

CHILD-PARENT RELATIONSHIP THERAPY (CPRT) WITH ADOPTIVE FAMILIES:
EFFECTS ON CHILD BEHAVIOR, PARENT-CHILD RELATIONSHIP STRESS, AND
PARENTAL EMPATHY

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This randomized controlled study is a preliminary investigation on the effects of Child-Parent Relationship Therapy (CPRT) with 61 adoptive parents. The participants in this study identified themselves as the following: 54 European American, 3 Black American, 3 Hispanic/Latino, and 1 individual who chose not to indicate ethnicity. The study included 23 couples and 15 individual mothers. The CPRT is a structured, time limited approach that trains caregivers to be an active participant as a therapeutic change agent in their child's life. Results from a two (group) by two (measures) split plot ANOVA indicated that adoptive parents who participated in 10 weeks of CPRT reported statistically significant decreases in child behavior problems and parent child-relationship stress. Statistically significant increases in parent empathy were also reported by raters blinded to the study. CPRT demonstrated a medium to large treatment effect on reducing children's behavior problems and parent-child relationship stress. In addition, CPRT demonstrated a large treatment effect on increasing parental empathy. The results of the study provide preliminary support for CPRT as a responsive intervention for adoptive parents and their children.

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This is not the end of journey, just the completion of one long curve in the midst of a winding road full of ups and downs. I have imagined writing this page with excitement knowing that this represents the completion of an endeavor full of personal meaning and passion.

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CHAPTER 1

INTRODUCTION

Individuals are created to be in relationship. Feelings of safety, acceptance, and love are directly impacted by unique experiences that occur within relationships (Axline, 1974; Landreth, 2002). The interaction between parent and child is the child's primary introduction to the world of relationships (James, 1994; Purvis, Cross, & Sunshine, 2007; Ryan & Wilson, 1995; Ryan & Bratton, 2008; Siegel & Hartzell, 2004; Van Fleet & Sniscak, 2003). The parent-child relationship is the initial and essential medium for creating safety and love.

The length of contact between biological parent and child can range from a few minutes to years of formative interactions. An infant's introductory relationships begin the framework for future interactions with others; however, an infant's initial relationships are often not conducive to facilitating a felt sense of safety and security. Children who have experienced frequent changes in caregivers, recurring neglect, and abuse can experience difficulty feeling safe in relationships with others (Forbes & Post, 2006; James, 1994; Kottman, 1997; Purvis & Cross, 2005; Purvis et al., 2007; Sweeney, 2003; Van Fleet & Sniscak, 2003). Commonly, children with these experiences learn premature independence as a way to protect self and control their environment. Children who have experienced adoption often present with unique challenges connected to disrupted relationships with primary caregivers.

Adoption is a familiar occurrence in society; "almost two-thirds of Americans have personal experience with adoption through their own family or close friends" (Department of Family Social Science, University of Minnesota, 2009). It is estimated that there are 1.5 million adopted children in the United States, over 2% of all U.S. children (Evan B. Donaldson Adoption Institute, 2007). Annually, approximately 127,000 adoptions occur in the United States: 15%

intercountry, 39% through publicly funded agencies, and 46% through private adoptions (Child Welfare Information Gateway, 2004b). Infant adoptions are overwhelmingly the majority of international adoptions, and stepparent adoptions are the most common form of adoption in the United States (Evan B. Donaldson Adoption Institute, 2007).

The number of primary caregivers, disrupted placements, and repeated traumatic events contribute to the overall mental health of the adoptee, and greater number of occurrences increases the risk of maladjustment (Hughes, 1999; Kottman, 1997; Verhulst, Althaus, & Beiman, 1992). The term *disrupted adoptions* is used to describe the termination of the adoption process after the child is moved into the adoptive home but before the adoption is finalized. The disruption rate in the U.S. is between 10 and 25 % (Child Welfare Information Gateway, 2004a). Professionals identify 84% of adoptions as successful; however, adoptees are over-represented in mental health facilities, approximately 5 % (Kadushin, 1980; Levine & Sallee, 1990; D. Smith & Brodzinsky, 1994). Therefore, evidence-based mental health services focusing on the needs of adopted children are needed.

