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Research Article

The Efficacy of Child-Parent Relationship Therapy in Reducing Perceived Rejection and Enhancing Academic Well-being of Fifth-Grade Female Students with Oppositional Defiant Disorder: A Preliminary Study

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ABSTRACT

Introduction: Oppositional defiant disorder (ODD) is a prevalent childhood behavioral disorder characterized by a persistent pattern of negative, defiant, and hostile behaviors, leading to significant impairments in social and academic functioning. Key consequences include pervasive peer rejection and diminished academic well-being.

Objectives: This study aimed to investigate the efficacy of child-parent relationship therapy (CPRT), a short-term filial therapy model, in reducing perceived peer rejection and enhancing academic well-being among fifth-grade female students with ODD.

Methods: This quasi-experimental research employed a pretest-posttest design with a control group. The statistical population consisted of all fifth-grade female students with ODD and their mothers in Islamabad-e-Gharb during the academic year 2023-2024. Using convenience sampling, 30 mother-daughter dyads were selected based on diagnostic criteria and randomly assigned to either an experimental group (n = 15) receiving CPRT or a control group (n = 15) receiving no intervention. Data were collected using the Academic Well-being Questionnaire, the Peer Rejection Questionnaire, and the Oppositional Defiant and Conduct Disorder Questionnaire. Data were analyzed using multivariate analysis of covariance (MANCOVA) in SPSS software (version 27), with pretest scores as the covariate.

Results: The results of the ANCOVA revealed that, after controlling for pretest scores, the experimental group showed a significant increase in academic well-being and significant decreases in peer rejection and oppositional defiant behaviors compared to the control group ($P < 0.001$).

Conclusions: CPRT effectively improves academic and psychosocial outcomes in female students with ODD by strengthening the parent-child relationship and reducing core symptoms. Its significant clinical results support its use by professionals and as a preliminary study, it establishes a clear pathway and robust foundation for future research in this domain.

Keywords: Parent-child relations, Oppositional defiant disorder (ODD), Play therapy, Academic success, Mothers

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1. Introduction

Oppositional defiant disorder (ODD) is a common childhood behavioral disorder characterized by a persistent pattern of angry/irritable mood, argumentative/defiant behavior, and vindictiveness toward authority figures, leading to significant impairments in social, academic, and family functioning (1). Its estimated global prevalence is 3.3% (2). Children with ODD often experience pervasive peer rejection due to poor social skills and conflictual interactions with others (3). Importantly, social isolation is not merely a risk factor or consequence but an intertwined component of impaired mental health (4).
Academic well-being, a multidimensional construct reflecting students' positive perceptions of their school functioning, is crucial for academic success (5). It comprises emotional (e.g., enjoyment in school activities) and cognitive (e.g., self-perceived competence) dimensions (6). Parental involvement, particularly maternal support, is a key facilitator of academic well-being (7). However, parents of children with ODD often struggle with hostile, bidirectional interactions that perpetuate the child's disruptive behaviors. Evidence suggests that interventions focusing on the parent-child relationship can break this cycle, reducing behavioral problems and improving parental outcomes (8).

Child-parent relationship therapy (CPRT), a structured, evidence-based filial therapy model, trains parents in core therapeutic skills (e.g., reflective listening, limit-setting, empathy) to serve as therapeutic agents for their children (9). CPRT has shown effectiveness in reducing parental stress and child behavior problems while enhancing parental acceptance (10,11). By fostering a secure attachment environment, CPRT improves family communication and emotional functioning (12,13).

However, critical research gaps persist. First, no study has simultaneously examined CPRT's effects on both academic well-being and perceived peer rejection in children with ODD. Second, fifth-grade female students with ODD have been systematically overlooked, despite developmental specificity (increased social sensitivity and academic pressure) and gender-differentiated manifestations of ODD (e.g., relational aggression). Third, academic well-being has never been directly targeted as an outcome in CPRT research for this population. To address these gaps prominently, the present study is the first to investigate the efficacy of CPRT in reducing perceived peer rejection and enhancing academic well-being specifically among fifth-grade female students with ODD.

