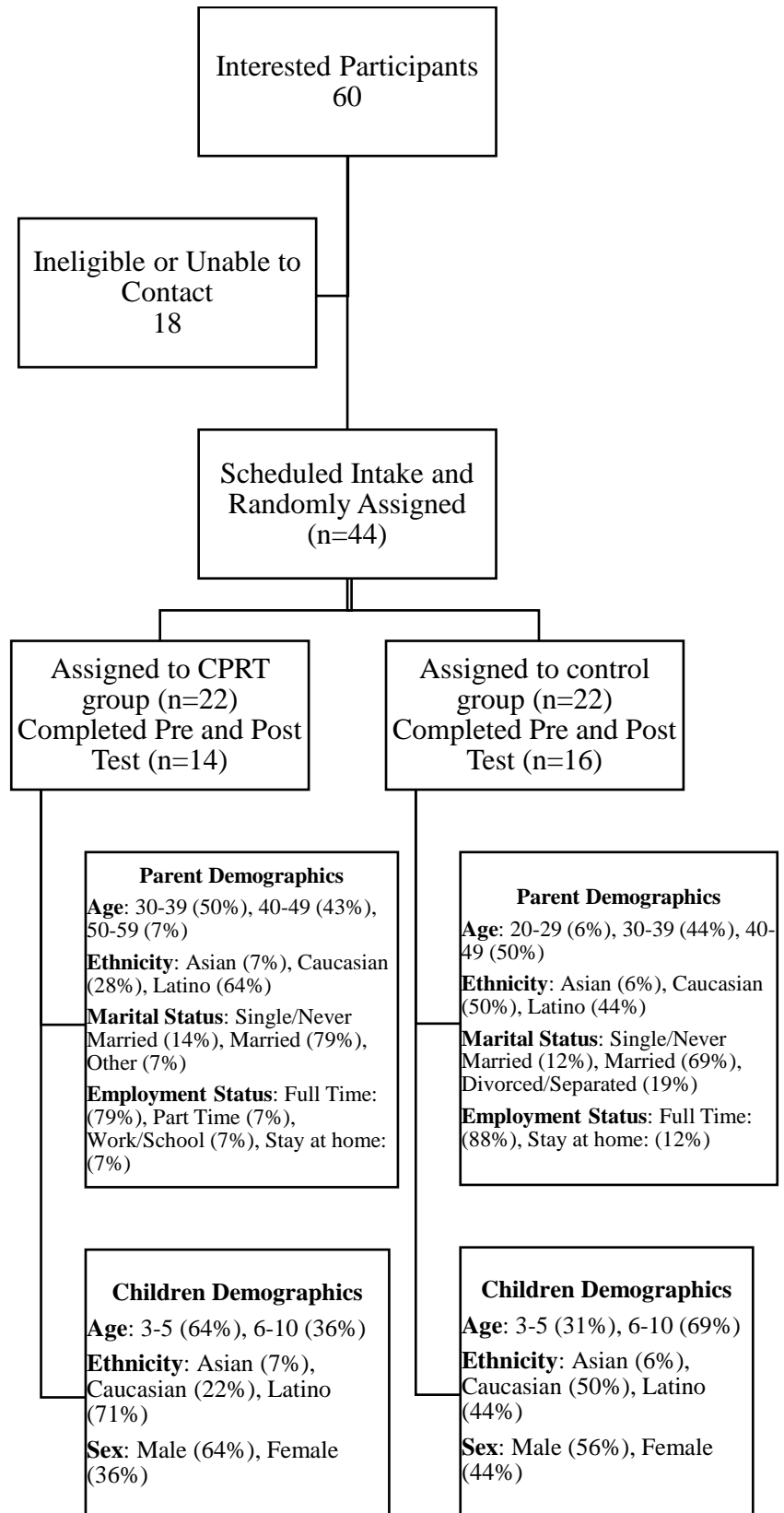


Figure B.1. Participants flow chart.

Distributions of age, ethnicity, marital status, and employment status of fathers across both groups are displayed in Table B.1. Distributions of age, sex, and ethnicity of children across both groups are displayed in Table B.2. Figure B.1. depicts the participant recruitment process, group assignment, and percentages of demographic variables for parents and children across both groups.

Table B.2

Demographic Information for Children in the Experimental Group (n=14) and Control Group (n = 16)

Demographic Variables		Experimental Group	Control Group
Age	3-5	9	5
	6-10	5	11
	Mean Age	5.29	6.44
Ethnicity	Asian	1	1
	Caucasian	3	8
	Hispanic/Latino	10	7
Sex	Male	9	9
	Female	5	7

Instrumentation

Child Behavior Checklist - Parent Version (CBCL)

The CBCL is one of the most frequently used assessment tools for children (Njoroge & Bernhart, 2011) and is often used in play therapy research (Lin & Bratton, 2015). It is a paper-based questionnaire completed by parents or caregivers and is comprised of 99-113 Likert-scaled items that measure parents' perceptions of their child's behavioral, emotional, and social functioning (Achenbach & Rescorla, 2000; Achenbach and Rescorla, 2001). Parents rate descriptive sentences on a scale of *not true*, *somewhat true*, or *very/often true*. The CBCL also

includes several open-ended questions to allow parents to express their opinions or feelings towards their children's behaviors, but these questions are only coded in the software as answered or not answered. Two versions of the CBCL exist, CBCL for preschool children 1½ - 5 and CBCL for children 6 - 18 years of age. Both versions were used for this study. The assessment takes approximately 15 minutes to complete.

The CBCL consists of three domains; Internalizing Problems, Externalizing Problems, and Total Problems (Achenbach & Rescorla, 2000; Achenbach and Rescorla, 2001). However, only the Total Problems domain will be interpreted as a dependent variable in the study as this domain is a combination of the Internalizing and Externalizing domains. All domains yield a *T* score that falls within normative, borderline, or clinical ranges and both version of the CBCL use comparable ranges. Anything above a 65 scores in the borderline or clinical range and anything below a 65 scores in the normal range.

The normative sample for the CBCL included 738 preschool children and 1,753 school-aged children from diverse populations (Achenbach & Rescorla, 2000; Achenbach and Rescorla, 2001). The preschool children were selected from preschools, pre-kindergartens, and childcare programs in the United States, Jamaica, Australia, and Canada. The sample consisted of 58% White, 17% African American, 9% Latino, and 15% mixed decent or other. The school-age sample selected from the United States and the District of Columbia and consisted of 60% White, 20% African American, 9% Latino, and 12% mixed decent or other (Achenbach and Rescorla, 2001).

The CBCL has acceptable psychometrics with strong test-retest reliability and criterion-related validity (Achenbach & Rescorla, 2000; Achenbach and Rescorla, 2001; Njoroge & Bernhart, 2011). Test-retest reliability was established through a longitudinal study where

researchers measured the consistency of scores on assessments administered anywhere from a few days apart to a few months apart (Achenbach & Rescorla, 2000; Achenbach and Rescorla, 2001). The mean score on both versions of the CBCL across all tests was $r = .90$. The authors also reported consistently revising and researching the assessment in order to maximize criterion-related validity.

Due to the age range of participant's children, both the CBCL 1½ - 5 and the CBCL 6-18 were used in this study. Achenbach and Rescorla (2001) maintained the continuity and consistency across both forms of the CBCL encouraging researchers to study children at different levels of development and multiple studies have been conducted that used both versions of the assessment (Akoury Dirani, Sinno, Wheeler, Tamim, & Charafeddine, 2018; Plotkin, 2014; Tan, 2011). Also, in order to include both English and Spanish speaking participants in the study, I used both the English and Spanish versions of the CBCL, which have been shown to be consistent across multiple studies.

Gross, Fogg, and Young (2006) examined the equivalence of the CBCL 1½ - 5 race/ethnicity and English versus Spanish versions. Researchers recruited 682 parents of children between the ages of 2 and 4. Hispanics represented 46.8% of the population with 319 Hispanic parents completing the CBCL. Of the 319 Hispanic parents, 102 parents filled out the Spanish version of the CBCL and 217 filled out the English version. Researchers found that there were no significant scale score differences between Hispanic parents who filled out the Spanish version and Hispanic parents who filled out the English version of the CBCL. Results of the study indicated that the CBCL 1½ - 5 is equivalent across ethnicities.

Viola, Garrido, and Rescorla (2011) tested the multicultural robustness of the Spanish version of the CBCL 6-18 in a national epidemiological sample in Uruguay. Authors referred to

multicultural robustness as a means of conveying an instrument's reliability and validity through international research. Participants included 1,374 children across Uruguay between the ages of 6 and 11. Results indicated substantial consistency between the two versions with a r of .82 between mean item ratings. Researchers concluded that the mean item rating, confirmatory factor analysis, and internal consistency were all comparable to previous research on the CBCL 6-18.

Parenting Stress Index, 4th edition Short Form (PSI-4-SF)

The PSI-4 measures parents' perceptions of their stress related to the parent-child relationship, as well as attributes of the parent and child that contribute to stress for the parent. The assessment has a Parent Domain, a Child Domain, Life Stress scale, and a Total Stress Score (Abidin, 2012). It is paper-based, self-administered assessment that takes approximately 15 minutes to complete and consists of 109 Likert-scaled items on a scale of *strongly agree*, *agree*, *not sure*, *disagree*, and *strongly disagree*.

The child domain assesses attributes of the child that contribute to stress in the parent-child relationship and has six subscales including: distractibility/hyperactivity, adaptability, reinforces parent, demandingness, mood, and acceptability. Similarly, the parent domain assesses attributes of the parent that contribute to overall stress and consists of seven subscales including: competence, isolation, attachment, health, role restrictions, depression, and spouse/parenting partner relationship. The life stress scale assesses situational or demographic stressors that may be affecting the parent outside of the parent-child relationship. In all domains, higher scores indicate a greater amount of stress added to the total stress score. The total stress score assesses parent's overall life stress and the impact of that stress on child behaviors and relationality. Thus, high total stress scores indicate not only that the parent is suffering from high levels of stress, but

also that the child is being negatively affected by the parent's stress and parenting behaviors (Abidin, 2012).

Abidin (2012) normed the PSI-4 on a stratified sample of 534 mothers and 522 fathers who were originally selected to represent the 2007 United States population in terms of education, ethnicity, child gender, and child age. Abidin reported that the PSI-4 has been translated in 40 different languages and maintains its validity across cultures. The test-retest reliability coefficients for the PSI-4 are $r = .55-.82$ for the Child domain, $r = .96$ for the Parent domain, and $r = .65-.96$ for the Total Stress domain (Abidin, 2012). The PSI-4 also has strong internal consistency with coefficient alpha scores ranging from $.75 - .98$ for the Parent and Child domains and a Total Stress score coefficient alpha of $.96$ (Abidin, 2012).

