

The Effectiveness of Child Parent Relationship Therapy in an Online Format

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The purpose of this study was to investigate the effectiveness of an online format of child parent relationship therapy (CPRT; Landreth & Bratton, 2006) in increasing parental acceptance of participants' children. Parental perceptions of CPRT in an online format were also explored. Eight participants from around the world completed CPRT online. Findings show significant improvement in parental acceptance and participants' satisfaction with the approach. Results, recommendations, and practical implications for this innovative online parent training approach are discussed.

Keywords: child parent relationship therapy, online, parent training, parental acceptance, Internet counseling

The prevalence of mental health disorders of children living in the United States is estimated to be 13% to 20% (Perou et al., 2013). Although early and effective treatment for children and their families is recommended, significant barriers to treatment still exist (Richards et al., 2014). Obstacles to treatment include access to therapists trained in children's mental health, time, and distance. These obstacles can be overcome through an online therapy format. With continued growth of computer ownership and Internet use worldwide, counselors have the opportunity to provide online therapy to expand the reach of therapeutic services.

One effective children's mental health treatment approach is child parent relationship therapy (CPRT; Landreth & Bratton, 2006). CPRT is a 10-week didactic, experiential therapeutic intervention in which play therapists teach parents basic child-centered play therapy (CCPT) principles and methods so they can conduct once-a-week 30-min play sessions with their own child. Parents are required to video tape

their play sessions so the play therapist can guide them in properly implementing the skills. The efficacy of CPRT in increasing children's mental health and parental acceptance has been demonstrated by numerous research studies (Baggerly, Ray, & Bratton, 2010; Carnes-Holt & Bratton, 2014; Dillman Taylor, Purswell, Lindo, Jayne, & Fernando, 2011; Lindo, Bratton, & Landreth, 2016). In addition, research on alternative delivery methods such as intensive formats (Ferrell, 2003; Socarras, Smith-Adcock, & Shin, 2015) and a school-based format (Villarreal, 2008) have shown that CPRT is a flexible model.

However, these studies have only offered CPRT in the traditional, face-to-face format. Logistics such as child care arrangements and accessibility due to distance have been found to be a barrier to parents receiving CPRT (Boswell, 2014). These barriers can be overcome by delivering CPRT in an online format. The need for online treatment approaches and the success of CPRT warrants investigation of the integration of CPRT and online technology.

The purpose of this mixed-methods, exploratory study was to investigate the effectiveness of CPRT in an online format to increase parental acceptance of their children. Parental perceptions of CPRT in an online format were also explored. In this article, we explain the rationale for the study, describe the methods, and discuss the results as well as implications.

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Rationale

The impact of children's behavioral and mental health disorders on society is significant. Chronic behavior and mental health problems in childhood are directly and positively correlated with antisocial behavior in adulthood (Gross et al., 2014). Approximately 65% of children whose aggression and behavioral problems begin in preschool and continue at age seven are still struggling with mental health problems in adulthood (Broidy et al., 2003). Intervention for children with mental health disorders can cost society up to \$60,000 per child once mental health services, grade retention, special education, and juvenile justice involvement are calculated (Gross et al., 2014). Children with more pervasive childhood disorders that are left untreated are more likely to be limited in earning potential as well as productivity in adulthood (Currie & Stablie, 2006). To address this problem, counselors need to offer mental health interventions for children and their parents.

Parental Involvement

Parental involvement in children's mental health treatment can promote better outcomes and longer lasting gains for the child (Silverman & Hinshaw, 2008). Diamond and Josephson (2005) stated "engaging parents in the treatment process . . . can contribute to better treatment engagement, retention, compliance, effectiveness, and maintenance of gains" (p. 872). The positive impact of parents' involvement in their children's treatment occurs through bidirectional interconnection in which children change their parents and parents change their children (Lollis & Kuczynski, 1997). "The behaviors of the parent and child are linked, one giving rise to the other, in cycles of reciprocal causality" (Kent & Pepler, 2003, p. 131). When parents are involved in the therapeutic process, they learn skills to maintain positive relationships with their children after the sessions have ended (Cates et al., 2006).