2. Objectives

This study aimed to address this gap by investigating the efficacy of CPRT on reducing perceived peer rejection and enhancing academic well-being among fifth-grade female students with ODD. We hypothesized that participants in the CPRT group would show significant improvements in academic well-being and reductions in peer rejection and ODD symptoms compared to a waitlist control group.

3. Methods

3.1 Study Design

This study employed a quasi-experimental design with a pretest-posttest control group.

3.2 Participants

The statistical population comprised all mothers and their fifth-grade female students in Islamabad-e-Gharb city, Iran, from September 2023-June 2024. A convenience sample of 30 mother-daughter dyads was selected based on initial screening using the Oppositional Defiant and Conduct Disorder Questionnaire (16) and confirmed via a clinical interview aligned with Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria (1).

The inclusion criteria for children included meeting the DSM-5 diagnostic criteria for ODD, being a fifth-grade female student, and having no comorbid psychological disorders and not using psychoactive medication. The inclusion criteria for mothers included a minimum education level of high school diploma, no history of major psychiatric disorders and willingness to attend all sessions. The exclusion criteria included absence from more than two sessions and irregular attendance.

Random assignment procedure (coin toss): To ensure random assignment, a simple coin-toss procedure was employed. After the pretest assessment, a research assistant with no clinical involvement in the study tossed a fair coin for each mother-daughter dyad. Heads indicated assignment to the experimental group (n = 15), which received CPRT, whereas tails indicated assignment to the control group (n = 15), which received no intervention during the study period. The coin tosses were performed sequentially, and the result was recorded immediately. Group allocation was concealed from the therapist who delivered the intervention until the first session. Sample size justification: Based on Abbasi et al. (17), a minimum sample size of 15 participants per group was estimated with a 95% confidence and a 10% dropout probability. Justification for targeting fifth-grade females: This developmental stage (late childhood) is characterized by increased social sensitivity, academic pressure, and peer comparison. Moreover, ODD in girls often

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manifests as relational aggression and internalizing symptoms, which may respond differently to relationship-based interventions. No prior CPRT study has specifically focused on this subgroup.

3.3 Scales

In addition to a demographic questionnaire (mothers' age and education levels), three instruments were used.

3.3.1 Academic Well-being Questionnaire*:* This 31-item self-report scale (Tuominen-Soini et al., 2012) assesses academic well-being on a 7-point Likert scale (1 = completely disagree to 7 = completely agree), covering three dimensions: school value, academic satisfaction, and school engagement. Total scores range from 21 to 147 (higher scores = greater well-being). The Persian version has shown good validity and internal consistency (Cronbach's $\alpha > 0.85$) (5).

3.3.2 Peer Rejection Questionnaire: Developed by Lev-Wiesel et al. (2013), this 21-item scale measures perceived peer rejection on a 5-point Likert scale (1 = never to 5 = always), assessing four factors: verbal/nonverbal insult, being ignored, accusation/rumors, and physical attack. Total scores range from 21 to 105 (higher scores = greater rejection). Psychometric properties are acceptable (18).

3.3.3 Oppositional Defiant and Conduct Disorder Questionnaire: This parent-report scale (Motamedin et al., 2021) is based on DSM-5 criteria and screens for ODD and conduct problems in elementary school children (originally validated for boys aged 6–12). The 18 items are rated on a 5-point Likert scale (0 = never to 4 = very often). Total scores range from 0 to 72 (higher scores = more severe symptoms). Factor analysis revealed three factors: argumentative/defiant behavior and angry/irritable mood. Validity and reliability have been confirmed (16). Although this questionnaire was originally validated on male students, its items are directly derived from DSM-5 diagnostic criteria for ODD, which are gender-neutral and apply equally to boys and girls. In the present sample of 30 female participants, we calculated Cronbach's alpha to assess internal consistency, which was 0.87, indicating acceptable reliability for this population. Nevertheless, the absence of formal validation specifically for female students is acknowledged as a methodological limitation (see Section 3.6). Future research should consider gender-specific validation or norming of this instrument.