The Spanish version of the PSI was evaluated by Solis and Abidin (1991) in a study of 223 Hispanic mothers. Researchers reported that Alpha coefficients for test-retest reliability were compared to the original study on the psychometric properties of the PSI. Alpha coefficients for the Spanish version of the test ranged from $.58 - .92$ for the parent domain, $.58 - .88$ for the child domain, and $.94$ for the total stress score (Solis and Abidin, 1991). Researchers concluded that the Spanish version of the PSI shares similar reliability and validity compared to the original English version.

Today, the only version of the PSI-4 that is available in both English and Spanish is the PSI-4-SF, or short form. This is an abbreviated version of the original PSI-4 with only 36 questions, which are also found on the long form. The three domains were renamed to Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC), which combine to form the Total Stress score. Multiple studies have shown similar reliability and consistency for the English PSI-4-SF compared to the original English PSI-4 (Harding, Murray,

Shakespeare-Finch, & Frey, 2018; Leung, Tsang, & Dean, 2010; Mersky, Topitzes, Janczewski, & McNeil, 2015). Pérez-Padilla, Menéndez, and Lozano (2015) conducted a study of 109 mothers in Spain to measure the reliability and consistency of the Spanish version of the PSI-4-SF. Results indicated a strong reliability and consistency for the Total Stress score, similar to the English version of the PSI-4-SF.

Adult-Adolescent Parenting Inventory, 2nd edition (AAPI-2.1)

The AAPI-2.1 was designed to assess parenting and child rearing attitudes of adolescents and adults and is useful in determining strengths and weaknesses in child-rearing (Bavolek & Keene, 2010). The AAPI-2.1 has two forms: Form A and Form B, which consist of 40 questions each and are traditionally offered as pre-test and post-test respectively. However, both forms can be administered at the same time to provide a slight increase to the overall reliability of the assessment (Bavolek & Keene, 2010). Both forms are paper-based, self-administered assessments that can be completed in approximately 10-15 minutes and consist of Likert-scaled items on a scale of *strongly agree*, *agree*, *disagree*, *strongly disagree*, and *uncertain*.

The AAPI-2.1 consists of 5 subscales called “constructs” including: Construct A - Expectations of Children, Construct B - Parental Empathy towards Children’s Needs, Construct C - Use of Corporal Punishment, Construct D - Parent-Child Family Roles, and Construct E - Children’s Power and Independence. The AAPI-2.1 was developed from the known parenting and child rearing practices of abusive and neglecting parents. Data generated from the administration of the AAPI indicate degrees of agreement and disagreement with maladaptive parenting behaviors. Responses to the AAPI-2.1 for each of the constructs are categorized as Low Risk, Moderate Risk or High Risk for child maltreatment. Unlike the aforementioned PSI-4

and CBCL, the AAPI-2.1 does not have a combined total score. For the purpose of this study, only the Empathy subscale scores will be analyzed.

That AAPI-2.1 has a total of six norm tables that are used to convert respondents raw scores to standard scores: Continental U.S. (1990 Census), Adult Female Parent, Adult Male Parent, Adolescent Female Non-Parent, Adolescent Male Non-Parent, and Adolescent Female Parent. A total of 52 agencies from 23 different states contributed data from over 1,400 ethnically diverse cases to norm and validate the 80-item AAPI-2.1 (Bavolek & Keene, 2010). For the combined forms, internal reliability was calculated using Chronbach's Alpha and resulted in strong reliability coefficients for each subscale ranging from .86 to .96 (Bavolek & Keene, 2010). Researchers conducted a factor analysis of the five constructs to determine construct related validity and reported strong evidence of the generalizability and validity of all five constructs (Bavolek & Keene, 2010). On their website, assessingparenting.com, the authors reported that the AAPI-2.1 has been developed and normed for both English and Spanish speaking families with appropriate scoring profiles and response interpretations. I attempted to contact both the publisher and the author, but my attempts were unsuccessful. A previous dissertation study used both the Spanish and English version of the AAPI-2.1 to examine the effects of postpartum adjustment on childrearing attitudes and found statistically significant results (Chiverton, 2008). Despite the lack of norm tables for the Spanish version of the assessment, I chose to continue with the assessment based on its similar use in a previous study as well as the definition of empathy that it gives. The authors define and measure empathy based on a parent's ability to: understand and value children's needs, allow children display developmentally appropriate behaviors, encourage children's positive growth, communicate with children, and recognize the feelings of children. These qualities of parental empathy fit well

within the framework of the CPRT program, but this assessment has never been used in CPRT research to date.

Procedures

I began the research process by partnering with local churches, schools, and community counseling clinics for advertising and the possible use of facilities to conduct CPRT groups. I made face-to-face announcements and/or provided flyers for the organizations to post and hand out to parents. Interested parents called the student investigator, who arranged for participants to have a preliminary phone interview with fathers to determine their eligibility and availability for the study. Spanish speaking research assistants were able to attend the phone calls that come from Spanish speaking fathers. I called each English-speaking father who had conducted the preliminary phone interview to schedule an in-person intake (In cases of Spanish-speaking fathers, I asked one of my bilingual co-facilitators to call them). During the intake, I or one of my co-facilitators, provided participants with all necessary information on the research study, including information about CPRT and random assignment. All fathers who agreed to participate in the study filled out the informed consent, family background form, CBCL, PSI-4-SF, and AAPI-2.1. These forms were given to participants in either English or Spanish, depending on participants' preferred language.

It took multiple rounds of recruitment and randomization over the course of 7 months in order to reach 44 total participants. Thus, in order to maintain experimental rigor while also accounting for location, and language, I used a block randomization technique to randomize by location and language. To ensure equal numbers of participants in the treatment and control groups, and to achieve a minimum of 4 and maximum of 8 parents in each CPRT group, I required a minimum of 8 consenting participants in one location who all spoke the same

language before I randomized. No couples or partners participated in the study. Thus, it was not necessary to randomize pairs of fathers.

Once I received at least 8 participants from one site who speak the same language, I randomly assigned them to either the treatment or control group and I began the intervention phase. I continued to recruit participants, randomize, and provide treatment in other blocks until concluding with the final number of participants in the study. Participants in the treatment group received CPRT in either Spanish or English. After completing the CPRT intervention within each block, I conducted post-assessments with all participants in both the treatment and control groups and began the CPRT intervention for the control group.

Experimental Group (CPRT)

Participants assigned to the CPRT treatment group were placed into groups of 4-8 parents. These groups met once a week for 2 hours for ten weeks as stated in the CPRT treatment protocol (Bratton et al., 2006). Days, times, and locations were decided according to the needs and availability of the participants, the clinics, and the therapist. I led one of the Spanish speaking groups with a level 1 CPRT certified parent educator as my coleader and translator. The other Spanish group was led by a doctoral level counselor who is a level three certified CPRT therapist. Both group leaders have had at least three graduate level classes in play therapy and one graduate level class in Filial/CPRT. The facilitators followed the CPRT protocol (Bratton et al. 2006) throughout the study. All group sessions were recorded and a faculty supervisor with advanced training and experience in CPRT provided weekly supervision to the counselors. The faculty supervisor also randomly viewed 20% of the recorded CPRT sessions using the CPRT Therapist Skills Checklist to determine treatment fidelity (See Appendix C).

Each group lasted two hours and consisted of didactic experiences, emotional support of

parents, and supervision of parent-child play sessions. The overarching goals for each session were to: (1) teach and supervise parents in CCPT attitudes and skills, and (2) support and encourage parents as they shared their struggles and integrated the CCPT philosophy into their way of being with their child (Bratton et al., 2006; Landreth & Bratton, 2006). Parents learned and practiced CCPT skills and attitudes during the group, then integrated their new learnings into their interactions with their children. After the third week of CPRT, parents began conducting 30-minute special play sessions with their “child of focus.” Parents recorded these sessions and, each week, at least two parents showed video of their sessions to the group for feedback and support (Bratton et al. 2006). Video cameras and toys kits were provided to the parents for their play sessions if necessary.

Following the CPRT treatment manual (Bratton et al., 2006), for the first three sessions, we focused on foundational CCPT attitudes and skills. The *be with* attitudes include: *I am here, I hear you, I understand, I care* (Bratton et al., 2006; Landreth & Bratton, 2006). Other basic CCPT attitudinal qualities include: empathy, unconditional positive regard, and congruence. All of these attitudes were modeled, taught, practiced, and encouraged throughout the CPRT treatment, but are the primary focus of the first three sessions. Facilitators also focused on teaching some of the basic CCPT skills to parents including: setting the stage, allowing the child to lead the play, and reflecting the child’s feelings and actions. Facilitators balanced didactic instruction, emotional support of parents, and role-plays/practice of the CCPT attitudes and skills. In these ways, facilitators prepared parents for their first play sessions with their “child of focus” after the third week of treatment.

Sessions 4-6 focus on identifying and encouraging parental strengths, teaching limit setting, and refining previously learned skills. In Session 4, parents began to bring their recorded

play sessions to the group (Bratton, et al., 2006). For the first 45 minutes of each group for the remainder of treatment, facilitators checked-in with all parents on their play sessions, then at least 2 parents showed video of their play sessions and facilitators and group members provided feedback and support to those parents (Bratton et al., 2006). Facilitators focused on encouraging the strengths that parents demonstrated in play skills and attitudes. In Sessions 4-6, the facilitators introduced limit setting and choice-giving as new CCPT skills for parents to incorporate into their play sessions with their children (Bratton et al., 2006). Parents learned and practiced these skills in the group before using them in their play sessions. Though new skills were introduced, facilitators continued to emphasize strengthening the basic CCPT attitudes and skills from the first the sessions.

Sessions 7 and 8 focus on helping parents to build self-esteem in the child and learning the difference between praise and encouragement (Bratton, et al., 2006). The skills that parents learned in these sessions help them to play and interact with their children in ways that increase their internal loci of control, motivation, and evaluation, thus increasing their self-esteem and ability to regulate self (Bratton et al., 2006; Landreth & Bratton, 2006). The parents continued to bring recorded sessions for feedback and support by the facilitators and the group. After reviewing tape, the parents learned and practiced the new skills to begin incorporating them into their interactions with their children. Up until this point, parents were encouraged to use these new skills only during their special play times so as not to overwhelm parents if they tried to use these skills in every interaction with their child (Bratton et al., 2006). This can be very difficult when first learning the skills and can make the parents feel defeated if they attempt to generalize too soon (Landreth & Bratton, 2006). However, after Session 7, parents were encouraged to begin incorporating these skills slowly and naturally into their interactions with their children

both in and out of the special play time.

Sessions 9 and 10 focus on summarizing and refining skills and attitudes learned in the group. In the last two sessions, parents showed their final recorded sessions to the group for feedback and support (Bratton, et al., 2006). Facilitators reviewed all of the skills and attitudes learned throughout the group and discussed with the parents how they have changed in their interactions with and feelings towards their children. Facilitators continued to teach parents how to incorporate these skills into their interactions with their children outside of the play sessions, but also encouraged parents to continue having this special play time with their children (Bratton et al., 2006; Landreth & Bratton, 2006). Facilitators also encouraged parents to stay connected after the group ends in order to be a support system for each other. The final session included a closing activity meant to help the parents focus on their relationship with their children when they started the treatment process and compare it to their relationships at the end of the treatment.