Parental Acceptance

Parental acceptance can also positively influence children's psychological well-being and mental health (Lee & Chyung, 2014; Uddin, Khaleque, Aktar, & Hossain, 2014). Hare, Marston, and Allen's (2011) longitudinal study

found the higher the perception of maternal acceptance in early adolescence, the greater the observed and self-reported emotional communication 3 years later. Parental acceptance has been conceptualized as "understanding, consent, expression of emotions, encouragement, and response to the child's expectations" (Teichman & Kefir, 2000, p. 194). When parents demonstrate acceptance of their children through respectful and supportive interaction, the bond between parent and child increases and children's behavior problems decrease (Landreth & Bratton, 2006).

CPRT Evidence Base

CPRT has strong evidence to support it as an effective children's mental health treatment intervention that involves parents and increases parental acceptance (Cornett & Bratton, 2015; Landreth & Bratton, 2006; Lindo et al., 2016). Numerous research studies have revealed the effectiveness of CPRT with various populations such as single parents (Dillman Taylor et al., 2011), court-ordered parents (Walker, 2007), and adoptive families (Carnes-Holt & Bratton, 2014). CPRT was also shown to be effective with differing populations of children, including those with behavior problems (Johnson-Clark, 1996); child victims of sexual abuse (Costas & Landreth, 1999; West, 2010); children with learning disabilities (Kale & Landreth, 1999); children with developmental disorders (Beckloff, 1997; Sullivan, 2011); children who are chronically ill (Tew, Landreth, Joiner, & Solt, 2002); and child witnesses of domestic violence (Kinsworthy & Garza, 2010; Smith & Landreth, 2003).

Numerous racial and ethnic groups have benefited from CPRT, including African American parents (Sheely & Bratton, 2010), Chinese families (Yuen, Landreth, & Baggerly, 2002), Iranian mothers (Alizadeh, Abu Talib, Abdullah, & Mansor, 2011), Israeli parents (Kidron & Landreth, 2010), Korean parents (Jang, 2000), Latino parents (Ceballos & Bratton, 2010), and Native Americans (Glover & Landreth, 2000).

A meta-analytic study of 53 controlled-outcome CCPT studies published between 1995 and 2010 also demonstrated the vast effectiveness of CPRT (Lin & Bratton, 2015). In this meta-analysis, studies involving parents who received training and supervision in implement-

ing play session with their own children demonstrated a larger effect size (.59) than play therapists (.33), and this difference was statistically significant. Although CPRT is an effective intervention, it is not readily available for many families due to geographical location, lack of training centers, or access to counselors trained in CPRT. These barriers can be overcome by providing CPRT in an online format.

Online Therapy

In 2013, the U.S. Census Bureau reported almost 84% of households in the United States have a computer and more than 74% of households use the Internet (File & Ryan, 2014). Further, computer ownership and Internet use are more likely among younger adults compared with older adults. It is probable that parents with young children are Internet users and technologically savvy (Internet User Demographics, 2014).

With continued growth of computer ownership and Internet use worldwide, counselors are seeking online therapy options to better serve their clients' mental health needs. Online therapy provides effective solutions to commonly cited treatment barriers related to geography, time, convenience, finances, or embarrassment of being seen at a counselor's office (Anderson, Carlbring, & Grimsrud, 2008). Online therapy gives clients the convenience of receiving treatment in their homes from experts who may be thousands of miles away. Many families with young children are likely to prefer virtual therapy instead of traditional therapy in a clinical setting (Richards et al., 2014).

