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PAKISTANI MOTHERS AS A THERAPEUTIC AGENT: CHILD-PARENT RELATIONSHIP THERAPY ON CHILDREN EXPOSED TO TRAUMA WITH INTERIALIZING AND EXTERNALIZING BEHAVIOR

Tayyaba Hanif[1*], Dr Iram Gul[2]

[1*]Lecturer, COMSATS University Islamabad, Ph.D. Scholar, Fatima Jinnah Women University, Rawalpindi.
[2]Associate Professor, Fatima Jinnah Women University, Rawalpindi, Email: iramgul@fjwu.edu.pk

***Corresponding Author:** Tayyaba Hanif
COMSATS University Islamabad, CUI Faculty Block-I Third Floor Department of Humanities Park Road, Tarlai Kalan, Islamabad 54440, Pakistan Tel: +923219196678 www.comsats.edu.pk, Email: tayyaba_hanif@comsats.edu.pk

Abbreviation
CPRT: Child-Parent Relationship Therapy
CABI: Child and adolescent Behavior Inventory
CATS-C: Child and adolescent trauma screen-Caregiver

Abstract
The aim of the study to examine the effectiveness of child-parent relationship therapy in decreasing externalizing and internalizing behavior among children exposed to trauma. It was conducted in Pakistan's twin cities (Rawalpindi and Islamabad).The selection of participants was based on inclusive criteria. Participants were selected using a purposive sampling technique. There were *N=60* mothers of children exposed to trauma in total were included as research participants and equally divided into intervention and control groups. CATS-C was used for screening children's trauma symptoms. CABI was used to assess the behavior of children in terms of externalizing and internalizing. CPRT therapeutic techniques were instructed to experimental group for 10 weeks in ten sessions. Results indicated that overall behavior of children were significantly difference between the pre-and post-tests for the intervention group with $t(29) = 9.78, p<.000)$ and Cohen's d 0.57 medium effect size and $r=.95, p<.000)$. In the intervention group, CPRT significantly reduced externalizing and internalizing behavior in the children as compared to control group, and the results showed that CPRT therapeutic techniques show its impact on children's behavior. A study has demonstrated that CPRT improves overall behavior, especially internalizing and externalizing behavior in children. The study implies that the behavior therapist, family therapist, school psychologist and play therapist will use it as a therapeutic training program for parents to contribute to their children's life.

Keywords: Child-parent relationship therapy (CPRT), Children Internalizing and Externalizing Behavior, Exposed to trauma.

Introduction

Children behavioral difficulties, such as externalizing and internalizing, have drawn a growing amount of attention from developmental psychopathology researchers in recent years (Cartwright, 2005). Identification of externalizing problems in children early on in their development is crucial In addition to peer pressure, parenting styles, parenting practices, and the environment, multiple etiological factors contribute to children's externalizing symptoms (Darling et al., 2006). There is evidence that children with externalizing behavior problems have negative interactions with their environments (Campbell et al., 2000; Eisenberg et al., 2001). "Externalizing behavior" refers to a variety of behavioral problems exhibited by children toward other individuals, objects, or events. "Internalizing behavior" refers to a child's emotional or psychological state and is commonly used to describe somatic complaints, anxiety disorders, and depressive disorders. Internalizing disorders are inward-focused and reveal a child's emotional and psychological health (Liu, 2011). The relationship between children and their parents greatly influences their actions and results. It is possible to negatively impact a child's development and negatively impact their behavior if their parents do not know how to interact with them (Baumrind, 1991). In addition to family dynamics, prior child abuse, exposure to neighborhood violence, and family conflict, there are several social-level risk factors (Higgins, & McCabe, 2001).

It has been demonstrated by researchers that CPRT is one of the most popular and successful parenting programs available for reducing children's behavioral problems. The purpose of play therapy therapists is to teach parents how to assist with the treatment of their children through child-centered play therapy and cognitive behavioral therapy (CPRT) (Landreth and Bratton, 2006). In addition to learning some basic skills, parents will also learn how to improve their children's self-esteem, recognize feelings, and listen carefully to them. Through this type of training, parents can learn how to foster a positive relationship between themselves and their children by creating a supportive, understanding environment. This CPRT parenting training package provides an extensive list of resource materials, including treatment outlines, study guides for therapists, parent handouts, guidelines for using toys, and additional materials for conducting a 10-session training program with parents whose children are exhibiting behavioral problems (Landreth and Bratton, 2006).