Waitlist Control Group

Parents assigned to the waitlist control group completed the intake and filled out the CBCL, PSI-4-SF, and AAPI-2.1. All pretest data was be collected after block randomization and before the treatment group in each block began treatment. After participants in the treatment group completed the CPRT protocol, all participants within the block completed post-assessments and the participants in the waitlist control group began the CPRT protocol.

Data Collection

Before beginning treatment, all parents completed a background form, CBCL, PSI-4-SF, and AAPI-2.1 during their intake. Within one week of finishing the treatment phase within each block, fathers from both the treatment group and control group completed the CBCL, PSI-4-SF

and AAPI-2.1 again as post-assessment measures. For all assessments, I provided a quiet place, free of distractions, where I could administer the assessments and observe the participants in person. To maintain confidentiality, all assessments were kept in a locked filing cabinet in the researcher's office. All files were assigned a three-digit code for electronic data entry so that no identifying information could be paired with participant scores.

Data Analysis

For all research questions, I used the Statistical Package for the Social Sciences (SPSS) to conduct a 2x2 (group x repeated measures) Factorial ANOVA to analyze each dependent variable (CBCL Total Problems, PSI-4-SF Total Stress, and the AAPI-2.1 Parental Empathy Construct). A decrease in scores on the CBCL and PSI-4-SF indicate improvement, while an increase in scores on the AAPI-2.1 indicates improvement. I looked at the group differences, changes across time, and, the interaction effect. Group assignment served as the between-subjects variable and time served as the within-subjects variable. In total, I conduct three ANOVA analyses. I also calculated and reported partial eta squared effect sizes for each analysis. Before interpreting the results, I checked the necessary assumptions for each analysis.

APPENDIX C
UNABRIDGED RESULTS

In order to evaluate the effectiveness of CPRT for fathers, I conducted 2 (group) by 2 (times) repeated measures ANOVAs on each dependent variable. The three dependent variables included the Total Problems score on the CBCL, the Total Stress score on the PSI-4-SF, and the Empathy score on the AAPI-2.1. The three research questions were as follows: According to parent report, 1) do children of fathers who participated in CPRT decrease in total problem behaviors compared to the waitlist control group? 2) do fathers who participated in CPRT decrease in parental stress compared to a waitlist control group? 3) do fathers who participated in CPRT increase in empathic attitudes towards their children compared to a waitlist control group?

I used the Statistical Package for the Social Sciences (SPSS) to check all assumptions, review the data, and conduct the three ANOVA analyses. The treatment group (CPRT/Waitlist control) served as the between-subjects variable and time (pretest/posttest) served as the within-subjects variable. I focused primarily on identifying an interaction effect between groups over time for each dependent variable, but also recorded change over time and differences between groups independently. In order to determine statistically significant differences, I used a .05 alpha level. I calculated partial eta squared effect sizes (η_p^2) as a measure of practical significance to determine the strength of the differences between the two groups over time. I interpreted effect sizes according to the Cohen (1988) guidelines on interpreting practical significance. Cohen's guidelines are .01 equals a small effect, .06 equals a moderate effect; and .14 equals a large effect. I also ran paired samples t-tests as post-hoc analyses for statistically significant main effects. I used a .05 alpha level to determine statistical significance and calculated Cohen's *d* effect sizes for each. I used the Cohen (1988) guidelines of .2 equals a small effect, .5 equals a medium effect, and .8 equals a large effect for each post-hoc analysis. I conducted G*Power analysis to determine computed power for all post-hoc analyses based on an alpha level of .05,

moderate treatment effect size of .5, and sample size within the analysis. Computed power equals .410 for sample sizes of 14, .438 for sample sizes of 15, and .465 for sample sizes of 16. The impacts of these low power levels are addressed in the discussion.

Data Screening and Assumptions

Prior to conducting the analyses, each dependent variable was examined to ensure the data met assumptions for a factorial ANOVA. The assumptions for normal distribution and homogeneity of variance were reasonably met for each analysis. Sphericity was assumed based on two points of measurement. The skewness and kurtosis for the continuous variables were within normal limits, positive or negative one and positive or negative three respectively (Pallant, 2010). Normality was evaluated using visual inspections of histograms and box plots. Though two outliers were noted overall, the removal of these outliers did not significantly impact the results of the study and were thus included in the final analysis. Homogeneity of variance was evaluated utilizing Levene's Test of Equality of Error Variance and Box's Test of Equality of Covariance Matrices. For Levene's Test a non-significant result of .05 or higher indicates the variance of the two groups are equal. The results for each of the dependent variables at pre and posttest were non-significant with $p > .05$ with the exception of the CBCL post-test at $p = .043$. Again, the removal of the outlier within the CBCL post-test did not affect this statistic and all other assumptions were met. I decided to proceed and interpret these results with caution recognizing that the error variance was not equal across groups on the CBCL post-test. I proceeded to examine Box's Test and the scores were larger than .001.

Research Question 1: Child Behavior Problems

The first ANOVA analyzed the total problems scale on the CBCL to address the question, "What is the effect of CPRT on parental perception of child behavior problems

compared to a waitlist control group?” Table C.1 presents the mean scores and standard deviations for the pre and post CBCL Total Problem scores for both the experimental and waitlist control groups.

Table C.1.

All Means and Standard Deviations on CBCL Total Problems Scale

	Experimental Group ($n = 14$)		Control Group ($n = 16$)	
	M	SD	M	SD
Pre-test	54.286	6.426	55.563	9.872
Post-Test	48.000	6.164	51.688	11.435

Results indicated that there was no statistically significant interaction effect between the two groups over two times of measurement $F(1,28) = .846, p = .366$ and showed a small effect size of $\eta_p^2 = .029$. Results also indicated no statistically significant main effect for group, $F(1,28) = .690, p = .413$ with a small effect size of partial $\eta_p^2 = .029$. However, results showed a statistically significant main effect for time, $F(1,28) = 15.02, p = .001$ with a large effect size of $\eta_p^2 = .349$. Figure C.1 shows the means of both groups at pretest and posttest.

In order to further explore the statistical significance for time, I ran paired samples t-tests to compare the difference between means at pre-test and post-test for each group on the CBCL total Problems scale. For the experimental (CPRT) group, there was a statistically significant decrease in Total Problem scores from pre-test ($M = 54.286, SD 6.426$) to post-test ($M = 48.000, SD = 6.164$), $t(13) = 4.076, p = .001$ (two-tailed). I also calculated a Cohen’s d effect size to determine the magnitude of the difference between the means. Results indicated a large effect size with Cohen’s $d = .998$. The results for the control group did not show a statistically significant decrease from pre-test ($M = 55.563, SD 9.872$) to post-test ($M = 51.688, SD = 11.435$), $t(15) = 1.895, p = .078$ (two-tailed). Results indicated a small effect size with Cohen’s

$d = .363$. A visual inspection of the graph supports the statistically significant change over time reported by the CPRT group.

Table C.2

ANOVA for CBCL Total Problem Score as Dependent Variable

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial η^2
Group	1	92.005	92.005	.690	.413	.024
Time	1	385.430	385.430	15.024	.001*	.349
Group*Time	1	21.696	21.696	.846	.366	.029
Error	28	718.304	25.654			
Total	30	1217.435				

*Statistically significant at $p < .05$

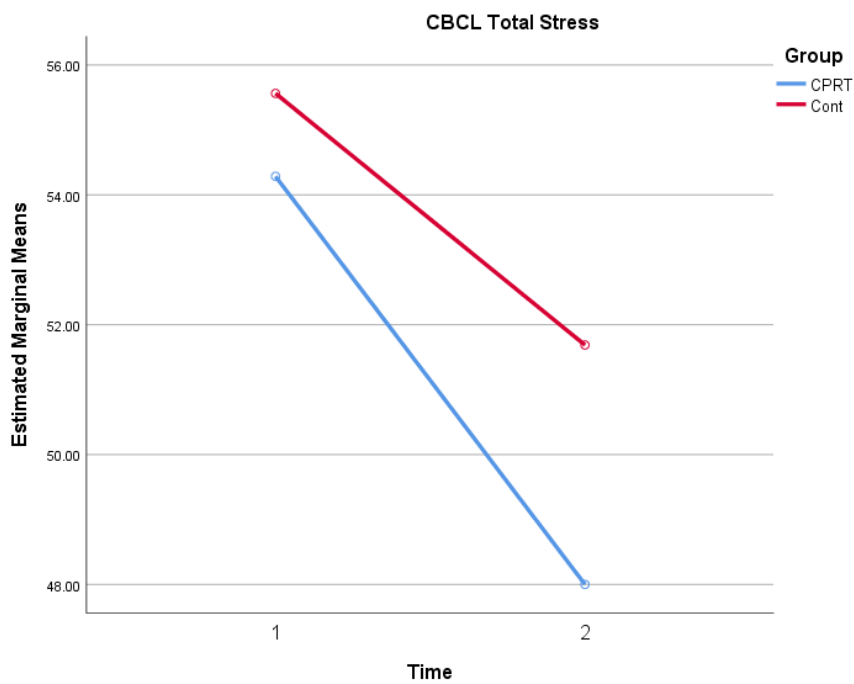


Figure C.1. Means between groups over time on CBCL Total Problem Score.

Research Question 2: Parental Stress

The second ANOVA analyzed the total stress scale on the PSI-4-SF to address the

question, “What is the effect of CPRT on parental stress compared to a waitlist control group?” Table C.3 presents the mean scores and standard deviations for the pre and post PSI-4-SF Total Stress scores for both the experimental and waitlist control groups. One participant in the control group did not complete the post assessment and that participant’s scores were removed from this analysis resulting in a total of 14 in the experimental group and 15 in the control group.

Table C.3.

All Means and Standard Deviations on PSI-4-SF Total Stress Scale

	Experimental Group (<i>n</i> = 14)		Control Group (<i>n</i> = 15)	
	M	SD	M	SD
Pre-test	77.857	21.640	88.400	16.724
Post-Test	67.000	17.146	83.200	17.989

Results indicated that there was no statistically significant interaction effect between the two groups over two times of measurement, $F(1,27) = .852, p = .364$ and showed a small effect size of partial $\eta_p^2 = .031$. Results indicated a statistically significant main effect for group, $F(1,27) = .4761, p = .038$ with a large effect size of $\eta_p^2 = .150$. However, results also showed a statistically significant main effect for time, $F(1,27) = 6.868, p = .014$ with a large effect size of $\eta_p^2 = .203$. Figure C.2 shows the means of both groups at pretest and posttest.