Research suggests that online therapy may be effective in the treatment of anxiety (Riva, Molinari, & Vincelli, 2002), depression (Richards et al., 2014), and excessive drinking (Linke, Brown, & Wallace, 2004). As a result of increasing frequency of online mental health interventions, new ethical guidelines have been developed for counselors providing treatment online (American Counseling Association, 2014; American Telemedicine Association, 2013). These ethical guidelines address common concerns such as confidentiality, avoiding harm, competence, informed consent, licensure reciprocity, and duty to report neglect, abuse, or suicidal ideation (Midkiff & Wyatt, 2008). In addition, software and Internet companies have

addressed the prominent concern of confidentiality by offering encrypted, secure sites that are HIPAA and HITECH compliant.

Although CPRT has been shown to be effective in a face-to-face setting, there have been no studies measuring the effectiveness of delivering CPRT in an online format. The purpose of this study was to answer the following research questions:

1. To what extent does CPRT in an Online format effect levels of parental acceptance of their children?
2. What are parental perceptions of the benefits and challenges of CPRT in an online format?

Method

The first author conducted a mixed-methods simultaneous triangulation design, collecting quantitative data to answer Research Question 1 and qualitative data to answer Research Question 2 (Creswell & Plano Clark, 2007). By combining both qualitative and quantitative data, a more holistic and full picture emerges of the process of CPRT in an online format. Punch (2009) stated, "we cannot find out everything we might want to know using only one approach, and we can very often increase the scope, depth, and power of our research by combining the two approaches" (pp. 294–295).

Participants

A convenience sample was sought from parents who had an online connection to the first author's website and social media channels. To recruit participants, a series of emails were sent to subscribers of the first author's newsletter; advertisements were posted on her website and social media channel; and printed versions of the advertisement were posted at local children's ministries and schools. An a priori analysis revealed that this study required 34 participants to attain a medium effect size (.15), a power of .80, and alpha of .05. Since average attrition rates for online therapies have been reported to be 20% (Al-Asadi, Klein, & Meyer, 2014), the recruitment goal was set at 42 parents.

When potential participants contacted the researcher, they were provided with an Internet

link to a survey to determine if they met the following inclusion criteria: (a) parent or primary caregiver for a child between the ages of 3 and 10 years; (b) ability to conduct an uninterrupted 30-min play session with their child each week; (c) high speed Internet; (d) video camera with the ability to upload recorded videos to a private YouTube channel; (e) Internet-connected device with a webcam that can access a secure online platform; (f) a free account to log into a secure online platform; (g) ability to obtain required toys for the special play times; (h) ability to commit to 10 weekly online training sessions, 10 weekly online video group sessions, and 7 weekly special play times with their child; (i) read, write, and speak English fluently; (j) not taken any parenting training programs within the last 2 years; (k) child has not been in counseling within the last 2 years; (l) willingness to complete a pretreatment assessment and a posttreatment assessment, as well as a post-treatment survey; and (m) available during one of the specified time slots for a synchronous, online-video group session lasting approximately 45 min.

Instruments

For the quantitative data collection, the Porter Parental Acceptance Scale (PPAS; Porter, 1954) was administered to participants pre- and posttreatment. The PPAS (Porter, 1954) was created by Blaine Porter in 1954 as a 40-item self-report inventory that measures parental acceptance levels as indicated by the parent's feelings and behaviors expressed with, toward, or about their child. PPAS has four subscales that measure (a) appreciation of the child's uniqueness; (b) respect for the child's feelings and his or her right to express them; (c) recognition of the child's need for independence and autonomy; and (d) unconditional love. These domains of the PPAS (Porter, 1954) are similar to the treatment goals of CPRT, making it an appropriate choice for this study.

Porter (1954) documented a split-half reliability correlation of .76, which was modified to .86 by the Spearman Brown Prophecy formula, significant beyond the .01 level. Validity of the assessment was determined by the agreement of at least three of five expert judges on each of the 40 items. Burchinal, Hawkes, and Gardner (1957) explored the internal consistency of the

PPAS by an item analysis and determined that 39 of the 40 items identified a distinction between low and high scoring parents at the .001 level of probability.