Person-Centered Theory, originally proposed in 1951 by Rogers, can assist parents and children in developing therapeutic play together. It is fundamental human characteristics such as growth and change that characterize an individual's "becoming" and striving for self-actualization. The goal of person-centered counseling is to provide children and their parents with the environment and stimulation they need. The helper's role is to foster a sense of optimism, empathic connection, and playful interaction with the child and to provide an environment that promotes their ability to express themselves freely. According to Rogers 1951, the helper encourages self-actualization by fostering a sense of optimism, empathy, and play. It has been observed that many of the problems that children face is the result of their parents' ignorance. According to Rogers' theory, the goals of CPRT for children are to reduce behavioral symptoms, develop coping mechanisms, boost positive self-confidence, and strengthen the bond between parents and children (Landreth and Bratton, 2006). The behavior of traumatized children in social, familial, and academic contexts can be affected by several problems (Van der Kolk, 2005). The effects of these traumatic events can last for years, especially if they are frequent and public (Cloitre et al., 2009). PTSD, anxiety, and hopelessness can be long-term consequences of trauma on the mental health of individuals. A traumatized individual may have difficulty establishing healthy relationships and may abuse drugs and alcohol. As a result, victims become more likely to become victimized as adults once they become adults (Kimerling et al., 2007). Pakistan has a prevalence rate of 57 percent for physical violence, which is more prevalent among male victims (68 percent) than female victims (46%). The research study found that physical abuse accounted for 57% of all types of abuse (46% for genders and 68% for genders) (Abbas & Jabeen, 2019, p. 125). Child emotional abuse occurs when a child is psychologically manipulated to prevent them from developing appropriately mentally and socially (Nekokara, 2021). Psychological abuse, physical neglect, emotional abuse, and neglect in childhood make children more susceptible to

personality disorders in adulthood. In later life, people with personality problems are more likely to experience traumatic events during childhood. Children may experience trauma because of maladaptive schemas. The relationship between early maladaptive schemas and childhood trauma can be explained by early maladaptive schemas (Alisic et al., 2018). Most of the abuse occurs because of emotional abuse (54% for women and 53% for men). As well as physical neglect, neglect can also include medical, psychological, and educational neglect. The percentage of people who are neglected is 40% (80% women and 20% men). Neglect can negatively affect a child's health, development, and well-being for years to come. A child's safety and well-being depend on recognizing the warning signs of neglect and taking appropriate action. According to the survey, 39% of women and 44% of men had been abused sexually. Parents (20%), friends (16%), and instructors (14%), in that order, were the most reported offenders (Abbas & Jabeen, 2019, p. 125)

Recent research indicates that child-parent relationship therapy (CPRT) can improve parent-child interaction and change parents' attitudes or behaviors. it was evaluated for its efficacy in treating chronically ill children. Parent participants in the filial therapy training group reported a significant reduction in challenges their children were facing and in parenting stress (Tew et al., 2002). Parents can learn some key concepts in CPR training that will help them understand their kids better and reduce behavioral issues, all while strengthening their relationship with their children. Based on the 10-session CPRT model, the following studies have been conducted to reduce behavioral issues in children and change parents' perceptions of their Children (Landreth and Bratton, 2006). According to the study, the stress levels of parents and children's behavior had significantly decreased. A quasi-experimental study was conducted on 14 Hispanic parents who spoke English and had children from two Texas elementary schools with externalizing problems (Villarreal, 2007).