Literature indicates that young children often present signs of co-morbidity, therefore making a single diagnosis is often difficult and/or inaccurate (Achenbach & Rescorla, 2000). Adopted children often present with a wide range of disruptive behaviors making it difficult to implement holistic therapeutic interventions. Juffer and Van Ijzendoorn (2005) conducted a meta-analysis on behavioral problems reported with international adoptees, domestically adopted children, and non-adopted children. The authors of this meta-analysis reported that adopted children demonstrated more internalizing and externalizing behavioral problems than non-adopted children.

Adoptive parents are faced with the challenge of developing a relationship and helping the child experience that relationships can be safe and trusting. Confusion, frustration, and heartache become part of the adoptive parents' daily life when it appears that their child continues to reject them, sabotaging the relationship (Ginsberg, 1989; Kottman, 1997; Purvis et al., 2007; V. Ryan, 2007; VanFleet, 2003). Adoptive parents often resort to blaming either self or the child, and familial relationships can quickly deteriorate.

Mental health professionals have the responsibility to educate potential adoptive parents and provide therapeutic resources for parents and children. Exploratory research conducted by McDaniel and Jennings (1997) assessed the extent to which therapists considered adoption issues when treating adoptive families. A case study of a family seeking counseling for their adolescent son, adopted when he was 3 days old, was sent to 32 therapists. The researchers facilitated interviews to determine whether therapists took into account the issues of adoption when they made treatment recommendations. Results of the research indicated that the majority of therapists interviewed for the study failed to take into account the issue of adoption when conceptualizing and making treatment recommendations for the family: 34.4% never mentioned adoption, 9.4% mentioned adoption but ruled it out as an issue, 25% mentioned adoption only once and included treatment interventions recommendation regarding adoption, 15.6% mentioned adoption several times but did not include any treatment recommendations specific to adoption, and 15.6% named adoption as an issue with specific treatment interventions specific to the adoption. Although this research is exploratory with a small sample size, the findings indicate the need for therapists to receive more education regarding the unique needs of adoptive families. In addition, Purvis and Cross (2005) conducted a survey and reported that only 7% of adoptive families felt they were "absolutely prepared" for the aftermath of institutional care and

its effects on their child. Supportive and comprehensive family services make a fundamental contribution to ensuring secure placement of adopted children.

Filial therapy is a relationship-focused mental health intervention focused on meeting the needs of both parents and children. Filial therapy empowers the parents to be the therapeutic change agents in the child's life (Ginsberg, 1989; B. Guerney 1969; Landreth, 2002; Landreth & Bratton, 2006; Van Fleet, 1994). Filial therapy provides an opportunity for the parent and child to engage weekly in a 30-minute child-centered play environment that promotes feelings of safety, acceptance, and love. Filial therapy is typically used for children ages 3 through 10 and their primary caregiver.

The relationship-based principles of filial therapy, combined with substantial research on child-parent relationship therapy (CPRT) to support its effects with a variety of presenting issues and populations, indicate that filial therapy could be a viable treatment modality for adoptive families (Bratton, Ray, Rhine, & Jones, 2005; L. Guerney, 2003; Landreth & Bratton, 2006; VanFleet, 2003, 2006; Bratton, Landreth & Lin, in press). Because attachment disruptions indicate the presence of a relationship-based problem, filial therapy's focus on the parent-child relationship makes it an appropriate therapeutic treatment modality for helping adoptive families respond to the challenge of establishing and maintaining a secure attachment relationship. In addition, the therapeutic nature of the group gives parents social support and responsive parenting interventions.