For the qualitative data collection, an open-ended eight question online survey was developed to assess participants' perceptions of CPRT in an online format. Sample questions were "please discuss the perceived benefits of an online format for this parent training" and "please discuss the drawbacks." A pilot test of the perception survey was conducted with three individuals who had previously completed online training. The three individuals represented varied ages, occupations, and online training experiences. In each case, the individual provided sufficient and appropriate responses to the survey questions, and offered only positive feedback about the survey itself. Participants completed this self-report survey through an online format after the last CPRT session.

Procedures

Participants who met the above listed inclusion criteria were directed to the first author's website to complete the institutional review board-approved informed consent form. The participants were required to watch a weekly 45- to 60-min CPRT training video developed by the researcher that discussed content, demonstrated skills, and explained homework in accordance with the content in the CPRT treatment manual (Bratton, Landreth, Kellam, & Blackard, 2006). These prerecorded videos served as a primer to allow more time for group discussions of the content during synchronized online-video group sessions. The content of the videos followed the CPRT treatment manual exactly. Specifically, Session 1 covered reflective responding; Session 2 principles of a play session and toys; Session 3 play session dos and don'ts, Session 4 limit setting ACT (e.g., Acknowledge the feeling, Communicate the limit, Target an alternative); Session 5 limit setting review; Session 6 choice giving; Session 7 self-esteem building; Session 8 encouragement versus praise; Session 9 using skills outside the play session; and Session 10 review rules of thumbs and other things to remember (Bratton et al., 2006).

Fidelity to the CPRT treatment manual was ensured in two ways. First, the researcher who

provided CPRT and developed the videos has the following credentials: a master's degree in counseling from a CACREP-accredited university; is a licensed mental health counselor; completed 12 hr of graduate coursework in play therapy and filial therapy, which was taught by a registered play therapy supervisor; has 5 years of experience teaching CPRT face-to-face; and maintains an active online presence. Second, two master's level therapists trained in filial therapy and CPRT were asked to watch the training video for Week 1. Both therapists indicated that the content aligned with the manualized protocol and that there was fidelity to the CPRT protocol.

Participants were also required to login to a secure online platform at their assigned group time and participate in the weekly live, synchronous online-video sessions that allowed for discussion of content, concerns, peer support, group dynamics, and review of one or two parents' weekly play session with their child of focus. These group meetings lasted approximately 45 min each. Beginning in the third week, participants began their weekly 30-min play sessions with their child and were required to record these sessions. Parents were required to upload at least one of their seven videos to YouTube under a private setting so that it could be viewed during the synchronous group session.

Online security was maintained through several mechanisms. First, the unique login that was provided to the participants had no personally identifying information, thereby protecting confidentiality. The participants also created or used an existing account username to login to a specific, secure online platform. Participants were informed that they could create usernames that would protect their identity. The participants also either created or used an existing YouTube username to upload special playtime videos with a privacy setting so that only the first author could access the video. The researcher's website and the secure online platform were encrypted to prevent unauthorized access and protect confidentiality and privacy of communication.

Compliance criteria for the participants was strict. Throughout the 10-week training, participants either withdrew voluntarily from the study or were informed that they could no longer participate for not meeting compliance cri-

teria. If a participant missed four group online-video sessions, without arranging to join a different group for a makeup session, she was excluded from the study. This was to ensure that data collected in the posttreatment assessment would reflect differences due to the training and not chance. All pretreatment data from participants who did not complete the 10-week training were removed from the data pool and were not included in the analyses.

Analyses

Prior to beginning online CPRT and at the end of the 10-week training period, parents were asked to complete the PPAS (Porter, 1954). Data were entered into SPSS. The PPAS (Porter, 1954) total scores and four subscale scores were analyzed by conducting a paired samples *t* test to determine whether statistically significant differences existed between pre- and posttests. Effect size was also calculated to determine practical significance.

In addition, parents completed the perception survey after completing the training period. The participant survey data were coded and themes were extracted. The researcher consulted with two other professionals throughout the coding process to confirm codes and themes.