In order to further explore the statistical significance for time, I ran paired samples t-tests to compare the difference between means at pre-test and post-test for each group on the PSI-4-SF Total Stress scale. For the experimental (CPRT) group, there was a statistically significant decrease in Total Stress scores from pre-test ($M = 77.857, SD 21.640$) to post-test ($M = 67.000, SD = 17.146$), $t(13) = 2.272, p = .041$ (two-tailed). I also calculated a Cohen’s *d* effect size to determine the magnitude of the difference between the means. Results indicated a medium effect

size with Cohen’s $d = .556$. The results for the control group did not show a statistically significant decrease from pre-test ($M = 88.400$, $SD = 16.724$) to post-test ($M = 83.200$, $SD = 17.989$), $t(14) = 1.335$, $p = .203$ (two-tailed). Results indicated a small effect size with Cohen’s $d = .299$. A visual inspection of the graph supports the statistically significant change over time reported by the CPRT group.

Table C.4

ANOVA for PSI-4-SF Total Stress Score as Dependent Variable.

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial η^2
Group	1	2589.446	2589.446	4.761	.038*	.150
Time	1	933.529	933.529	6.868	.014*	.203
Group*Time	1	115.874	115.874	.852	.364	.031
Error	27	3670.057	135.928			
Total	29	7308.906				

*Statistically significant at $p < .05$.

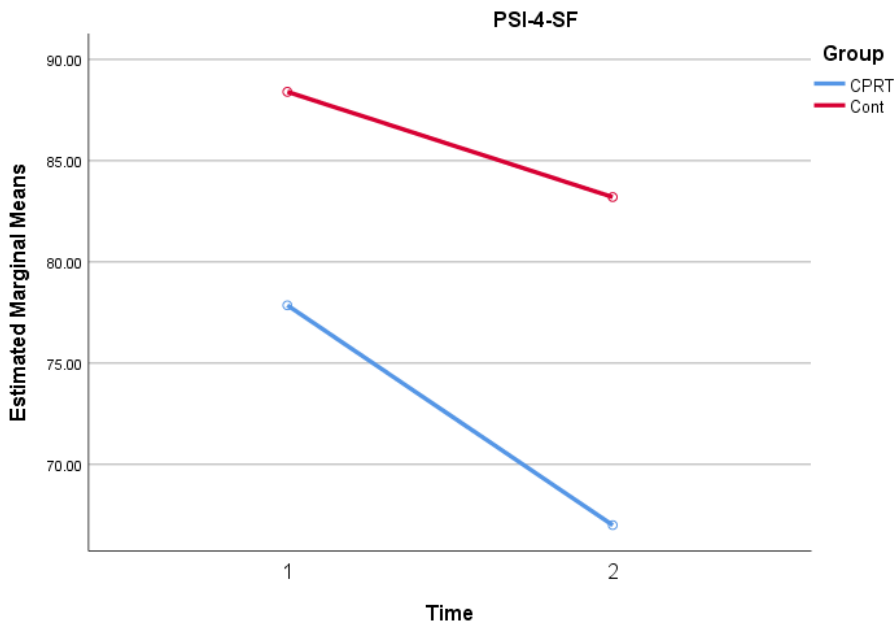


Figure C.2. Means between groups over time on PSI-4-SF Total Stress Score.
Research Question 3: Parental Empathy

The final ANOVA analyzed the Empathy subscale on the AAPI-2.1 to address the question, “What is the effect of CPRT on the parental empathy compared to a waitlist control group?” Table C.5 presents the mean scores and standard deviations for the pre and post AAPI-2.1 Empathy subscale scores for both the experimental and waitlist control groups.

Table C.5.

All Means and Standard Deviations on AAPI-2.1 Empathy Subscale

	Experimental Group (<i>n</i> = 14)		Control Group (<i>n</i> = 15)	
	M	SD	M	SD
Pre-test	6.210	1.847	5.940	2.175
Post-Test	7.071	1.979	7.312	1.815

Results indicated that there was no statistically significant interaction effect between the two groups over two times of measurement $F(1,28) = .462, p = .502$ and showed a very small effect size of $\eta_p^2 = .016$. Results also indicated no statistically significant main effect for group, $F(1,28) = .001, p = .977$ with a small effect size of $\eta_p^2 < .001$. However, results did indicate a statistically significant main effect for time, $F(1,28) = 8.576, p = .007$ with a large effect size of $\eta_p^2 = .234$. Figure C.3 shows the means of both groups at pretest and posttest.

In order to further explore the statistical significance for time, I ran paired samples t-tests to compare the difference between means at pre-test and post-test for each group on the AAPI-2.1 Empathy Subscale. For the experimental (CPRT) group, there was a statistically significant increase in Empathy Subscale scores from pre-test ($M = 6.214, SD 1.847$) to post-test ($M = 7.071, SD = 1.979$), $t(13) = -2.482, p = .028$ (two-tailed). I also calculated a Cohen’s *d* effect size to determine the magnitude of the difference between the means. Results indicated a small-medium effect size with Cohen’s $d = .448$. The results for the control group did not show a

statistically significant increase from pre-test ($M = 5.938$, $SD 2.175$) to post-test ($M = 7.313$, $SD = 1.815$), $t(15) = -2.133$, $p = .05$ (two-tailed). Results indicated a medium effect size with Cohen's $d = .686$. A visual inspection of the graph supports the statistically significant change over time reported by the CPRT group.

Table C.6

ANOVA for AAPI-2.1 Empathy Subscale as Dependent Variable

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial η^2
Group	1	.005	.005	.001	.977	.000
Time	1	18.601	18.601	8.576	.007*	.234
Group*Time	1	1.001	1.001	.462	.502	.016
Error	28	60.732	2.169			
Total	30	80.339				

*Statistically significant at $p < .05$.

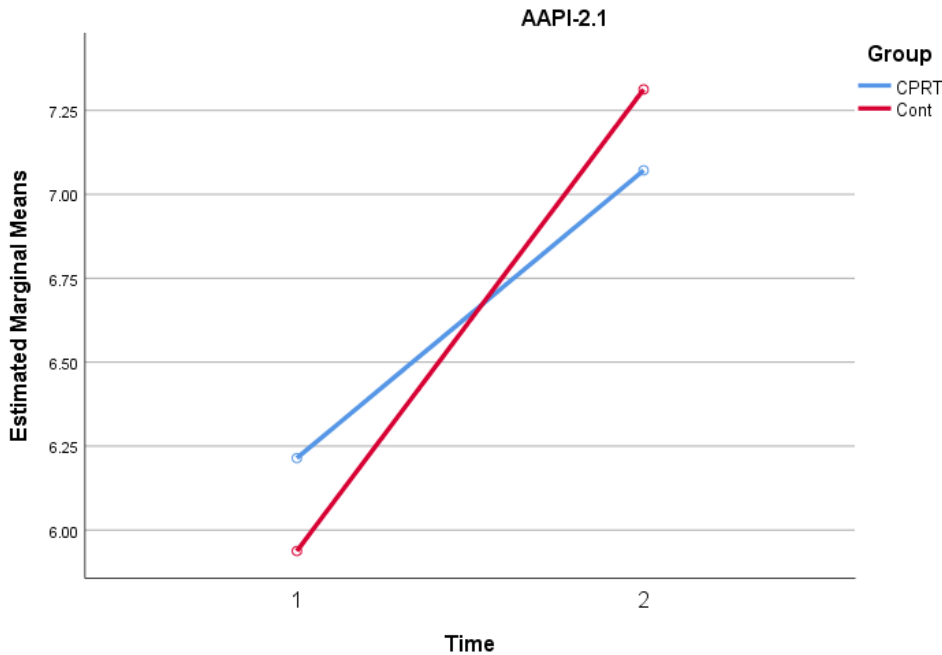


Figure C.3. Means between groups over time on AAPI-2.1 Empathy Subscale.

APPENDIX D
EXTENDED DISCUSSION

The purpose of this study was to measure the effectiveness of child-parent relationship therapy for fathers compared to a waitlist control group. Specifically, I aimed to measure the effect of the CPRT program on child behavior problems, parental stress, and parental empathy. A secondary purpose of this study was to increase the volume of literature and research support for parenting programs that may be effective for fathers. CPRT is an effective and evidence-based program for parents (Lin & Bratton, 2015), but approximately 80% of the participants in CPRT research to date are mothers (Bratton et al., 2015) and only one study has been conducted on its effectiveness for fathers (Landreth & Lobaugh, 1997). This was the first randomized controlled study on the effectiveness of CPRT for fathers and is also the first study to include both English and Spanish CPRT groups.

The results of the present study indicate that there were no statistically significant differences between the groups over time on the dependent variables and the effect sizes associated with these results were small. Each analysis yielded statistically significant differences for time with various levels of practical significance. Post hoc analysis of the main effect for time showed that the experimental (CPRT) group reported a statistically significant change across time on all dependent variables, while the control group did not. However, by not reaching the necessary number of participants designated by the G*Power analysis, the statistical significance findings must be interpreted in light of the lack of power and increased possibility of type 2 error on all analyses. Due to the lack of power, the effect sizes may provide more accurate information for the interpretation of the results. A more specific discussion on the findings for each dependent variable is included in the following sections.

Child Behavior Problems

Results of the ANOVA analysis for the CBCL indicated no statistically significant interaction effect with a small effect size. However, a visual inspection of the standard deviations in Table C.1 can be taken into account when interpreting this result. The experimental group showed consistent deviation over time, while the control group standard deviations varied dramatically. In fact, the variance in the control group scores at pretest were close to not meeting the assumption of homogeneity at $p = .051$ and the variance in the control group scores at posttest did not meet the assumption for the homogeneity at $p = .043$. This violation in the assumption of homogeneity of variances inhibits an accurate result pertaining to an interaction effect between groups over time.

Results did indicate a statistically significant main effect for time. When controlling for group assignment, fathers scored statistically significantly better at posttest than at pretest. The magnitude of this difference over time is shown in the partial eta squared effect size of $\eta_p^2 = .349$, which indicates a large practical significance across time. The post hoc analysis indicated that the CPRT group reported a statistically significant change over time, while the control group did not. With low power for the post-hoc analysis, the Cohen's d effect sizes play an important role in the interpretation of the results. The large effect size of .998 for the experimental group compared to the small effect size of .363 for the control group shows a more significant change over time for the experimental group. A visual inspection of the means in Table C.1 shows a greater decrease in the total problem score for the experimental group (6.286) than for the control group (3.875).

With a statistically significant change over time and a large effect size in the post hoc analysis, CPRT showed promising results as an effective program for fathers in reducing child-

behavior problems. However, due to the lack of an interaction effect, more research is necessary to support this finding when compared to a waitlist control group. A larger sample size and a more homogenous data set would increase the power of this analysis and provide more information on the effectiveness of this program for fathers and child behavior problems.