Statement of the Problem

Children deserve the experience of belonging to a family that prizes and nurtures their unique abilities and gifts they have to offer the world, but attachment disruptions coupled with trauma often compromise a child's ability to feel safe, loved, and accepted in the context of a

positive relationship. Filial therapy offers an empowering treatment modality for families striving to feel connected and secure. The empirical support for the effectiveness of filial therapy continues to grow (Bratton et al., 2005; L. Guernsey, 2000; Landreth & Bratton, 2006; Bratton, Landreth & Lin, in press). Barth et al. (2005) argued that “it is the parent-child relationship that is the central reason that adoptive parents come to therapy. Evidence-based interventions that address parent-child relationships and the parent’s expectations about them also deserve testing with adoptive families” (p. 264). The growing need for effective interventions for adoptive families and the proven effectiveness of CPRT, a 10-session filial model, send a message of hope to resilient families worldwide. Although many mental health professionals advocate the use of CPRT/filial therapy with adoptive families, a thorough review of the literature revealed no published outcome studies focused on CPRT with this population. Therefore, research examining CPRT’s effectiveness as an intervention to support and respond to the unique needs of adoptive families is needed.

Purpose of the Study

The purpose of this study is to examine the effects of CPRT with adoptive families on: (a) reducing children’s behavioral problems as reported by parents on the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000), (b) reducing total parent-child relationship stress as reported by parents on the Parenting Stress Index (PSI; Abidin, 1995), and (c) on enhancing parental empathy as assessed by the Measurement of Empathy in Adult Child Interaction (MEACI; Stover, Guernsey, & O’Connell, 1971).

CHAPTER 2

REVIEW OF RELATED LITERATURE

The review of related literature includes: (a) needs and common concerns of adoptive families, (b) treatment programs for adoptive families, (c) child-centered play therapy, (d) filial therapy, (e) child-parent relationship therapy (CPRT), and (f) rationale and possible adaptations of CPRT with adoptive families.

Needs and Common Concerns of Adoptive Families

The majority of Americans have a positive view of adoption, and 4 out of 10 adult Americans have considered adoption for their families. A national adoption survey conducted in 2002 reported that if 1 out of 500 adults considering adoption actually adopted a child, all of the 134,000 children in foster care waiting for adoption would have permanent, loving families (Dave Thomas Foundation for Adoption, 2002). However, fears related to the return of the birth parents, adoption expenses, and the overall health and behavior of the child paralyze the development of potentially adoptive families. Increased public awareness and effective mental health services are essential in uniting adults and children as safe, loving, and permanent families.

A growing concern is the number of children in the U.S. foster care system available for adoption. Foster care adoptions represent only 15% of adoptions in the United States. Most adoptive families do so because of infertility and are primarily interested in adopting an infant; only 2% of children available in the foster care system are infants. Ninety percent of children adopted through foster care are 5 years old or older (Evan B. Donaldson Institute, 2007). Excerpts from statistics updated March 2008 from the U.S. Department of Health and Human Services (2008) detail this growing concern:

Table 1

Children in Public Foster Care Waiting to be Adopted FY 1999 thru FY 2006

State	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
California	9,448	12,004	7,682	15,794	15,851	16,299	16,700	18,028
Colorado	1,665	1,776	1,445	1,873	1,479	1,543	1,737	2,090
Florida	4,610	5,395	7,696	8,043	8,166	7,684	7,374	7,478
Louisiana	1,477	1,541	1,439	1,471	1,315	1,179	1,162	1,079
Oklahoma	1,832	1,766	2,390	2,434	2,565	4,409	3,191	3,587
Texas	6,592	7,190	7,887	8,440	8,625	9,913	10,768	12,191

A child's classification as available for adoption in the foster care system indicates that the biological parents' rights have been terminated. Therefore, no additional reunification opportunities are available to the biological parents. Children waiting for adoption in foster care remain in this system until they are 18 years of age or adopted. It seems logical to conclude that children awaiting adoption in the foster care system may have experienced significant attachment breaks and traumas. Therefore, the need to equip parents with therapeutic skills is essential to the success of creating a new family.