Results

Forty-nine potential participants expressed an interest in the study. However, only 31 met the inclusion criteria. Of these, 22 completed the informed consent and were admitted. Only 15 completed the first week's requirements, and only 8 participants completed the entire study. The reasons participants gave for not remaining in the study included going on vacation for 3 weeks, being too busy at work, and being admitted to the hospital. The attrition rate was 46.67%.

The 8 participants who completed the study were female. Five participants were Americans living in the United States. Three of the participants were from other countries; 1 was from South Africa, and 1 was originally from Norway living in England. Of the 8 participants, 7 reported their ethnicity to be not Hispanic or Latino, and 1 reported her ethnicity to be Hispanic or Latino. All 8 of the participants reported their race as White. The range of ages of

participants was 24 to 39, with a mean age of 33 years ($M = 33$). Education levels varied, but every participant completed at least 2 years of college. Six of the participants were married, and 2 were unmarried. The participants had children ranging from three to 10 years old, with a mean age of 6 years old ($M = 6$). All 8 of the participants focused their play sessions on their biological children. Six participants chose to focus their play sessions on their sons, and 2 participants chose to focus on their daughters.

Parental Acceptance

Results indicated a statistically significant increase and practical significance in the PPAS total score and two of the four subscales. Specifically, analysis of the PPAS total score pretest ($M = 140.88$, $SD = 16.81$) and posttest ($M = 164$, $SD = 13.07$) indicate a statistically significant increase $t(7) = -3.51$, $p = .01$, with a large effect size ($d = .82$). The Respect for the Child's Feelings subscale pretest ($M = 36$, $SD = 3.74$) and posttest ($M = 44.38$, $SD = 3.54$) showed a statistically significant increase $t(7) = -4.99$, $p < .01$, with a large effect size ($d = .88$). The Autonomy subscale pretest ($M = 39.13$, $SD = 5.03$) and posttest ($M = 46$, $SD = 3.67$) also showed a statistically significant increase, $t(7) = -6.11$, $p < .01$, with a large effect size ($d = .92$). However, the Appreciation of Child's Uniqueness subscale pretest ($M = 34.75$, $SD = 5.92$) and posttest ($M = 39.63$, $SD = 5.53$) did not show a statistically significant improvement, $t(7) = -1.7$, $p = .20$, but did have an effect size in the small to medium range ($d = .47$). Likewise, the Unconditional Love subscale pretest ($M = 30.88$, $SD = 8.40$) and posttest ($M = 33.38$, $SD = 12.73$) did not show a statistically significant improvement, $t(7) = -0.8$, $p = .45$, but did have a small effect size ($d = .29$).

Positive Perceptions

Participants were asked to discuss the perceived benefits of CPRT in an online format. Coding of these positive perceptions resulted in several themes as are described in the following sections.

Convenience. The most prominent theme was convenience with 100% ($N = 8$) of the participants mentioning this benefit. Parti-

cipants described convenience in a number of ways as indicated subsequently.

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

Accessibility. Half of the participants ($n = 4$) reported that the online training format allowed them to watch videos and assess the material at any time. One participant replied,

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

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

From home. Half of the participants ($n = 4$) indicated that they believed that competing the entire training at home was also a benefit, particularly because they did not have to arrange for childcare. A participant reported,

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

Global access. Three of the participants (38%) expressed that being able to access the training from anywhere in the world was beneficial because they lived outside the United States. Participants ($n = 2$, 25%) also accessed the training while traveling for work or vacation. One participant said,

The online format makes it possible to have access to parent training even if you are on the other side of the globe! We live in a small town in South Africa, and if it wasn't for this online training course, I probably would never have had the opportunity to learn and practice the play therapy skills I acquired during this online training. I do not know of any play therapists in our area.

Sharing in the online hangout. Another theme that emerged was the online interaction. Five of the participants (68%) responded that the sharing and camaraderie within the group via a secure online-video platform was very positive. The group dynamic of support and encouragement is a large part of the CPRT training, and the online format was no exception. One participant said, "Enjoyed support and community with other moms" in the group sessions. Another participant enjoyed "getting to know other parents and watch their play sessions" during the group sessions.