A strong father-child relationship has been shown to positively impact child behaviors throughout their development. Positive father-child experiences have been linked to higher levels of self-control and lower levels of acting out in school (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008; Anthes, 2010). Teenagers who report having emotional support from and positive interactions with their father report fewer behavioral problems than teenagers who do not have those positive qualities in their father-child relationship (Carlson, 2006). A positive father-child relationship has also been connected to a decrease in more severe behavioral issues such as: risky sexual behaviors, delinquency, and substance abuse (Bronte-Tinkew, Moore, & Carrano, 2006; Green et al., 2014). These studies show that a positive father-child relationship directly impacts the positive development of child behaviors and previous research in CPRT has shown support in building parent-child relationships and decreasing child-behavior problems.

CPRT can directly impact child-behavior problems, not only by building stronger father-child relationships, but also by teaching fathers how to appropriately limit and discipline their children through the relationship that they build throughout the program (Landreth and Bratton, 2020). Sessions 1-3 of the CPRT program focus on helping fathers to learn a specific “way of being” with their children that communicates attitudes of, “I See you, I hear you, I understand, and I care” (Bratton, et al., 2006, p.7). Fathers learn to listen to how their children communicate through play in order to better understand and grow closer to their children. Fathers also learn how to reflect and respond to their children in ways that help their children to feel understood

and to better understand themselves. Sessions 4-7 focus on limit setting and choice giving, which directly impact children's behaviors and decision making. Rather than an authoritarian approach, which can be met with resistant, or a laissez-faire parenting style, which can lead to unruly and immature behaviors, the CPRT program teaches fathers how to address child-behavior problems in a way that decreases resistance and increases the child's sense of responsibility and self-control (Landreth and Bratton, 2020). Past research has shown CPRT to be an effective approach for decreasing child-behavior problems (Ceballos & Bratton, 2010; Opiola & Bratton, 2017). With a statistically significant main effect for time and a substantial decrease in mean scores for the CPRT group, this study supports the findings of previous CPRT research.

Parental Stress

Results of the ANOVA for the PSI-4-SF showed statistical significance for the main effects of group and time independently, but not for the interaction effect. The statistically significant main effect for time is important to note in that all fathers reported a decrease in parental stress over time. Similar to the CBCL scores, Table C.2 shows that the mean difference from pretest to posttest for fathers in the experimental group (10.857) is twice as large as the mean difference for fathers in the control group (5.200). Post hoc analysis of the change over time indicated that the experimental (CPRT) group reported a statistically significant decrease in parental stress, while the control group did not. The medium effect size of .556 for the experimental group compared to the small effect size of .299 for the control group shows a more significant change over time for the experimental group. Results indicate that CPRT may be an effective approach to reducing parental stress for fathers. However, the lack of an interaction effect in this study necessitates further research to examine how this change over time compares to a waitlist control group.

These results showing a reduction in parental stress are important due to the impact that stress can have on the father-child relationship, and thus, the child. Fathers who have achieved a sense of work-life balance report better father-child relationships, while fathers with high levels of work stress and work-family conflict report poor father-child relationships and low-quality interactions with their children (Lau, 2010; Goodman, Crouter, Lanza, & Cox, 2008). Thus, high parental stress leads to low quality father-child interactions, which have a variety of negative impacts on children's overall wellness and development. Similar to the findings of this study, previous research on CPRT has shown that parents who participate in CPRT report a decrease in parental stress after the program (Carnes-Holt & Bratton, 2014; Ceballos & Bratton, 2010; Opiola & Bratton, 2017).

The group format of CPRT is one aspect of the program that can help parents to connect with one another and let go of feelings of isolation in their parenting struggles. Parents bond with other parents in the group and learn, not only that it is okay to struggle sometimes, but also that others are struggling as well (Landreth & Bratton, 2006). This could lead to a decrease in feelings of shame and doubt, which are significant contributors to stress. The CPRT group also serves as a process group for parents where they can discuss the issues they are facing at home and experience the acceptance, genuineness, and unconditional positive regard of the other parents and the group facilitator (Opiola & Bratton, 2017). In this study, many fathers took full advantage of the opportunity to express their struggles and concerns to each other.

Another aspect of the CPRT program that may impact parental stress is the weekly playtimes they have with their children (Bratton et al., 2006). Fathers in this study verbally reported how meaningful these playtimes were, both for themselves and for their children. Many children memorized the times that their fathers had planned to play with them and asked

regularly throughout the week for more play times. These playful and positive experiences, combined with the supportive group format, may contribute to the decrease in parental stress seen in this study. The statistically significant post hoc analysis, along with the medium effect size seen in this study support the findings of previous research (e.g. Ceballos & Bratton, 2010; Opiola & Bratton, 2017; Sheely & Bratton, 2010; Tew, Landreth, Joiner & Solt, 2002) and show that CPRT may be an effective approach for decreasing parental stress for fathers. However, with no statistically significant interaction effect found in this study, more randomized controlled trials with larger sample sizes are needed to further support this claim.

Parental Empathy

Results of the ANOVA analysis for the AAPI-2.1 indicated a statistically significant main effect for time with a large effect size of $\eta_p^2 = .234$. When controlling for group assignment, fathers reported a statistically significant increase in parental empathy over time. Post hoc analysis of the main effect for time indicated that the CPRT group reported a statistically significant increase in empathy, while the control group did not. However, due to the lack of power in the post-hoc analysis, an examination of the effect sizes may yield a more accurate interpretation of the results. The medium effect size of .686 for the control group compared to the small-medium effect size of .448 for the CPRT group shows a slightly more significant change over time for the control group, which can be seen in Figure 4. Though the control group showed a greater mean difference than the CPRT group, they did not report a statistically significant increase in empathy. This result is most likely due to the lack of power and the standard deviation in the control group pretests.

Though many factors may be contributing to these results, they must be interpreted with caution for multiple reasons. Both the English and Spanish versions of this assessment were used

and it is not clear if the Spanish version has been properly normed and validated. Also, the AAPI-2 is not commonly used in CPRT research. It is thus difficult to compare the results of this study to others. Many CPRT studies use the Measurement of Empathy in Adult-Child Interactions (MEACI) to measure change in empathy over time. This is an objective measure that requires blinded observers to rate the level of empathy observed in a parent-child interaction. The MEACI has yielded positive results in many CPRT study and shows the effectiveness of CPRT on increasing parent's empathic interactions with their children (Carnes-Holt & Bratton, 2014; Costas & Landreth, 1999; Glover & Landreth, 2000; Opiola & Bratton, 2017). In contrast, the AAPI-2.1 is a subjective assessment that bases the measurement of empathy more on the parent's attitudes and beliefs than on interactions and behaviors. Thus, the variation in definition and measurement between the MEACI and the AAPI-2.1 may explain the more robust interaction effects found in previous studies compared to this one. Nevertheless, examining the CPRT group alone in the post-hoc analysis shows a statistically significant change over time with a small-medium effect size. These results support the findings of previous research on the effectiveness of CPRT on parental empathy, but also highlight the need for future research to include a larger sample size and more homogenous data.

The increase in empathy reported by the CPRT group is important due to the impact of parental empathy on child development. An empathic understanding of children is a key component in developing a stronger relationship with them and encouraging their optimal development. Studies show that children who experienced quality interactions and emotional support from their fathers also experienced more emotional stability, higher academic achievement, and stronger behavioral adjustment throughout childhood (Adamson & Johnson, 2013; Bavolek & Keene, 2010; Michiels, Grietens, Onghena, & Kuppens, 2010; Newland, Chen,

& Coyl-Sherherd, 2013; Stern, Borelli, & Smiley, 2015). Thus, it is important that fathers experience empathic interactions with and understandings of their children. CPRT aims to increase the empathic understanding of parents for their children through its psychoeducational components. It also helps to increase the opportunity for empathic interaction through the one-on-one play times that are required throughout the group (Opiola & Bratton, 2017). These play times are opportunities for parents to express and experience empathy with their children. They also serve as a form of practice for parents as they learn to interact empathically with their children on a regular basis outside of the play sessions as well.

The results of the post hoc analysis align with previous research on the effectiveness of CPRT for increasing parental empathy (Carnes-Holt & Bratton, 2014; Costas & Landreth, 1999; Glover & Landreth, 2000; Opiola & Bratton, 2017). However, with low power and the lack of an interaction effect in this study, more randomized control research with a larger sample size is necessary in order to compare the effectiveness of CPRT on parental empathy to a waitlist control group.

Researcher's Observations

Throughout the study, I made multiple observations of the participants which are worth noting in this discussion. My observations include: the recruitment process, data collection, and the multicultural experiences of fathers.

Variables Affecting Recruitment

In the recruitment phase, over 60 fathers expressed interest and were contacted by the student researcher. Over 80% of the fathers who participated in the study identified as being employed full-time. Of the three fathers who identified as stay-at-home dads, two actually worked full-time from home and shared their struggles around trying to work while their children

were home. Along with full-time employment, these fathers were attempting to take their children to sporting events and activities throughout the week and on weekends. In order to include as many fathers as possible, I maintained flexible scheduling of groups and attempted to find the best day and time for each father assigned to a specific group. Even so, multiple fathers were forced to drop out of the study due to scheduling conflicts, some before their group officially started. This conflict in scheduling around full-time employment and extracurricular activities made reaching the necessary number of participants difficult. However, this study shows that future research on the effectiveness of CPRT for fathers is both possible and necessary. Many of the fathers who participated in the study expressed thankfulness for a program specifically geared towards fathers. Though some fathers reportedly participated due to spousal request, which is a separate factor addressed below, I believe that we received 60 interested participants because fathers were looking for a place where they could connect with other fathers and receive the help they needed at the same time. With more time and a wider range of advertising, this study could have included over 60 fathers in less than two years.

Data Collection

During intakes, data collection, and group processing, some fathers mentioned that their partners heard about the study and encouraged them to take part. Additionally, two fathers who dropped out before completing pre-tests said that their wives had signed them up for the study and they were not actually interested in participating. The frequent mention of spousal encouragement, begs the question of whether or not some of the men were interested in the study to begin with or if they participated at the behest of their spouses. The primary motivation of participants may seem trivial, but it can have tremendous effects on various outcomes in the study, especially with the small sample size seen in this study. Though the initial intentions of

some fathers may not be clear, their opinions on CPRT and the group process were evident by the end of their groups, both in the treatment groups and the control groups. The majority of fathers thanked the leader and co-leader for their time, discussed the differences that they felt in their relationships with their children and in themselves as parents, and reported that they would refer their friends and family to this program in the future if they could. The verbal response to CPRT by the end of the groups was overall positive and thankful. In fact, not one father in the study, after receiving the treatment, expressed any negative feelings or disappointment towards the program or the experiences they had with their children.