The study randomly assigned parents to one of two waitlist control groups and one of two CPRT groups. A statistically significant reduction in externalizing behaviors was reported by parents in the CPRT group. The effectiveness of CPRT was examined by 24 parents of elementary school students with behavioral problems. The CPRT training program was adapted and used at the school to investigate parents' perceptions regarding the program (Foley et al.,2006). To examine specific elements of the CPRT training program, qualitative research methods were used to analyze the experiences of six parents who were enrolled in the program. After being assigned to the control waitlist, twenty-four additional parents were included in the experimental group. In the experimental group, those who used CPRT and completed pre- and post-tests reported significantly less externalizing (Ceballos, 2008). Thirty parents enrolled in a CPRT program whose children ranged in age from 3 to 10. Children with externalizing behavior problems showed significant differences between pre- and post-test results after CPRT intervention (Reed, 2009).

Researchers examined how CPRT changed non-warm parents' empathy, child behavior, and relationships with their children. Eight parents from both the experimental and control groups participated in the 11-week CPRT program. Furthermore, each parent completed a post-interview form detailing the qualitative changes they experienced, including improved communication, greater acceptance, improved parent-child relationships, positive behavior changes, and a noticeable improvement in discipline. Research shows that parenting stress is reduced, and children's behavioral issues were also reduced (West, 2010). Another research study evaluated the effectiveness of CPRT in the treatment of separation anxiety disorder in children. The design of this quasi-experimental study included pre- and post-tests, as well as a control group. A study was conducted on preschoolers and first-graders in Iran, Additionally, the study facilitated mother-child relationships and enhanced mothers' self-efficacy, which resulted in a reduction in mothers' stress. In addition to being an effective intervention and reduce the symptoms of a child's separation anxiety, CPRT can also be used as an educational protocol to reduce tension, boost mothers' self-efficacy, and enhance mother-child relationships (Ahmadizadeh et al., 2022, p. 20). Play-based parenting was the focus of the study. The main variables of the research study were child behavior, mindfulness parenting, and parent-child relationships. Quantitative and qualitative data were collected using a mixed methods design. There was a significant difference between mindfulness discipline in parenting and social support after

program participation. A significant change was observed in peer interactions. Despite the lack of quantitative measures, the program positively impacted parent-child relationships. While the limited sample size and weak statistical power of updated online play-based parenting programs limit their ability to meet COVID-19's parenting demands, the results suggest that they may nevertheless fit the needs of COVID-19 (Wisen-Vincent & Bokoch, 2023, p. 37).

Since it can useful and important outcomes in Pakistan (Rawalpindi and Islamabad). This investigation aims to fill the knowledge gap by investigating how CPRT affects children's externalizing and internalizing symptoms due to exposed to trauma. Child-parent relationship therapy (CPRT) has been shown to improve a child's externalization and internalization of behavior indicators through the modification of behavior by their mothers as a therapeutic agent.

Material and Method

Objectives

The objective of the current study was to assess the efficacy of CPRT to decrease internalizing and externalizing behavior of children exposed to trauma.

Hypothesis

CPRT would demonstrate reduction in mean scores on children behavior in terms of internalizing and externalizing behavior within and between waitlist control group and intervention group of time I (baseline assessment) and time-II (post-intervention).

Participants

The purposive and convenient sampling techniques for selection of sample. The sample was selected according to the inclusive sample criteria were also included the mothers of children between the age group of 3-10 years of both gender and whose exposed to traumatic event: Child Abuse Physical abuse, Emotional Abuse) or witness of abuse, yelling on child, Bullying (verbal Bullying or physical Bullying), Fighting (street fighting or home Fighting) or witness of fighting, fighting within family, Traumatized Grief (death of loved one, parent or grandparent, to whom child was closed) , Parents' Separation and witness of Robbery. Furthermore, English proficiency was also on the list of inclusion criteria for the sample. As part of the traumatic events screening assessed the child through CATS-C) , Sachser et al. (2017, p.189). An intervention study involved 100 participants and volunteer mothers. Following screening and randomization, n= 60 research participants were selected for the intervention phase randomization process of RCT, and the group size was calculated by using G* power software. The process of randomization resulted in (*n=30* experimental and *n=30* control groups). There were six subgroups in the experimental group. Each group had 6-7 research participants as required by the CPRT protocol. Research participants in the intervention and control groups have the same sociodemographic characteristics. The average age of mothers was 36.8 years, the average qualification was 18 years, and the average child age was 6.6 years. According to CPRT, the children's ages should also be between 3 and 10 years old for special play time with their mothers (research participants). The first step after enrollment was to screen for inclusive and exclusive criteria. Step II Time-1 baseline assessment assessed through study measures and completed screening according to sample criteria. Third step: Randomizing and allocating intervention and control groups. Two groups of 60 participants will be randomly assigned. Both intervention and control groups had an equal sample size.