3.4 Intervention

Both groups completed a pretest. The experimental group then received the 10-session CPRT model (Landreth & Bratton, 2019) (9), delivered by a trained therapist. The intervention consisted of ten 90-minute weekly sessions teaching mothers child-centered play therapy skills (e.g., reflective listening, limit-setting). Mothers conducted weekly special play sessions at home with their children. The control group received no intervention during the study but was offered CPRT after the posttest. A posttest was administered to both groups after the 10 weeks.

Due to space constraints, Appendix A presents the detailed session-by-session content. Table 1 presents a summary of session topics.

Table 1. Summary of Child-Parent Relationship Therapy (CPRT) Session Topics (10 Sessions)

Session	Topic
1	Introduction, pretest, playroom rules, reflective responding
2	Basic principles, toy selection, recognizing four emotions
3	Child-directed play, reflecting feelings, limit-setting basics
4	Toy collection assembly, three-stage limit-setting protocol
5	Choice-giving and responsibility training
6	Supportive communication, descriptive statements vs. questions
7	Using choices for behavior management and rule enforcement
8	Fostering self-confidence, separating actions from identity
9	Praise vs. encouragement, avoiding external rewards
10	Review, consolidation, posttest

3.5 Data Analysis

Data were analyzed using IBM SPSS (version 27). A multivariate analysis of covariance (MANCOVA) was conducted with pretest scores as covariates. Prior to analysis, assumptions were tested: normality (Shapiro-Wilk, $P > 0.05$ for all variables), homogeneity of variances (Levene's test, $P > 0.05$), homogeneity of regression slopes ($P > 0.05$), and homogeneity of variance-covariance matrices (Box's M test, $P > 0.05$). Statistical significance was set at $\alpha = 0.05$. Partial eta squared (η^2) was reported as a measure of effect size. No additional covariates were entered due to the small sample size, but baseline equivalence between groups was confirmed for demographic variables (age, education). The authors acknowledge the following methodological constraints, which are further addressed in the Discussion section: Convenience sampling and small sample size (n = 15 per group): these limit generalizability and statistical power, increasing the risk of type II error. Reliance on self- and parent-report measures: This may introduce response bias (e.g., social desirability). To mitigate this, anonymity and confidentiality were assured. Lack of blinding: Participants, therapists, and assessors were not blinded to group assignment, which may introduce performance

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and detection bias. No follow-up assessment: Long-term effects of CPRT could not be evaluated. Lack of active control group: The control group received no intervention, which may overestimate treatment effects compared to a placebo or alternative treatment.

3.6 Ethical consideration

This study was approved by the Ethics Committee of Payame Noor University (IR.PNU.REC.1402.289). Parents and students expressed their consent to participate in the study after being informed about the study's purpose, procedures, potential risks and benefits. The confidentiality and privacy of all participants were strictly maintained throughout the study, and data were anonymized for analysis.

4. Results

An independent-samples t-test indicated no significant age difference between the experimental group (M = 31.0, SD = 4.7) and the control group (M = 31.2, SD = 5.0); t (28) = 0.26, p = 0.797. Levene's test confirmed homogeneity of variances (F = 0.914, P = 0.347). A chi-square test showed no significant difference in maternal education level distribution between groups ($\chi^2 = 0.83$, $P = 0.361$).

Table 2 presents the descriptive statistics (M ± SD) for all study variables, measured at both pretest and posttest for the experimental and control groups. The experimental group showed improvements in academic well-being and reductions in peer rejection and oppositional defiance.