International adoption is a growing trend and serves as a viable option for many couples wishing to adopt a younger child. "The number of children adopted worldwide via intercountry adoption is increasing each year, and 2005 statistics indicated that more than 20,000 children were adopted to the United States alone" (Gribble, 2007, p. 14). Potential maladjustment risks related to international adoptions are present. The majority of these children are adopted from orphanages with a high ratio of children to caregivers.

An infant who is rarely touched or spoken to during the first weeks and months of life can suffer critical mental and behavioral impairments, even death. Orphanage nurseries

tend to be eerily quiet because babies quickly discover no one comes when they cry.

(Purvis et al., 2007, pp. 26-27)

Medical histories, prenatal care, and early living conditions are typically not available to the adoptive parents. Gribble (2007) acknowledged that adoptive parents may have difficulty providing care based on emotional rather than chronological age due to the Western values of promoting early independence. This can be particularly challenging for parents adopting young international children, who were not expecting intense emotional and behavioral struggles. Parents of internationally adopted children may benefit significantly from learning therapeutic skills for meeting the child's need to form a secure attachment.

Attachment and Trauma Concerns Associated with Adopted Children

Attachment is the “reciprocal, enduring, emotional, and physical affiliation between child and a caregiver. The child receives what she needs to live and grow through this relationship, and the caregiver meets her needs to provide sustenance and guidance” (James, 1994, p. 2). This attachment relationship develops the framework for the child's perception of the world, relationships and self-concept.

Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler or a schoolchild but throughout his adolescence and his years of maturity as well, and on to old age. From these intimate attachments a person draws his strength and enjoyment of life and, through what he [sic] contributes, he gives strength and enjoyment to others. (Bowlby, 1980, p. 442)

Healthy attachment enhances one's ability to feel safe and secure and to self-regulate. The primary caregiver's ability to meet the basic needs of an infant in a genuinely nurturing and consistent manner is basic to the formation of secure attachment. Hughes (1999) referred to the

ability of parents to help their child establish a secure attachment as facilitating the “psychological birth” of their child.

Barriers to attachment are commonly connected to the primary caregiver is being unavailable to the child emotionally or physically and providing inconsistent care. Hunter’s “Autobiography of a Baby,” as cited in Robb (2003), provides vivid insight into the world of an infant in relationship with an emotionally unavailable caregiver:

I have moved through panic to desolation. I need to be with my mother. She needs to be with me. She does not allow me. In this desolation I know this which I didn’t know before. She needs my love. Without it she cannot love and feed me. I need to love her. I cannot love her from my emptiness. I want no-one else. I do not cry out. My desolation is better than the pain of their touch. I speak to my mother soul to soul. But my words smash against the iron-door shut against them. I cannot enter. (p.15)

One cannot underestimate the early trauma and future risk factors associated with a significantly impaired early attachment process. It is a false assumption to discount implications regarding the infant’s experience because the infant cannot cognitively remember this experience. In addition, infants who are difficult to soothe due to situations such as early medical trauma or frequent illness may have difficulty with attachment formation. This attachment process is intrinsically connected to the holistic development of the child.

Attachment and trauma are often integrative factors, particularly in the lives of adopted children. “Loss of a primary attachment figure represents a loss of everything to a child: loss of love, safety, protection, even life itself” (James, 1994, p. 7). Repeated traumatic events, such as any form of abuse, as well as losses associated with the primary caregivers, significantly disrupt the attachment process. In addition, how the child makes meaning of these events must be taken

into account. A child who lacked attentive and protective parenting is continually searching for a way to achieve a felt sense of safety, commonly manifesting in hypervigilance (Perry, 1994). Increased fear, sensory processing issues, difficulty self-regulating, disorder of memory, and short-term memory loss are some of the consequences present in the lives of children who have experienced attachment breaks and trauma (Forbes & Post, 2006; Hughes, 1999; James, 1994; Purvis et al., 2007; Siegel & Hartzell, 2004). An understanding of the interrelationship between trauma and attachment is essential in both parenting and providing mental health services to the adopted child.