Process of Priori G Power Analysis*

A priori power analysis G* power software (Faul et al., 2007) determines for independent t-test the minimum effect size $d = .80$, $\alpha = 0.05$, and power $(1-\beta) = 0.80$. Don't put of non-centrality parameter $\delta = 2.88$, critical $t = 2.00$ with $df = 50$ so the sample of Group-I size: $n = 26$ *and* the same for Group-II size: $n = 26$, shows the total group size for this study is $N = 52$. There was $n = 30$ for each group size finalized.

Measures

Child And Adolescent Trauma Screen-Caregiver (CATS-C)

The child and adolescent trauma screen-caregiver (CATS-C) is developed for young children to adolescent. This screen questionnaire has been designed to assess the potential impact of trauma on children and adolescents and the presence of post-traumatic stress symptoms (PTSS). The criteria for the diagnosis of PTSD are based on those provided. It is suitable for use by preschoolers, children, and adolescents. Two versions of the questionnaire are available: one for 3–6-year-olds and one for 7-17-year-olds. A self-report measure is also available online. Children ages 3-6 receive the younger child version, which follows the criteria for PTSD symptoms of DSM-5 (APA, 2013). The administration takes approximately 15 minutes. There are 15 items measuring traumatic events, 20 items measuring symptoms of PTSD, as well as five items measuring psychosocial functioning. It is recommended that children ages 3-6 receive the younger child version of the PTSD symptoms assessment which complies with the DSM-5 (APA, 2013) criteria. A 15-minute administration period is required (Sachser et al., 2017, p.189). In the current study, the coefficient alpha reliability collectively was α=.82.

Children and Adolescent Behavior inventory (CABI)

CABI is a highly effective and reliable tool. A tool such as this may be used before and after the clinical evaluation to identify potential problems as quickly as possible. It can be used to compare parental-provided assessments with children's self-administered assessments (Cianchetti et al., 2013). It is intended for parents and caregivers. It is also useful for screening, epidemiology, and for preparing for and completing clinical evaluations in child and adolescent psychiatry (Cianchetti et al., 2013). It is important to note that normative data sets include three distinct age groups: ages 6–10, 11–13, and 14–18, as well as differences between genders and ages. it assigned two points for each "True" response, one point for "Partially or sometimes true," and zero points for "False/Not true." The raw scores of the CABI items constituting each subscale were totaled and converted into T-scores. A majority of CABI items are based on diagnostic criteria from DSM-IV-TR ((American Psychiatric Association, 2000), which were retained in DSM-5 (American Psychiatric Association, 2013). In the current study, the coefficient alpha reliability collectively was α=.88.

Child-Parent Relationship Therapy(CPRT)

A CPRT treatment manual group guide divided the group into small groups. Each session for the intervention group lasted two hours, for a total of 10 sessions for 10 weeks.

Procedure

After doing a literature review, a gap was identified. The research sample was selected based on inclusion criteria. 100 participants were targeted and sixty were finalized for a randomized controlled trial. The randomization process was completed using a Research Randomizer (2007). Before starting the trial, the ethical review committee gave clearance for conducting an experimental trial. A baseline assessment of the behavior of children was conducted using the following measures: A consent form, a demographic sheet, and the parent version of the CABI (Cianchetti et al., 2013a, 2017b). CATS-C is a tool to assess trauma-related symptoms among caregivers of children who have experienced trauma. Sachser et al., 2017, p.189). Selected research participants were also subjected to ethical considerations. In the group sessions, therapeutic training (Bratton & Landreth, 2019) was implemented. In the sessions, parents were taught several objectives: (1) to gain a deeper understanding of their children; (2) to improve parental skills and the parent-child dynamic; (3) to develop parents' abilities to communicate empathetic understanding and parental support to children; and (4) to encourage self-direction and responsibility. The three Ds are Describe, Demonstrate, and Do. The therapist describes and teaches the skill, then shows a video, then asks parents to role-play. Parental practice of the skill is then encouraged by the therapist. There were 10 sessions for ten weeks and every week there were 2 hr. sessions. In all three sessions, special play time materials were