Another important variable that may have contributed to the outcome of this study is the way in which fathers completed their pre and post assessments. During the intake process, the research noticed that some fathers quickly filled out the assessments. When asked about some of the issues they were experiencing, these fathers reported that they only had a few small issues with their children. These observations may also be related to the primary motivation of fathers participating in the study mentioned earlier. However, when they started their groups, these same fathers would slowly begin to discuss the difficulties they were experiencing with their children. They were more willing to discuss these difficulties when they saw that other fathers were struggling with similar behavioral issues with their children. I then considered the possibility that the fathers may have scored their assessments defensively at the beginning of the study, but were more honest in their responses once they had built relationships with me and discovered some of the issues that they were afraid to report or discuss in the beginning. Given this observation, it is also possible that participants in the control group underreported on their pre and post assessments as they had not yet built relationship with me or with other fathers.

Multicultural Experience of Fathers

Throughout treatment, fathers across the study discussed some of the societal expectations that they felt as fathers in the United States. It was an incredible process to see these fathers have genuine conversation with one another regarding a topic that some men may feel is taboo. In its most common form, this discussion revolved around feeling the need to financially support their families, be physically and emotionally available for them, and also be the primary disciplinarian. This discussion directly correlates with the studies pertaining to the stressors that fathers experience (Bryan, 2013; Guzzo, 2011). Fathers discussed the difficulty in wanting to take their children to practice in the evenings, but not getting off of work in time or taking their children to practice, but being physically and emotionally exhausted by the end of the day. Fathers also discussed how they struggled with how best to discipline their children. This topic brought about frequent discussion around the relationships that participants had with their fathers growing up.

Most participants agreed that they did not want to discipline in the way that their fathers did, but they admitted that their fathers' methods seemed to be effective for them. Many participants seemed torn by the discrepancy within these feelings, but connected with each other because of it. Limit setting and choice-giving were helpful tools for these fathers to add to their disciplinary repertoire. Participants also discussed how difficult it was for them to open up emotionally to their children and reflect their feelings, because it was something that they had never experienced from their fathers. Some parents expressed that they had never reflected their children's feelings before this group and even became emotional when they told the group about how meaningful it had been for their children and for themselves.

At the end of each group, the fathers expressed their gratitude for the experience and encouraged me to continue providing services for fathers. Though some fathers wished that their spouses could have shared in this experience, they were thankful for the all-male groups and reported that it helped them to feel more comfortable in opening up to the leader and to one another about their struggles.

Limitations of the Study and Recommendations for Future Research

Multiple limitations exist within the current study which may have affected its outcome, including: sample size, the use of parent-report assessments, and the heavy involvement of the lead researcher. Sample size was a difficult and continuous process throughout the study. Over 60 fathers were recruited to participate in the study, which met the goals for the study and was well beyond the necessary number of participants based on the g-power analysis. However, due to ineligibility, dropout, and inability to contact recruited participants, the overall number of fathers included in the study dropped to just 30, which is below the g-power requirement. Thus, all results from the present study must be interpreted with care and the most significant limitation to the study is sample size. However, this study shows that CPRT research with fathers is possible, but may require more time and energy from the researcher to screen participants and adjust for work schedules and dropout.

Another limitation to the study is the use of parent report assessments which measure the parents' perceptions of stress, empathy, and child-behaviors problems. These measurements are focused solely on the parent's perspective and may not capture the full reality of the relationship. Also, I noticed that many fathers rushed through the assessments in an attempt to complete them quickly. Testing that should have taken between 45-60 minutes tended to be finished between 30-45 minutes. Also, I noticed that some fathers completed the assessments defensively at pre-

test, verbally discussed their parent-child relationship issues during the group, then did not complete the assessments defensively on post-test. This observation may show that fathers struggled to fill out the assessments honestly before building relationships with me and other fathers in the group. The group process and the relationships built may have helped them to be more honest with themselves and on the assessments about the issues that they were facing in their parent-child relationships.

Another limitation of the assessments is related to the lack of published norms and psychometrics for the Spanish version of the AAPI-2.1 and the PSI-4-SF. The AAPI 2.1 has a published set of norms for the English version and the developers claim that it is translated, normed, and validated in Spanish as well. However, it is not clear if the Spanish norm tables and validation studies have been published. I emailed the publisher and author for more information, but I was unable to receive any information. Similarly, for the PSI-4-SF, the publishers did not provide specific data, but they noted on their website that it had similar psychometrics to the original PSI-4, and that it had been validated by various studies, which I found and included in the review of literature.

Implications and Recommendations for Future Research and Practice

The results of this study support the premise that CPRT could be an effective treatment modality for fathers, but also indicate that more research with larger sample sizes is necessary. CPRT is an evidence-based and empirically supported parenting program for all parents. According to SAMHSA's NREPP (2017), CPRT has been recognized as effective for family cohesion and disruptive behavior disorders and symptoms as well as promising for internalizing problems in children. Although mothers make up the vast majority of participants in CPRT research (Bratton et al., 2015), many CPRT studies have included fathers and their findings

support the effectiveness of CPRT for all parents (Bratton & Landreth, 1995; Carnes-Holt & Bratton, 2014; Chau & Landreth, 1997; Cornett & Bratton, 2014; Costas & Landreth, 1999; Landreth & Lobaugh, 1998; Opiola & Bratton, 2017). The purpose of this study was to increase the body of evidence on the effectiveness of CPRT for fathers and, though the study did not find a statistically significant interaction effect, it did result in statistically significant post hoc analyses which support findings in previous research as well as a need for similar studies with larger samples.

When choosing a treatment plan for parents and families, mental health practitioners can look to the body of literature that exists in support of CPRT. Clinicians can pair previous research with the statistically significant post hoc analyses reported in this study to see that CPRT may be an effective approach for fathers specifically. Clinicians can also look to the observations made in this study that detailed how fathers appreciated the father only groups and recognized the difference that the program made in their lives and in their relationships with their children.

Conclusion

Research shows that high levels of quality father involvement in childhood are associated with optimal childhood development (Adamsons & Johnson, 2013; Ferreira et al., 2016). On the contrary, absent fathers and poor father-child relationships are significantly correlated with negative outcomes such as adolescent alcohol and substance abuse (Goncya & van Dulmena, 2010; Mandara & Murray, 2006), lower academic achievement (McLanahan, Tach, & Schneider, 2013), and emotional/behavioral problems (Ramchandiet al., 2013). Despite the importance of the father-child relationship, statistics show that fathers feel less experienced and more stressed about their parenting roles (Evans, Carney, & Wilkinson, 2013). In response, this

study sought to examine the effects of the child-parent relationship therapy on reducing parental stress and child misbehaviors and on increasing parental empathy. In CPRT, parents learn to develop genuine, empathic, and unconditionally accepting relationships with their children. Given the importance of the father-child relationship for child-development, CPRT presents itself as a viable option for helping father to build these types of relationships with their children.

The statistical and practical significance of the interaction effects showed that there was no substantial difference between the experimental group and the control group over two points of time. However, the statistical and practical significance of the post hoc analyses indicated that CPRT may be effective for fathers in increasing parental empathy and decreasing parental stress and child behavior problems, but more stringent research with a larger sample size is necessary.

APPENDIX E
INFORMED CONSENT



THE OFFICE OF RESEARCH INTEGRITY AND COMPLIANCE
Research and Economic Development

December 7, 2018

Dr. Peggy Ceballos
Student Investigator: Damian McClintock
Department of Counseling & Higher Education
University of North Texas

Re: Human Subjects Application No. 18-487

Dear Dr. Ceballos:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled "The Effects of Child-Parent Relationship Therapy (CPRT) for Fathers." The risks inherent in this research are minimal, and the potential benefits to the subject outweigh those risks. The submitted protocol is hereby approved for the use of human subjects in this study. **Federal Policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only, December 7, 2018 to December 6, 2019.**

Enclosed are the consent documents with stamped IRB approval. Please copy and **use this form only** for your study subjects.

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. The IRB must also review this project prior to any modifications. **If continuing review is not granted before December 6, 2019, IRB approval of this research expires on that date.**

Please contact The Office of Research Integrity and Compliance at 940-565-4643, if you wish to make changes or need additional information.

Sincerely,

A handwritten signature in black ink that reads "Shelley Riggs". The signature is written in a cursive style.

Shelley Riggs, Ph.D.
Professor
Chair, Institutional Review Board

SR:jm

UNIVERSITY OF NORTH TEXAS

1155 Union Circle #310979 Denton, Texas 76203-5017

940.369.4643 940.369.7486 fax www.researchunt.edu

PROUDLY USING ENVIRONMENTALLY FRIENDLY PAPER

Parent Informed Consent

Before agreeing to your consent in the research study, it is important that you read and understand the following explanation of the purpose and benefits of this study and how it will be conducted.

Title of Study:

The Effects of Child-Parent Relationship Therapy (CPRT) For Fathers.

Principal Investigator:

Peggy Ceballos, PhD., Nationally Certified Counselor (NCC), University of North Texas, Department of Counseling and Higher Education.

Student Research Assistant:

Damian McClintock, M.A., Licensed Professional Counselor-Intern (LPC-Intern), University of North Texas, Department of Counseling and Higher Education.

Purpose of the Study:

You are being asked to participate in a research study to explore the effectiveness of a group parenting intervention, child-parent relationship therapy (CPRT), aimed at enhancing the relationship between fathers and their children. The goal of CPRT is to help parents to build a stronger relationship with their children, better understand their children's needs, and learn developmentally appropriate discipline strategies and responses that foster children's healthy development. Specifically, the purpose of this study is to explore the effects of CPRT on children's behavior problems, stress in the father-child relationship, and father's empathy towards children's needs.

Study Procedures:

Upon your consent, you will be randomly assigned to participate in either group 1: the CPRT intervention group or Group 2: the waitlist control group. For the intervention, you will meet once a week for 2 hours for 10 weeks. In addition, you will participate in weekly, 30-minute planned one-on-one play time with your child. Total amount of time for completing the intervention and assessments is approximately 25 hours.

Before the ten-week training / ten-week waiting period, you will be asked to answer some basic questions about yourself, your child, and your relationship with your child. This will be done in written form by completing a family background form and three standard assessment forms: the Parenting Stress Index (PSI-4-SF), the Child Behavior Checklist (CBCL), and the Adult-Adolescent Parenting Inventory (AAPI-2.1). The PSI-4-SF asks questions about your stress level related to parenting your child. The CBCL is a standard assessment form that includes questions about your child's behavior. The AAPI-2.1 asks questions about various aspects of your relationship with your child including: attachment, communication, discipline, etc.

After the ten-week training / ten-week waiting period, you will be asked to complete the PSI-4-SF CBCL, and the AAPI-2.1 again.