Adoption, regardless of age, is a traumatic event due to the break in attachment from the primary caregivers. Scans of pregnant mothers indicate that a significant amount of attachment is already occurring in the womb (Piontelli, 1992). “Research confirms that a mother’s emotional circumstances during pregnancy can profoundly affect her newborn” (Purvis et al., 2007, p. 23). Generally speaking, while in the womb, a baby experiences the same benefits and risks of the mother’s current lifestyle and emotional health as after the child is born. Maternal malnutrition is linked to developmental and cognitive problems in children (p. 24). Therefore, risk factors for attachment challenges may be developing prior to the birth of the child.

As an infant enters early childhood, the testing of boundaries and the initial process of individuation occurs (Hughes, 1999; Purvis et al., 2007). A child with healthy attachment has the ability to explore limits with the confidence that caregivers are present to keep the child safe and secure. Stress and anxiety increase for children when their environments are unpredictable and chaotic, because they wonder what will happen next (Perry, 1994). Children who have previously experienced inconsistent care, neglect, and abuse perceive that, in order to be safe, they must control their own environment (Hughes, 1999). The child’s need to master premature

independence disrupts the natural developmental process. This control may manifest itself through behaviors such as extreme tantrums, aggression, indiscriminate affection, and isolation from others. These are the survival skills the child has developed as a way to maintain personal safety and control.

A child with a previous history of attachment breaks and traumas is often confused and frightened at the opportunity to have a consistent interactive relationship with a caregiver. Feelings of confusion and fear permeate the adoptive parents because the child may resist interactions, cling to the caregiver at times, increase oppositional behavior, and make excessive attempts to control the environment. Adoptive parents commonly experience feelings of rejection and sadness associated with establishing a healthy attachment with their new child. “After years of living with a child who is unable to reciprocate respect, affection, and love, parents go from being a lavish rainforest of love to an arid dry, desert – hostile, angry, and depleted” (Forbes & Post, 2006, p. 31). Therefore, the need for specialized treatment focusing on the parent-child relationship for adoptive families is critical.

Treatment Programs and Adoptive Families

Professionals in the field of mental health have a desire to provide effective interventions to the population they serve. The availability of evidence-based treatments is essential. Disagreements among researchers in the field exist regarding the definition of evidence-based (Rubin, 2008). Interventions that are not deemed evidence-based may still be effective; however, lack of treatment protocols and controlled outcome studies may limit the credibility of the intervention (APA Presidential Task Force on Evidenced Based Practice, 2006)

Dyadic Developmental Psychotherapy

Becker-Weidman (2006) described dyadic developmental psychotherapy (DDP) as an evidence-based treatment of trauma-attachment disorder, often the label that health providers give adopted children who receive mental health services. Becker-Weidman stated that DDP is the only “evidence-based” treatment for trauma-attachment challenged children because researchers have published studies of it in peer reviewed journals (Becker-Weidman & Hughes, 2008, p. 329). In addition, Craven and Lee (2006) determined that DDP is a supported and acceptable treatment. Daniel Hughes originally developed this intervention for children who have early separation from primary caregivers resulting in emotional distress for the child. The goal of DDP is to help the child heal, primarily by developing a trusting and safe relationship with caregivers.