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

Personal benefit. A final positive theme that emerged was personal benefit. Five of the participants (62%) responded that they gained great personal benefit for themselves, their parenting skills, and their family by participating in the training. One participant said, "I saw immediate benefits in my relationship with my kids. I learned skills that I otherwise would not have been exposed to that have improved my interactions with my kids on a daily basis."

Negative Perceptions

To elicit negative perceptions, participants were asked to discuss the perceived drawbacks of an online format for parent training and to indicate what they liked least about the online format.

Technical difficulties. Three of the participants (38%) indicated that Internet connectiv-

ity and technical difficulties were drawbacks. Two of these participants were in South Africa, where there are noted bandwidth issues causing delays in the uploading and viewing of videos. One participant responded, "In RSA, some weeks it was a real challenge to watch the whole video end to end, as our bandwidth was limited and caused the video to buffer a lot."

Length of the group online video sessions. Three of the participants (38%) responded that the synchronous group online-video sessions were too short each week. Each session was scheduled for 45 min so that the participants were able to talk with the other moms and go over questions and concerns. One participant said, "I felt the time of 45 minutes for a group was too little and by wanting to ask more questions I felt a bit that I would be of bother to all, since time always went above."

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

Discussion

Parental Acceptance

Overall, these results suggest that CPRT in an online format did improve participants' parental acceptance, particularly in respecting the child's feelings and autonomy. These findings are consistent with face-to-face CPRT studies that also showed an increase in levels of parental acceptance (Costas & Landreth, 1999; Kale & Landreth, 1999; Tew et al., 2002; Yuen et al., 2002). Statistically significant increases in respect for the child's feelings and recognition of the child's need for autonomy were not surprising since these subscales correspond with major skills taught in the CPRT training. Parents received extensive training in reflecting their child's feelings, allowing children to lead the play time, and returning responsibility. Previous

studies such as [Tew et al. \(2002\)](#) also found parents who participated in filial therapy scored significantly higher than parents in the control condition on respect for the child's feelings and recognition of the child's need for autonomy.

Although the Unconditional Love subscale did not indicate a statistically significant increase, it did reflect a change in that direction. The 10-week training program may not be long enough to cultivate a fundamental change in a parent's approach to expressing unconditional love for their child. Testing the participants after they practiced the skills for a longer time period may have shown an additional increase in unconditional love toward the child. Another reason for this finding may be that [Porter \(1954\)](#) reported that the Unconditional Love subscale correlated less well than the other scales with the total score.

Although the Appreciation of Child's Uniqueness subscale did not show a significant difference, the mean score was higher after the training. A possible reason for this finding could be conflict between the wording of the questions and CPRT skills. For example, one question asked, "When my child is unable to do some things as well as others in the group, I . . ." CPRT teaches parents to "encourage him/her to keep trying" but the PPAS ([Porter, 1954](#)) scores this response as neutral rather than positive.

Benefits of Online Format

Convenience was the most prominent positive perception of CPRT in an online format. This finding is consistent with previous research that notes accessibility as a benefit of online counseling. [Speyer and Zack \(2003\)](#) stated, "Online counseling offers convenience and remote access, serving clients with limited mobility, time restrictions, or anyone seeking help who is reluctant to see a counselor in person. It makes keeping appointments at a specific time and place unnecessary" (p. 11). The convenience of CPRT in an online format overcomes the common barrier of distance and time required in clinical settings ([Richards et al., 2014](#)). Mothers in particular seem to be wary of adding another responsibility or obligation due to limited time. The results of this study indicate parents with limited time may be able to achieve their goal of obtaining parent training in a time-

sensitive fashion through CPRT in an online format.

The synchronous group online-video sessions each week was another perceived benefit because the interaction helped create a sense of community within the participants. This important finding shows that a key CPRT element of mutual support and encouragement among participants is viable in an online format.