Group 1: Child Parent Relationship Therapy (CPRT):

You will learn skills that are designed to strengthen your relationship with your child, understand your child's needs, and help you know how to respond to your child in difficult situations. The group is designed, to help you feel understood and accepted by the facilitator and the other parents in the group who may have similar life experiences. Demonstrations, live practice sessions, role-plays, and group discussion will be used to help you learn and apply CPRT skills. You will be required to conduct seven 30-minute weekly one-on-one play times with your child. You will also be required to record your one-on-one times with your child and bring the recordings to the weekly group meetings. During the group meetings, you will receive feedback from the facilitator and other parents. The 2 hour weekly group sessions will also be video and audio recorded for the purpose of the CPRT facilitator's supervision. The sole purpose of these video/audio recordings is to further build your skills as a parent, and thus, enhance the parent-child relationship.

OR

Group 2: Waitlist Control:

The waitlist control group will not immediately begin receiving CPRT services. After Group 1 has completed the intervention and all assessments have been completed. You will receive the same CPRT treatment as Group 1 listed above.

Foreseeable Risks:

There are no significant personal risks foreseen as likely from involvement in this study. Your participation in this study is completely voluntary. You may withdraw at any time during the course of the study. The investigator will attempt to minimize discomfort by ensuring that you do not feel pressured to disclose information that causes discomfort. Possible risks may include one or more of the following:

1. Anything that is said or done during the intervention is considered confidential, meaning that the counselor will not reveal anything that happens in the session. However, if you disclose child abuse, elderly abuse, neglect, exploitation, or intent to harm self or another person, the counselor is required by law to report it to the appropriate authority.
2. Because these groups are counseling interventions, you may experience thoughts or emotions that could be challenging for you. The counselors are experienced and trained to help you work through these emotions. If any potential harmful effects are noted, the counselor will consult with a supervisor. If it is determined by the counselor and supervisor that remaining in the group would not be beneficial or would be harmful to you, the counselor will meet with you to provide an appropriate referral.
 - a. 24 hour help resources:
 - i. University Behavioral Health of Denton – 940-320-8100
 - ii. Sante Center for Healing – 866-238-3164
 - iii. MHMR Psychiatric Triage Clinic – 940-381-9965

Benefits to the Participants or Others:

Possible positive outcomes for you participating in the study may include a closer and less stressful parent-child relationship, increased confidence in parenting and reduced problem behaviors for your child. You may also benefit from meeting other parents who are experiencing similar situations with their children. The results of this study may provide mental health practitioners across the county with knowledge that helps them enhance parent-child relationships for fathers.

Procedures for Maintaining Confidentiality of Research Records:

You will be assigned a code and only that code will be used on any stored information you provide, including videos. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study. Unless subpoenaed by the court, CPS, or an attorney, no one will view your group recordings other than the investigators mentioned above. Your recordings will be kept for no more than three years beyond the end of data collection and then the recordings will be destroyed by the investigators. All recordings and assessments will be securely locked in a secure location in 425 S. Welch St. Complex 2 at the University of North Texas, Denton, TX.

Please be advised that although the researcher will take every precaution to maintain confidentiality of the data, the nature of the group setting prevents the researchers from guaranteeing confidentiality. The researchers would like to remind participants to respect the privacy of your fellow participants, and not repeat what is said in the group to others.

Questions about the Study:

If you have any questions about the study, you may contact Dr. Peggy Ceballos at (940) 565-2842 or Peggy.Ceballos@unt.edu. You may also contact Damian McClintock at (661) 428-0750 or Damian.McClintock@unt.edu.

Review for the Protection of Participants:

This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-4643 with any questions regarding the rights of research subjects.

Research Participants Rights:

Your signature below indicates that you have read or have had read to you all of the above and you confirm all of the following:

- You understand the possible benefits and the potential risks and/or discomforts of the study.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the research participant and you voluntarily consent to your participation in this study.
- You understand you may keep a copy of this form.

Your initials _____ indicate your permission to audio/video record the groups.

Printed Name and Signature of Participant

Date

For the Student or Principal Investigator:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

Signature of Student or Principal Investigator

Date

Formulario de Consentimiento

Antes de aceptar participar en este estudio de investigación, es importante que lea y comprenda este formulario, el cual explica el propósito y los beneficios de este estudio y cómo se llevará a cabo.

Título del estudio:

Los efectos de la Terapia de Relación entre Hijos-Padres para los padres.

Investigador Principal

Peggy Ceballos, PhD., Nationally Certified Counselor (NCC), University of North Texas, Department of Counseling and Higher Education.

Estudiante Asistente de la Investigación:

Damian McClintock, M.A., Licensed Professional Counselor-Intern (LPC-Intern), University of North Texas, Department of Counseling and Higher Education.

Propósito del estudio:

Se le está pidiendo que participe en un estudio de investigación para explorar la efectividad de una intervención grupal para padres, la Terapia de Relación Entre Hijos-Padres, dirigida a mejorar la relación entre los padres y sus hijos. El objetivo de este entrenamiento es ayudar a los padres a construir una relación más sólida con sus hijos, comprender mejor las necesidades de sus hijos y aprender estrategias y respuestas de disciplina apropiadas para su desarrollo que fomenten el desarrollo saludable de los niños. Específicamente, el propósito de este estudio es explorar los efectos que esta intervención tiene en los problemas de comportamiento de los niños, el estrés de los padres, y en la empatía del padre hacia las necesidades de los niños.

Procedimientos de estudio:

Una vez que de su consentimiento, se le asignará al azar el participar en el grupo 1: el grupo de intervención o en el grupo 2: el grupo de control de lista de espera. Para la intervención, se reunirá una vez a la semana durante 2 horas durante 10 semanas. Además, se le pedirá que haga con su hijo una sesión de juego semanalmente durante 30 minutos. El tiempo total para completar la intervención y las evaluaciones es de aproximadamente 25 horas.

Antes de participar en el entrenamiento de diez semanas / o ser asignado al grupo de espera de 10 semanas, se le pedirá que responda algunas preguntas básicas sobre usted, su hijo y su relación con su hijo. Esto se hará por escrito completando un formulario de antecedentes familiares y tres cuestionarios: el Índice de Tensión de los Padres, Cuestionario Sobre El Comportamiento del Niños (as) y el Inventario de padres de adultos y adolescentes. El Índice de stress hace preguntas sobre su nivel de estrés relacionado con la crianza de su hijo. El Cuestionarios Sobre Los Compartimientos de los Niños(as) es un formulario de evaluación estándar que incluye preguntas sobre el comportamiento de su hijo. El AAPI-2.1 hace preguntas sobre varios aspectos de su relación con su hijo, incluyendo: apego, comunicación, disciplina, etc.

Después del entrenamiento/ or las 10 semanas de espera, se le pedirá que vuelva a llenar los tres cuestionarios.

Grupo 1: Terapia de relación entre Hijos y Padres:

Aprenderá habilidades que están diseñadas para fortalecer su relación con su hijo, entender las necesidades de su hijo y ayudarlo a saber cómo responder a su hijo durante situaciones difíciles. El grupo está diseñado para ayudarlo a compartir con otros padres en el grupo que pueden tener experiencias similares. Se usarán demostraciones, sesiones de práctica en vivo, y discusión grupal para ayudarlo a aprender y aplicar las habilidades del entrenamiento. Se le pedirá que conduzca siete sesiones de juego con su hijo; estas sesiones serán una vez a la semana por 30 minutos. También se le pedirá que grabe estas sesiones con su hijo y que lleve las grabaciones a las reuniones de grupo semanales. Durante las reuniones de grupo, usted podrá mostrar estas grabaciones y recibir comentarios del facilitador y de otros padres. Las sesiones grupales semanales de 2 horas también serán grabadas en video y audio con el propósito de que el terapeuta pueda recibir supervisión. El único propósito de estas grabaciones de video / audio es seguir desarrollando sus habilidades como padre y, por lo tanto, mejorar la relación padre-hijo.

O

Grupo 2: Control de lista de espera:

El grupo de control de la lista de espera no comenzará inmediatamente a recibir el entrenamiento. Después de que el Grupo 1 haya completado la intervención y se hayan completado todas las evaluaciones. Padres en este grupo, recibirán el mismo entrenamiento que los padres en el Grupo 1 mencionado anteriormente recibieron.

Riesgos previsibles:

No se predice que haya riesgos personales significativos por participar en este estudio. Su participación en este estudio es completamente voluntaria. Puede retirarse en cualquier momento durante el curso del estudio. El investigador intentará minimizar la incomodidad asegurándose de que no se sienta presionado para revelar información que le cause incomodidad. Los posibles riesgos pueden incluir uno o más de los siguientes:

3. Todo lo que se diga o se haga durante la intervención se considera confidencial, lo que significa que el consejero no revelará nada de lo que suceda en la sesión. Sin embargo, si revela abuso infantil, abuso de ancianos, negligencia, explotación o intento de hacerse daño a sí mismo o a otra persona, la ley exige que el consejero lo reporte a la autoridad correspondiente.
4. Debido a que estos grupos son intervenciones de consejería, puede tener pensamientos o emociones que podrían ser incómodas para usted. Los consejeros tienen experiencia y están capacitados para ayudarlo a superar estas emociones. Si se observan efectos dañinos, el consejero consultará con un supervisor. Si el consejero y el supervisor determinan que permanecer en el grupo no sería beneficioso o sería perjudicial para usted, el consejero se reunirá con usted para referirlo a servicios adecuados.

- a. Sitios que proporcionan ayuda 24 horas:
 - i. University Behavioral Health of Denton – 940-320-8100
 - ii. Sante Center for Healing – 866-238-3164
 - iii. MHMR Psychiatric Triage Clinic – 940-381-9965

Beneficios para los Participantes u Otros:

Los posibles resultados positivos por su participación en el estudio pueden incluir una relación más estrecha y menos estresante entre padres e hijos, una mayor confianza en sus habilidades para la crianza de los hijos y una reducción de las conductas problemáticas en su hijo. También puede beneficiarse de conocer a otros padres que están teniendo situaciones similares con sus hijos. Los resultados de este estudio pueden proporcionar a los profesionales de la salud mental un conocimiento que los ayude a los padres a mejorar las relaciones entre padres e hijos.

Procedimientos para mantener la confidencialidad de los registros de investigación:

Se le asignará un código y solo ese código se usará en cualquier información almacenada que proporcione, incluidos los videos. La confidencialidad de su información individual se mantendrá en cualquier publicación o presentación relacionada con este estudio. A menos que sean citados por el tribunal, el CPS o un abogado, nadie verá las grabaciones de su grupo aparte de los investigadores mencionados anteriormente. Sus grabaciones se mantendrán por no más de tres años después de finalizar la recopilación de datos y, a continuación, los investigadores las destruirán. Todas las grabaciones y evaluaciones se guardarán en un lugar seguro en 425 S. Welch St. Complex 2 en la Universidad del Norte de Texas, Denton, TX.

Tenga en cuenta que aunque el investigador tomará todas las precauciones para mantener la confidencialidad de los datos, la naturaleza del entorno grupal impide que los investigadores garanticen la confidencialidad. A los investigadores les gustaría recordar a los participantes que respeten la privacidad de sus compañeros participantes y que no repitan lo que se dice en el grupo a otros.