prepared based on the CPRT therapist manual. Session four to nine implication of therapeutic techniques, all sessions have its own rule of thumbs. Session ten is based on generalization (Bratton & Landreth, 2019). All the special play time videos were shown by each participant. After the ten weeks sessions, the post-assessment was conducted on both groups (experimental and waitlist control group) to examine the efficacy of CPRT on children's behavior.

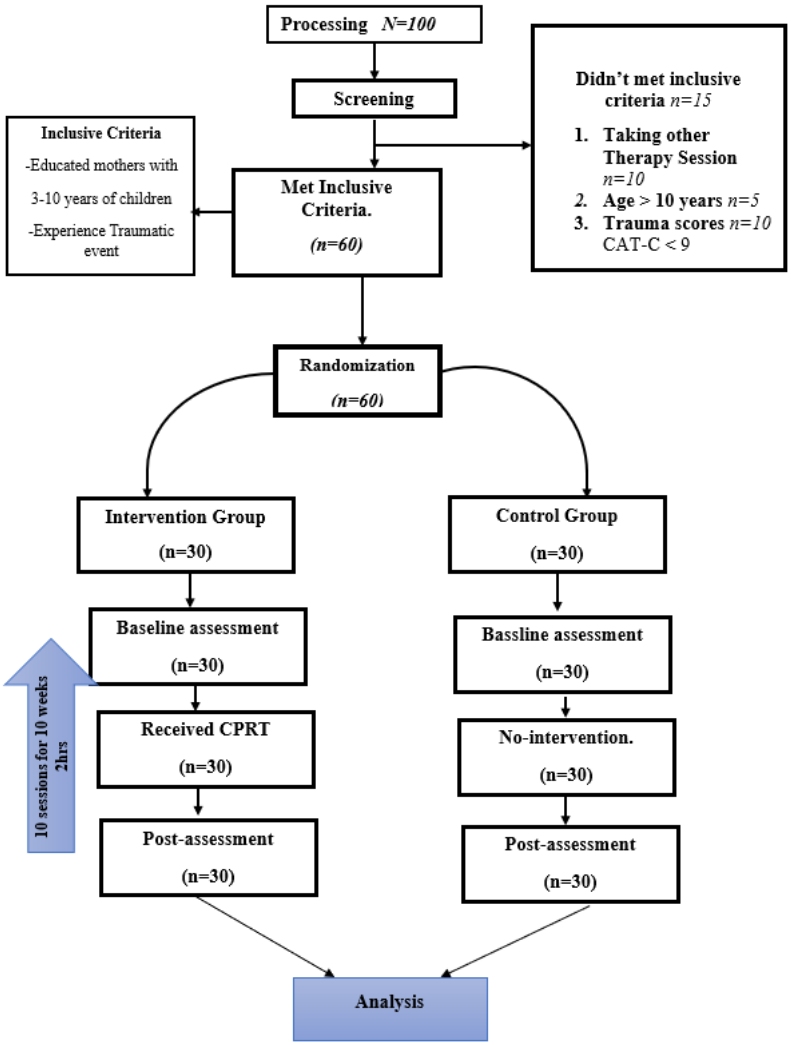
Ethical considerations

The present study complies with the ethical guidelines for research published by the American Psychological Association. Researchers provided informed consent to participants as well as information regarding the study's purpose and objectives. As a second consideration, confidentiality must be considered. Researchers have taken measures to ensure the confidentiality of information and the identity of participants in the current study. The researcher is also having certification of CCPT and CPRT approved by association of play therapy.