User experience was another essential ingredient to the success of CPRT in an online format. Participants reported appreciating the well-organized presentation of the material and the content. They complimented the user-interface and easy-to-navigate website. Participants also appreciated the high quality of the training videos. [Donald Norman \(2002\)](#) confirmed the importance of designing a user-centered website:

Think of the user's point of view. Assume that every possible mishap will happen, so protect against it. Make actions reversible. Try to make them less costly. Make the results of each action apparent. Make it possible to determine the system state readily, easily, and accurately, and in a form consistent with the person's goals, intentions, and expectations. (p. 140)

Website functionality and an aesthetically pleasing format are important to consider when designing an online training.

Recommendations for Overcoming Drawbacks

Technical issues were a reported drawback but only for the 2 participants from South Africa and the one participant who had a slow Internet connection. One of the requirements of the training, per the inclusion criteria, was high-speed Internet. Participants with technical difficulty may not have understood the impeding impact of a limited Internet connection prior to beginning the parent training. Therefore, it is recommended that counselors ask prospective online parents to view an online test video and participate in a short synchronous discussion prior to beginning formal CPRT in an online format.

The length of the group online video sessions was perceived as too short by the participants. They stated the limited time hindered the amount of sharing, interaction, questions, and discussion about concerns, issues, or the material. Traditional, face-to-face CPRT group meetings typically last 90 min. The online

Group Hangout was modified to 45 min because participants were required to watch a 45- to 60-min prerecorded asynchronous teaching video prior to the synchronous Hangout. Nevertheless, participants desired more interaction time with the instructor. Therefore, it is recommended that online hangout sessions be extended to 60 min.

Paradoxically, although participants positively perceived the convenience of the online format, some perceived the virtual group setting as a drawback. Participants did not engage in spontaneous, in-the-moment conversation that would have been easier in a traditional, face-to-face format. Rather, they appeared to wait for the therapist to moderate conversation rather than freely adding to the conversation. This aligns with a previously conducted study revealing that students had “slightly more positive perceptions about the instructor and overall course quality” when the training was conducted face-to-face as compared with an online delivery of the training, even though “the two methods of delivery were reported to produce no difference in several measures of learning outcomes” (Johnson, Aragon, Shaik, & Pama-Rivas, 2000, p. 29). A recommendation to address this drawback came from a participant who said: “It helped a lot when you said ‘E, will you please share . . .’ instead of ‘Who would like to share?’ It was hard to anticipate who is going to start talking first and then we ended up staring at each other.”

Implications for Practice

The most salient implication from this study is the potential for play therapists to expand the scope of their practice to serve a vast number of parents who otherwise would not receive treatment due to access, distance, and other barriers. These study participants were unable or unwilling to receive CPRT in any other way than through an online format as indicated by statements such as “if it wasn’t for this online training course, I would never have had the opportunity to learn and practice the play therapy skills.” Even in the online format of CPRT, participants were still able to achieve an important treatment goal of increasing parental acceptance, and some reported improvement in their relationship with their children. Therefore, this study provides play therapists with needed evi-

dence that an online delivery option of CPRT is effective. However, before attempting to offer CPRT in an online format, play therapists must seek appropriate training and supervision in CPRT.

A related implication is that those who are interested in providing online CPRT must have a sufficient background and competency in Internet and website technology. It is not enough to just be trained in the therapeutic intervention. Rather, the ability to interface the existing training with the technological platforms and capabilities is crucial. If play therapists do not have these skills, they can hire website consultants to develop an aesthetically pleasing and technologically sound website. In addition, play therapists must be aware of the ethical and legal standards related to online treatment in their particular jurisdiction for their particular license (American Counseling Association, 2014; American Telemedicine Association, 2013). For example, some states (e.g., Arkansas) require additional certification to provide counseling services using distance technology.

Another implication is that universities offering graduate courses in play therapy and CPRT might begin to integrate technology and virtual elements into standard curriculum. As the world becomes more virtually connected through the Internet, it is critical for the counseling field to remain relevant and helpful by merging counseling interventions with technical capabilities. This study indicates that the future of parent training may not be in a therapist’s office but in homes where parents can partake in treatment from their living rooms on their laptops. Universities need to prepare their counseling students for this worldwide opportunity.