Prior to hypothesis testing, the assumptions for MANCOVA were checked. The Shapiro-Wilk test confirmed that the data for all dependent variables were normally distributed ($P > 0.05$).

Table 2: Descriptive Statistics (Adjusted Mean and Standard Deviation) for the Study Variables Across Experimental and Control Groups at Pretest and Posttest Stages

Variable	Group	Pretest Adjusted Mean± SD	Posttest Adjusted Mean ± SD
Academic well-being	Experimental	84.3 ± 9.2	95.9 ± 8.9
	Control	79.0 ± 7.7	79.0 ± 7.8
Peer rejection	Experimental	65.4 ± 7.2	48.7 ± 9.8
	Control	61.5 ± 8.4	61.7 ± 8.5
Oppositional defiance	Experimental	62.4 ± 7.1	51.5± 9.1
	Control	63.3 ± 8.3	63.4 ± 8.2

Levene's test showed homogeneity of error variances (p > .05), and the test of homogeneity of regression slopes confirmed no significant interaction between the covariate and the independent variable ($P > 0.05$).

A one-way MANCOVA was conducted with group (experimental vs. control) as the fixed factor, pre-test scores as covariates, and post-test scores of academic well-being, peer rejection, and oppositional defiance as dependent variables. Using Pillai's trace, there was a significant multivariate effect of group, V = 0.774, $F_{(3, 23)} = 26.20$ $F_{(3, 23)} = 26.20$, $P < 0.001$, partial $\eta 2 = 0.774$. This large effect size indicates that approximately 77.4% of the variance in the combined dependent variables can be attributed to the CPRT intervention. (The other multivariate statistics—Wilks' Lambda, Hotelling's Trace, and Roy's Largest Root—yielded identical F values and are therefore not reported separately.)

Based on the results of Table 3, the ANCOVA results confirm that the CPRT intervention had a statistically significant effect on all three dependent variables ($P < 0.001$). The effect sizes (partial eta squared) for academic well-being ($\eta^2 = 0.710$), peer rejection ($\eta^2 = 0.606$), and oppositional defiance ($\eta^2 = 0.575$) were all large, further supporting the efficacy of the intervention. However, due to the small sample size (n = 30, 15 per group), these effect size estimates may be inflated and should be interpreted with caution. The high observed power (≥ 0.96) is also likely influenced by the small sample and large effect sizes; replication in larger samples is recommended.

5. Discussion

This study was conducted among fifth-grade female students with ODD and their mothers in Islamabad-e-Gharb, Iran. The primary objective was to examine the efficacy of CPRT in enhancing academic well-being and reducing perceived peer rejection and oppositional defiant behaviors. The results strongly support our hypotheses, indicating that CPRT is an effective intervention for this population.

Our findings are consistent with prior research showing that CPRT reduces ODD symptoms in preschool children (19) and decreases internalizing and externalizing symptoms in abused children (20). Similarly, CPRT has been shown to improve social adjustment in children with ADHD (21), which aligns with our observed reduction in peer rejection. Soltani and Farhadi (22) also reported reduced aggression following CPRT, corroborating our results.

The effectiveness of CPRT can be explained through two complementary mechanisms (23, 24). First, by training parents in child-centered play therapy skills (e.g., reflective listening, limit-setting),

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Table 3: Results of the Analysis of Covariance (ANCOVA) for Each Dependent Variable