Analysis schemes

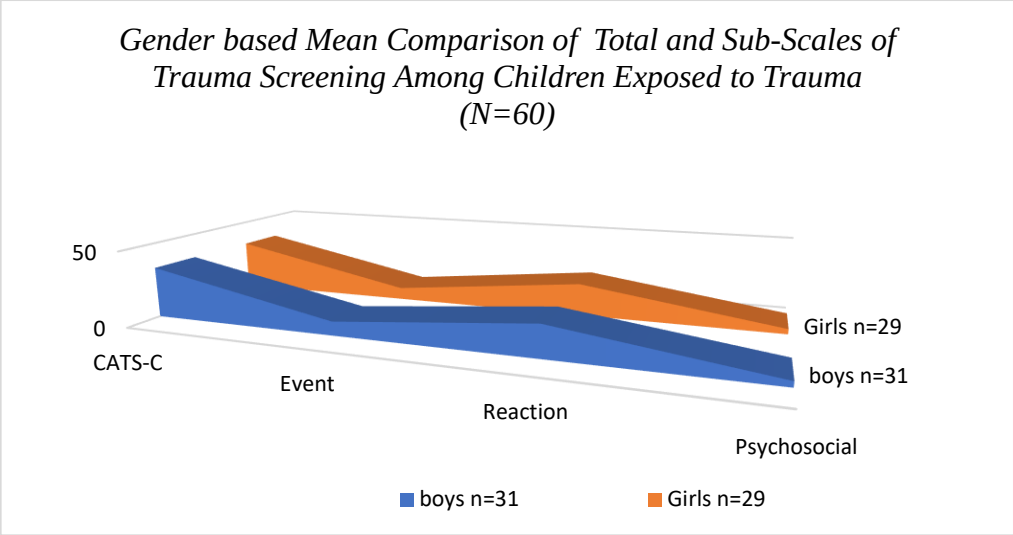
SPSS version 26 was used to analyze the data in this study. The difference between experimental and control groups was assessed using an independent t-test. Additionally, the researcher sought to determine the differences between the pre- and post-tests between the two groups. The Paired t-test was used to determine the differences between experimental and control groups before and after testing.