Limitations and Future Directions

Two significant limitations in this study, power and generalizability, are both related to the small sample size ($n = 8$). As indicated above, although 49 potential participants were recruited for the study, only 22 were admitted to the study and 8 completed the study. The small sample size and high attrition rate were due to (a) limited time of 4 weeks for recruitment, (b) stringent inclusion criteria, (c) required 10-week commitment of 2 to 2.5 hr a week, and (d) an inconvenient timeframe corresponding to the end of children’s school year and start of sum-

mer vacations. In addition, the high attrition rate may have been impacted by the fact that there was no financial cost to the participants, which may have lowered participants' perceived value of the training (Sawyer, 2014).

Power. An a priori power analysis revealed that this study would require 34 participants to attain a medium effect size (.15), a power of .80, and alpha of .05. As a result of the study being underpowered, there is a greater chance of a large effect size (Gelman & Weakliem, 2009). Consequently, it is more difficult to determine whether CPRT truly had the effect that the data revealed. Therefore, only preliminary conclusions should be drawn from this investigative study, even though the outcomes were positive.

Generalizability. The small sample size ($n = 8$) did not represent the world's population regarding race, ethnicity, and gender. All eight of the participants in this study were White females, which does not accurately reflect the race nor gender distribution in the world. Because 7 of the 8 participants reported as non-Hispanic, and only one reported as Hispanic, the sample did not reflect worldwide ethnic distribution.

As a result of the bias in the sample, it is difficult to assess whether these results would be observed with other racial and ethnic groups, or with fathers. Therefore, although the sample in this study had participants from around the world, it is not reflective of outcomes that would be replicated with all races, ethnicities, or fathers.

One other limitation of this study was the particular online-video platform that was used. Although it was encrypted, it does not currently meet HIPPA, HITECH, and FERPA compliance and the particular company does not execute Business Associate Agreements (BAA) for their online-video platform. Play therapists and future researchers should only use HIPPA, HITECH, and FERPA compliant platforms that execute BBA such as eVisit, Thera-link, Doxy.me, or others listed at <http://telehealth.org/video/>

Future Study

Because of the small and biased sample size, it would be prudent to replicate this study with a larger and more representative sample. Allow-

ing more time for recruitment and targeting diverse populations will aid in obtaining the needed diverse sample. A randomized control study would also increase the generalizability of findings.

Future researchers may consider offering CPRT in a condensed 8-week format. Some study participants stated some of the weeks' materials could have been combined. Considering the high attrition rates in this study, an 8-week format may help increase initial interest in the study or decrease high rates of attrition.

Finally, future researchers may consider conducting a follow up assessment of the PPAS (Porter, 1954) 6 months posttreatment to measure the longitudinal effects of CPRT in an online format compared to a traditional, face-to-face format. Asking participants whether or not the child and parent have continued play sessions might offer insight into whether measured outcomes are related to the continual practice of the learned skills.

Conclusion

Approximately one in five children have mental health concerns (Perou et al., 2013). Yet, many parents do not seek mental health treatment for their children due to barriers of time, distance, and access. Parents of young children are likely to prefer and embrace online treatment that would overcome these obstacles. CPRT has been proven to be an effective children's mental health treatment in a traditional, face-to-face format. However, until this study, there was no evidence that CPRT would be effective in an online format. This study demonstrated that participants had statistically significant increases in parental acceptance after receiving CPRT in an online format and reported overwhelmingly positive perceptions of the online format.

These findings open up vast and expansive opportunities for counselors to reach children and their families by providing CPRT in an online format. By doing so, counselors could improve children's mental health by increasing parental involvement and parental acceptance of their children. Online CPRT groups can be easily organized, facilitated, and managed by counselors who are trained in CPRT and have Internet technology skills or resources. In so

doing, counselors can have a worldwide impact on children's mental health.

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