Dependent Variable (Posttest)	Source	Sum of Squares	*df*	Mean Square	F	*P*-value	Partial Eta Squared (η^2)	Test Power
Academic well-being	Pretest (Covariate)	1565.6	1	1565.6	102.6	< 0.001	0.792	1.00
	Group	1007.4	1	1007.4	66.04	< 0.001	0.710	1.00
	Error	411.9	27	15.25				
Peer rejection	Pretest (Covariate)	1328.8	1	1328.8	34.3	< 0.001	0.560	1.00
	Group	1607.3	1	1607.3	41.5	< 0.001	0.606	1.00
	Error	1044.7	27	38.7				
Oppositional defiance	Pretest (Covariate)	1421.7	1	1421.7	55.9	< 0.001	0.674	1.00
	Group	927.5	1	927.5	36.5	< 0.001	0.575	0.96
	Error	686.1	27	25.4				

the intervention establishes a foundation of unconditional acceptance. This allows children to express previously suppressed emotions (e.g., anger, frustration) without fear of punishment or rejection. In turn, parents' reflective responses serve as a form of emotional co-regulation, reducing the child's physiological arousal and defensive oppositionality. Consequently, the child internalizes a more positive self-concept and develops greater self-control, which directly weakens the coercive cycle typical of ODD. Second, CPRT transforms the quality of parent-child attachment by creating a predictable, emotionally safe environment. Within this context, parents learn to respond to challenging behaviors with calm, consistent limit-setting rather than harsh or impulsive reactions. This shift disrupts the bidirectional reinforcement loop where child opposition triggers parental hostility, and parental hostility exacerbates child defiance. Over time, positive interactive experiences replace daily power struggles, reinforcing secure attachment and mutual trust. These relational improvements generalize to school settings, where better emotion regulation and reduced perceived rejection enhance academic engagement and well-being.

The improvements observed in academic well-being can be explained by the generalization of emotion regulation skills acquired during CPRT. Children learn to identify, express, and modulate negative affective states (e.g., anger, frustration) within the safe context of parent-child play. These self-regulatory capacities are directly transferable to the classroom setting, where impulse control and adherence to rules are essential for academic success—domains in which children with ODD typically exhibit deficits. Furthermore, the reduction in perceived peer rejection appears to be mediated by positive changes in the child's self-concept. As the parent-child relationship becomes more accepting and less conflictual, the child internalizes a sense of being valued and understood. This revised self-perception reduces expectations of social exclusion, thereby decreasing sensitivity to peer rejection and fostering a greater sense of school belonging. Consequently, enhanced cognitive resources become available for learning, leading to increased academic engagement and sustained motivation.

The present study faced several limitations. These include the use of convenience sampling, the selection of participants based on a screening questionnaire for ODD, and the lack of a follow-up assessment to assess the long-term effects of the intervention. To enhance the external validity and generalizability of the findings in future research, it is suggested to utilize random sampling methods, employ a structured clinical interview for more accurate diagnosis, and include a follow-up stage. The limitation of the small sample size in generalizing the data should be considered.

5.1 Conclusion

In conclusion, this research provides robust evidence for the effectiveness of CPRT as a valuable therapeutic intervention for addressing the multifaceted challenges—behavioral, social, and academic—faced by fifth-grade female students with ODD. By strengthening the parent-child bond and altering negative interaction patterns, CPRT successfully reduced core symptoms of ODD and feelings of peer rejection while significantly enhancing academic well-being. These findings underscore the critical importance of family-based, relationship-focused interventions in child mental health and highlight

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CPRT as a powerful, evidence-based tool for promoting positive developmental outcomes in children with behavioral disorders.

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Statements

Authors' Contribution: B. A. conceptualized and designed, supervised the research process, critically revised the manuscript, and approved the final text, formatted the manuscript to conform to the journal's style and structure. M. Y. H. extracted the English manuscript of the article from the dissertation. M. J. implemented the treatment protocol and collected the data, analyzed and interpreted the data. M. A. F. reviewed and commented on the final manuscript.

Conflict of Interest: The authors declared no conflicts of interest.

***Data Availability*:** The dataset presented in the study is available on request from the corresponding author during submission or after publication.

Ethical Approval: The present study was approved by the Ethics Committee of Payame Noor University (IR.PNU.REC.1402.289)

Funding: This study received no funding.

Informed Consent: Students were included in the study after obtaining written consent from their parents.