Figure 1CONSORT Flow Chart of Pilot Study



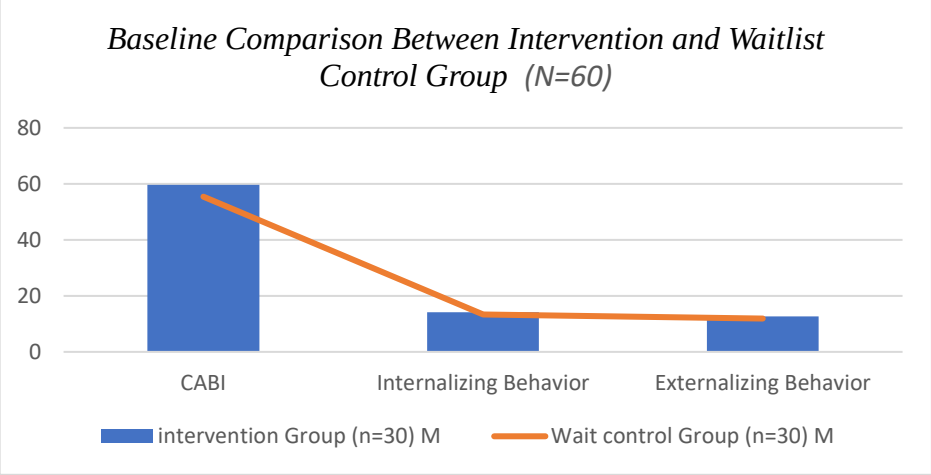
Results

Figure 2



According to Figure 2, trauma screening did not differ significantly between boys and girls *(t (58) = .10).* In total scores of CATS-C, boys scored *(M =33.55, SD = 6.72)* a little higher than girls *(M =33.31, SD = 10.63).* According to Cohen's d, the effect size was small at 0.27. There is no significant difference between the onsets of trauma in boys and girls, *t (58) = 9.13, p>0.05*. It was also a bit higher for the boys *(M =9.13, SD = 3.49)* than for the girls *(M =8.17, SD = 3.64).* The Cohen's d, the effect size was small at 0.26. There was no significant difference between boys and girls in reaction to traumatic events. A boy's reaction score *(M =20.90, SD = 5.56)* was lower than a girl's *(M =21,72, SD = 8.73).* In Cohen's d, the effect size was less than small at 0.11. A non-significant difference exists between boys and girls *t (58) = .34, p>0.05.* Psychosocial factors were higher in boys *(M=3.51, SD=1.81)* than in *girls (M=3.41, SD=1.12).* Whenever Cohen's d size is between .2 and .8, it indicates a small or large effect size (Cohen, 1988, p.82).

Figure 3 *Baseline Comparison Between Intervention and Waitlist Control Group of CABI (N=60)*



In Figure 3, the intervention group exhibited significantly higher scores than the control group, based on independent t-test results. There was no significant difference between the intervention (*M=60.60, SD=12.97)* and control groups *(M=55.43, SD=17.66)* in the (Time-I) baseline comparison. CABI, *t(58) 1.09, p > 0.05*, Cohen's d value 0.25, indicating a small effect size *(< 0.50).* Internalizing Behavior, and externalizing behavior scores were also similar between the groups in the CABI. Generally, Cohen's d values between 0.2 and 0.8 indicate small or large effect sizes (Cohen, 1988, p.82).

Table 1 *Mean Comparison of Time-I (baseline-assessment) and Time-II (Post-Assessment) Intervention group of measure outcomes (N=30)*

Variables	Bassline-Assessment Time-I	Post-Assessment Time-II				Cohen's d
	M(SD)	*M (SD)*	*t(29)*	*r*	*p*	
CABI						
Total Score	59.70(12.10)	52.70(12.26)	9.78	.95**	.00	0.57
Internalizing Behavior	14.13(3.59)	11.53 (3.62)	7.08	.85**	.00	0.72
Externalizing Behavior	13.53(4.25)	11.30(3.77)	6.74	.91**	.00	0.56

*p > 0.01 ** Note. M=Mean SD=Standard Deviation, r= correlation Child and adolescent Behavior Inventory(CABI),*

Table 1 shows that paired t-test statistically significant mean difference has been observed between time-I and time-II of the intervention group. Finding indicates that there was significant mean difference of CABI between intervention group *t(29)=9.78 , p >0.05),* pre-assessment *(M=59.70, SD=12.10)* and post-assessment *(M=52.70, SD=12.26)* Two sets of scores were significantly correlated *r=.95, p > 0.05*. The value of Cohen's d was 0.57 (> 0.80) , which indicates large effect size**.** Total CABI scores significantly difference in mean score within groups. The children's behavior was also significantly different within the group in internalizing and externalizing behavior. The value of The Cohen's d size between< .2 to <.8 indicate small to large effect size (Cohen,1988, p.82).

Table 2 *Mean Comparison Between Time-I(Baseline Assessment) and Time-II Testing of Control Group of Children's Behavior (N=30)*

Variables	Baseline (Time-I)	Post-Assessment (Time-II)				Cohen's d
	M(SD)	*M (SD)*	*t(29)*	*r*	*p*	
CABI						
Total Score	55.43(17.66)	56.70(14.14)	-1.23	.96**	.22	0.07
Internalizing Behavior	13.30(6.62)	14.70(4.88)	-2.42	.89**	.02	0.24
Externalizing Behavior	11.90(6.34)	12.93(3.34)	-2.49	.94**	.01	0.20

*Note. M=Mean SD=Standard Deviation, Child and adolescent Behavior inventory, **P<.001*

Table 54 shows that paired t-test statistically significant mean difference has been observed between time-I and time-II of the waitlist control group. Finding indicates that there was no significant mean difference of CABI between intervention group *t(29)=-1.23 , p >0.05),* pre-assessment *(M=55.43, SD=17.66)* and post-assessment *(M=56.70, SD=14.14).*Two sets of scores were significantly correlated *r=-.98, p > 0.05*. The value of Cohen's d was 0.07 (< 0.80)which indicates very small effect size**.** Total CABI scores non-significantly difference in mean score within groups. The children's behavior was also non-significantly different within the group when comparing externalizing and internalizing. The value of The Cohen's d size between< .2 to <.8 indicate small to large effect size (Cohen,1988, p.82).