Preguntas Acerca del Estudio:

Si usted tiene alguna pregunta acerca del estudio, usted puede contactar a la Dra. Peggy Ceballos at (940) 565-2842 or Peggy.Ceballos@unt.edu. Usted también puede contactar a Damian McClintock at (661) 428-0750 or Damian.McClintock@unt.edu.

Revisión para la protección de los participantes:

Este estudio de investigación ha sido revisado y aprobado por la Junta de Revisión Institucional (IRB) de UNT. Se puede contactar al IRB de UNT al (940) 565-4643 con cualquier pregunta sobre los derechos de los sujetos de investigación.

Investigación de los derechos de los participantes:

Su firma a continuación indica que ha leído o se le ha leído todo lo anterior y confirma todo lo siguiente:

APPENDIX F

FLYERS



University of North Texas

The UNT Department of Counseling and Higher Education is Conducting a Research Study on **The Effectiveness of Child-Parent Relationship Therapy (CPRT) for Fathers** in Denton, Texas. CPRT is a 10-session, evidence-based program that helps parents build stronger relationships with their children. In 10 weeks, you will learn skills and strategies to help you:

Understand your child's emotional needs

Develop your child's self-control and self-esteem

Effectively discipline & limit inappropriate behavior

Communicate more effectively with your child

Feel more in control as a parent

If you are a father with a child between the ages of 3 and 10, you may qualify to participate in this research study examining the effects of child-parent relationship therapy (CPRT) on parental stress, child behavior problems, and the parent-child relationship. **By participating in this study, you receive the 10-session CPRT program for FREE!**

Principal Investigator: Peggy Ceballos, PhD., RPT, Assistant Professor

UNT Department of Counseling and Human Services

Student Investigator: Damian McClintock, M.A., LPC-Intern, Doctoral Candidate

UNT Department of Counseling and Human Services

For more information, please contact the Center for Play Therapy at 940-565-3864 or Damian McClintock at 940-268-3142 and ask about the CPRT research study.



University of North Texas

El Departamento de Counseling and Higher Education de UNT esta realizando un estudio de investigación sobre la efectividad de la Terapia de Relación Niño-Padre para padres en Dallas, Texas. La Terapia de Relación Niño-Padre es un programa de 10 sesiones que ayuda a los padres a establecer relaciones más sólidas con sus hijos. En 10 semanas, aprenderás habilidades y estrategias para ayudarlo a:

Entender las necesidades emocionales de su hijo

Desarrollar el autocontrol y la autoestima de su hijo.

Efectivamente disciplinar y limitar el comportamiento inapropiado.

Comunicarse más efectivamente con su hijo.

Sentirse más en control como padre

Si usted es un padre con un niño entre las edades de 3 y 10 años, puede calificar para participar en este estudio de investigación que examina los efectos de la Terapia de relación niño-padre (CPRT, por sus siglas en inglés) sobre el estrés de los padres, los problemas de comportamiento del niño y la relación de padre-hijo. Al participar en este estudio, ¡recibe el programa CPRT de 10 sesiones GRATIS!

Investigadora Principal: Peggy Ceballos, PhD., Associate Professor

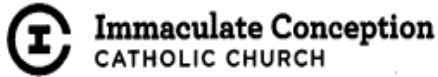
UNT Department of Counseling and Human Services

Estudiante Investigador: Damian McClintock, M.A., LPC-Intern

UNT Department of Counseling and Human Services

Para mas información, por favor contacte el Center for Play Therapy llamando al (940)-565-3864 o llamando a Damian McClintock al teléfono (940)-268-3142. Cuando llame, pregunte por el estudio de CPRT y alguien le atenderá en Español.

APPENDIX G
SITE APPROVAL LETTERS



Dr. Peggy Ceballos and Damian McClintock
University of North Texas
425 S. Welch Street
Denton, TX 76203-5017

August 30, 2018

Dear Dr. Ceballos and Damian McClintock:

I am writing in response to your request to conduct research on Child-Parent Relationship Therapy (CPRT) with fathers. Immaculate Conception Catholic Church is excited to partner with you regarding offering CPRT services to fathers. We understand and agree with the design and methodology you will employ and we are willing to work with you to advertise to parents in our congregation and provide meeting space for parenting groups if available and necessary. We look forward to this opportunity and believe this will be a valuable experience for our families.

Sincerely,

A handwritten signature in black ink, appearing to read "Rev. D. Timothy Thompson".

Rev. D. Timothy Thompson
Pastor



**Jewish Family Service
of Greater Dallas**

An open door to all in need



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President

Julie Liberman
President-Elect

Mike Friedman
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- Betty Spomer
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October 2, 2018

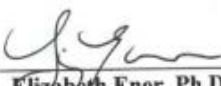
Dr. Peggy Ceballos and Damian McClintock
University of North Texas
425 S. Welch Street
Denton, TX 76203-5017

Dear Dr. Ceballos and Damian McClintock:

I am writing in response to your request to conduct research on Child-Parent Relationship Therapy (CPRT) with fathers. Jewish Family Services is excited to partner with you regarding offering CPRT services to fathers. We understand and agree with the design and methodology you will employ and we are willing to work with you to advertise to parents and provide meeting space for parenting groups if necessary baring IRB approval. We look forward to this opportunity and believe this will be a valuable experience for our families.

Sincerely,


Ariela Goldstein, MS., LCSW
Clinical Director
 5402 Arapaho Rd, Dallas, TX 75248
 P: 972.437.9950*
 F: 972.437.1988
 www.JFSdallas.org


Elizabeth Ener, Ph.D., LPC, RPT
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 www.JFSdallas.org


Gustavo Barcenas, PhD, LPC
Clinician
 907 Bank Street, Dallas, TX 75223
 P: 214.887.1364 Ext. 271 ♦
 F: 214.887.1955
 www.JFSdallas.org





Start Young. Involve Parents.

Dr. Peggy Ceballos and Damian McClintock
University of North Texas
425 S. Welch Street
Denton, TX 76203-5017

Dear Dr. Ceballos and Damian McClintock:

I am writing in response to your request to conduct research on Child-Parent Relationship Therapy (CPRT) with fathers. Lumin Education is excited to partner with you regarding offering CPRT services to participating fathers in our Head Start program. We understand and agree with the design and methodology you will employ and we are willing to work with you to advertise to parents in Bachman Lake Together Family Center and provide meeting space for parenting groups if necessary. We look forward to this opportunity and believe this will be a valuable experience for our families.

Sincerely,

Veronica Alvarez
Family and Community Partnerships Coordinator

A handwritten signature in black ink that reads "Veronica Alvarez, FCPC 11/1/18".

Veronica Alvarez, FCPC
Lumin Bachman Lake Community School

A handwritten signature in black ink that reads "Damian McClintock 11/1/18".

Damian McClintock, Student Investigator
University of North Texas




6500 Crawford Road
Argyle, Texas 76226
940.387.6223
www.stmarkdenton.org

Dr. Peggy Ceballos and Damian McClintock
University of North Texas
425 S. Welch Street
Denton, TX 76203-5017

Dear Dr. Ceballos and Damian McClintock:

I am writing in response to your request to conduct research on Child-Parent Relationship Therapy (CPRT) with fathers. St. Mark Catholic Church is excited to partner with you regarding offering CPRT services to fathers. We understand and agree with the design and methodology you will employ and we are willing to work with you to advertise to parents in our congregation. We look forward to this opportunity and believe this will be a valuable experience for our families.

Sincerely,


Father George
Pastor

APPENDIX H
DEMOGRAPHIC FORMS

Demographic Form

Father's Name: _____
Last First M.

Date of Birth: _____ **Ethnicity:** _____

Occupation: _____

Father's Education Level

8th grade or below _____ Trade School/Some College _____ Undergraduate Degree _____
 High School _____ GED _____ Graduate Degree _____

Marital Status

Never married _____ Currently married _____ Divorced _____ Widowed _____ Deceased _____

Have you ever received mental health services (psychiatrist, psychologist, or a counselor)? Yes No

Dates of Service: _____

*** INFORMATION ON CHILD OF FOCUS***

Child's Name: _____ **Date of Birth** ____/____/____
Last First MI

Child's Sex: Male _____ Female _____ **Age** _____ **Ethnicity** _____

Child's relationships with siblings:

Name of Sibling(s)	Age	Sex	How would you describe their relationship?

Do you have any specific concerns related to your child (please list)? _____

If so, how have you attempted before now to deal with this issue? _____

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

Anything else you would like to share about your child? _____

Demographic Form

Nombre del padre: _____
Apellido Nombre
Fecha de Nacimiento: _____ **Grupo Étnico o Raza:** _____

Ocupacion: _____

Nivel Educativa del padre

Octavo grado o menos _____ Educación de Universidad ____ Título Universitario ____
 Bachillerato ____ GED ____ Educación de posgrado ____

Estado Civil

Casado ____ Divorciado ____ Viudo ____ Vive con pareja ____

¿Alguna vez ha recibido servicios de salud mental (psiquiatra, psicólogo o consejero)? Si no

Fecha de los servicios: _____

*** INFORMACION DEL NINO(A) DE ENFOQUE***

Nombre del Nino(a): _____ **Fecha de Nacimiento** ____/____/____
Apellido Nombre

Sexo del Nino(a): Masculino ____ Femenino ____ **Edad** ____ **Grupo Étnico o Raza**
 y _____

Relacion del Nino(a) con hermanos:

<i>Nombre de Hermanos</i>	<i>Edad</i>	<i>Sexo</i>	<i>Cómo describiría su relación con el niño de enfoque?</i>

Tiene alguna preocupación acerca de su niño(a)? _____

Si responde Si, Como ha intentado usted liderar con este problema? _____

Que es lo que mas usted disfruta de su hijo(a)? _____

Que es lo que se le hace mas difícil acerca de su hijo(a)? _____

Algo mas que usted quiera agregar acerca de su hijo(a)? _____

APPENDIX I
CPRT THERAPIST SKILLS CHECKLIST

Child Parent Relationship Therapy (CPRT)
Therapist Skills Checklist—Session # _____
 Form B -Treatment Integrity (Supervision and Research)

Date: _____

Group meeting day(s): _____



- / ✓	SKILLS/ATTITUDES	Examples/Comments
	Structure:	
	Organized /Stayed on track	
	Established a climate of safety, warm acceptance, empathic understanding, and genuineness	
	Allocated balanced time between didactic, supervision and group process/support	
	Responses:	
	Modeled Reflective Responding	
	Attuned to needs of each parent	
	Demonstrated Knowledge of CPRT content	
	Demonstrated group skills as appropriate: linking parents and normalizing and generalizing parents' concerns	
	Nonverbals:	
	Modeled "Be With" attitudes: Genuine/Authentic	
	Comfortable/Confident as facilitator	
	Protocol	
	Covered essential elements of protocol for this session; other content covered based on clinical judgment of parents' needs	

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