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Appendix A

In the present study, the training program of the Child-parent relationship therapy (CPRT) designed by Landreth and Bratton in 2019 was used. Table 1 presents the summary of the child-parent relationship therapy (CPRT) sessions.

Summary of the Educational Content of the Intervention Group's Training Sessions

Sessions	Outlines and Content of Sessions
1st	Introducing members to each other, conducting a pretest, to facilitate the child's complete emotional expression, the psychotherapist began treatment by setting playroom rules and creating a corresponding poster. Addressing basic issues, such as encouraging and strengthening parents, empathizing with parents, and normalizing communication problems between parents and their children. And teaching reflective responding. Supplemental homework worksheets were assigned to support this process.
2nd	The basic principles of play sessions, the list of toys used in play sessions were discussed. The four main emotions (joy, sadness, anger and fear) were recognized and then we guided them in using and practicing empathetic responses.
3rd	The four principles of play: the child guides the play sessions, paying attention to the child's feelings, reflecting the parents' perceptions of the child's feelings, and being firm about limits were taught. The child's feelings through facial expressions, body, tone of voice, and speech of the child were considered. Foundational boundaries and the rules of conduct for the play session (the dos and don'ts of the play session) were established.
4th	This session involved two key steps: first, assembling a collection of toys that facilitated real-life simulation, emotional expression (such as anger), and creative exploration; and second, establishing session protocols based on the three stages of determining the limit, which include fixed time and location, consistent toy organization, and the fundamental rule that the child directs the play.
5th	Emphasis on the right to choose, i.e., responsibility and decision-making training was implemented. Training on skills to set limits for inappropriate behaviors was implemented. Parents were trained as agents of behavioral correction to manage the child's maladaptive behaviors through the establishment of structured limitations. This process begins with an empathetic and affectionate reflection of the child's inner emotions. This reflection sets the stage for clearly stating the limitation and ultimately guides the child toward an alternative, adaptive behavior.
6th	This segment covers effective and supportive communication strategies for how to engage in purposeful dialogue with a child. Emphasizing the critical importance of acknowledging and validating their emotions. Allowing the child to direct the play's narrative, refraining from intrusive questioning and replacing questions with descriptive statements to avoid putting the child on the spot and to encourage them to share more freely.
7th	In this session, parents learned how to use targeted methods to grant the right to choose to their child. This practice not only strengthens the child's autonomy and sense of self-efficacy but also serves as a powerful tool for behavior management and reinforcing household rules. The methods for granting the right to choose were introduced through three main approaches: granting simple and empowering choices; using choice as a means to achieve positive outcomes and employing choice to strengthen and uphold household rules. Combining these three methods helps parents create an environment where the child feels empowered, responsible, and respected, while the necessary structures and boundaries for their healthy development are consistently maintained.
8th	This session is dedicated to understanding the pivotal role of self-confidence in a child's healthy development. Parents learned practical strategies to foster an internal sense of competence and worth in their child, shifting from a corrective to an encouraging model of interaction. Parents were taught to separate actions from the child's identity and personality when mistakes and harms occur and to engage in actions without blame so that encouragement replaces punishment and blame.
9th	The session began by establishing a clear understanding that praise and encouragement are not the same; they serve different purposes and have different long-term effects on a child's development. It was explained to parents that: Praise focuses on evaluating the outcome and gaining adult approval while encouragement focuses on the child's effort, progress, and own feelings. An overreliance on praise and habitual use of praise can condition children to seek external rewards, shifting their focus away from the inherent satisfaction of a task and toward the goal of gaining approval.
10th	In the final session, the following items were completed: A review of previous sessions and the skills taught, aimed at consolidating the learning and generalizing it from the educational setting to the home environment; An expression of gratitude for their participation, celebrating achievements, and sharing feelings and feedback about the psychoeducational course and one week after this session, the posttest phase was conducted.

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