Table 3 *Mean Comparison Between Time-II intervention group and Control Group of Measure Outcome (N=60)*

Variables	Intervention Group *(n=30)*	Waitlist Control Group *(n=30)*			Cohen's d
	M(SD)	*M (SD)*	*t(58)*	*p*	
CABI					
Total Score	52.70(12.26)	56.70(14.14)	-1.09	.27	0.30
Internalizing Behavior	11.53 (3.62)	14.70(4.88)	-2.85	.00	0.73
Externalizing Behavior	11.30(3.77)	12.93(3.34)	-1.37	.17	0.45

Note. M=Mean SD=Standard Deviation, Child and Adolescent Behavior inventory

Table 54 shows that independent t-test statistically significant mean difference has not been observed between the intervention group and the control group. The intervention group demonstrated significantly higher scores than the control group. For the , CABI no significant mean difference was found between the intervention group*(M=52.70, SD=12.26)* and the control group *(M=56.70, SD=14.14*) with *t(58)=-1.09, p > 0.05.* Cohen's d value was 1.36, a very large effect size *(> 0.80)*. Total CABI scores did not significantly differ between the groups, and internalizing and externalizing behavior scores were also similar. It's important to note that Cohen's d values between *< 0.2 to < 0.8* indicate small to large effect sizes (Cohen, 1988, p.82).

Discussion

Children with externalizing behavioral problems are effectively treated with Child-Parent Relationship Therapy (CPRT). Parents are now more likely to believe that the results of this study can help them reduce their children's internalizing and externalizing behavioral issues, as has already been mentioned. It has been shown (Tew et al., 2002; Smith and Landreth, 2004; Foley et al., 2006; Villarreal, 2007; Sheely, 2008; Ceballos, 2008; Reed, 2009;West, 2010; Amiri et al, 2015; Ahmadizadeh et al., 2022 and Wisen-Vincent & Bokoch, 2023) that CPRT reduces children's behavioral problems and enhances child-mother interaction. It has been demonstrated that parents may be able to modify their children's behavior by receiving appropriate and helpful training because they can internalize what they have learned. It is easier for mothers who recognize this useful intervention to provide for their children, as well as to maintain order in the home without resorting to force. According to the research, children exhibit a decrease in behavioral symptoms, learn coping mechanisms, gain confidence in themselves, and have the potential to develop into healthy, well-adjusted adults in the future. Counselors and psychologists may think about utilizing CPRT when it has been demonstrated to be remarkably effective in reducing children's misbehavior and enhancing mother-child relationships. This could offer a potential solution.

Psychologists or counselors may be able to use CPRT as a solution to resolve issues involving parents and children if the program is shown to have a significant impact on children's misbehavior and mother-child relationships. During the present study, only mothers' pre- and post-training reports were collected. The responses of parents as well as those of children themselves should be considered in future studies to compare the responses. As a result, other variables, including attachment, stress level, and empathy level of Pakistani mothers, should also be investigated when implementing CPRT.

A conclusion can be drawn that CPRT training teaches parents how to be their children's primary healers and catalysts of change. CPRT training emphasizes the importance of parents being the primary change agents in their children's lives as well as in their relationships with their children. This is to help parents raise their children in an accepting, nonjudgmental, and understanding environment. Additionally, CPRT improves parent-child relationships since it involves expressing children's choices, self-esteem, decision making and encourgment.

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Inform Consent Statement: All Participants in the research study were sign an informed consent form.

Permissions: All formal permissions for measures have been granted.

Conflict of Interest: The current study has no conflicts of interest.

Institutional Ethical Review Board statement: FJWU/EC/2023/60

Randomized Controlled Trial Code: NCT06087302

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