DDP is based on the following principles. The first is that experiential therapy is essential to the healing process. Therapists use the acronym PACE (playful, accepting, curious, and empathic) as the guideline for the techniques and interventions utilized in therapy. In addition, treatment must be family-focused. The caregivers of the child are taught the additional acronym PLACE, reminding caregivers of the need to provide a home environment that is playful, loving, accepting, curious, and empathic (Becker-Weidman, 2006). The belief that trauma must be directly addressed is essential to DDP. The child’s trauma is revisited in the context of a caring adult so that the child can integrate the trauma into his or her sense of self. In addition, an environment of safety and security is essential in the home and therapy setting. The therapy is consensual and never coercive (Becker-Weidman & Hughes, 2008). The structure of therapy sessions usually has three components: (a) meeting with caregivers for support and teaching attachment parenting methods, (b) facilitating therapy with the child to create

attunement, cognitive restructuring, and psychodramatic reenactments (caregivers are present in the session or observe through a 2-way mirror); (c) meeting with the caregiver without the child present, to process the session and continue treatment planning.

Becker-Weidman (2006) conducted a research study examining the effects of DDP on children ages 5 through 16 who met the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV)* criteria for reactive attachment disorder (RAD). The treatment group was comprised of 34 children, and the control group was comprised of 30 children. The children in this study were either residing with their adoptive family or were currently in foster care. The treatment group received DDP while the control group received usual care such as play therapy, family therapy, individual therapy, and residential care. The researcher involved in this study did not indicate the use of random assignment for experimental and control group. The parents of the children in the treatment group reported clinically and statistically significant improvements in their child's functioning as measured by the Child Behavior Checklist (CBCL), whereas children in the control group showed no measurable change by ratings of caregivers on the CBCL outcome variables measured after 1 year of treatment. A follow-up exploratory study was conducted approximately 4 years after the initial study. About two thirds of the families that participated in the initial study were located and responded to the follow-up questionnaire. One hundred percent of the control group families continued in treatment with other providers, and none of them had received DDP. The control group reported an increase in symptoms over the 3.3 years. Forty-two percent of the treatment group received treatment after completing DDP, and caregivers reported results within the normal range on the CBCL. This initial study appears to yield promise regarding the effectiveness of DDP. Having another source of measure besides

caregiver report, narrowing the age range of participants, and increasing sample size would all advance research in DDP treatment intervention.

Parent-child Interaction Therapy

Parent-child interaction therapy (PCIT), developed by Sheila Eyeberg, is an empirically supported and family-centered treatment approach that has been adapted for working with abused and at-risk children. PCIT is an intervention that is continuing to be researched and is gaining in popularity with a wide variety of populations, particularly children with externalized disruptive behaviors such as oppositional and attentive seeking behaviors. Foster parents and pre-adoptive parents have participated in this therapy intervention with children who have experienced interpersonal trauma (Fricker-Elhai, Ruggiero, & Smith, 2005; McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Timmer et al., 2006). PCIT therapists coach parents utilizing a “bug in the ear” while the parent interacts with the child. PCIT has a strong behavioral component and trains parents in strategies to reinforce the child’s positive behaviors. Play is utilized throughout the treatment; however, the use of play is fundamentally different from humanistic play therapy approaches. For example, child-centered play therapy is rooted in the philosophy that play is the child’s language, toys are the words, and play is the child’s primary form of communication (Landreth, 2002). Professionals using PCIT use play as the medium for teaching and reinforcing desired behaviors (Child Welfare Information Gateway, 2007). Therefore, the utilization of play with children is rooted in a different philosophy.

PCIT has two components: child directed interaction (CDI) and parent directed interaction (PDI) (Fricker-Elhai et al., 2005). The CDI portion of the treatment includes the use of positive parent attention: while the child chooses toys to play with, parents are coached to praise the child for appropriate play and behavior. During this time, parents use skills

represented in the acronym PRIDE: praise, reflection, imitation, description, and enthusiasm (Child Welfare Information Gateway, 2007). The parent or therapist may use selective ignoring for behaviors considered undesirable. The PDI component of the treatment focuses on creating consistency and predictability within the parent-child relationship. The therapist trains parents to give specific and positively worded commands to the child. Typically, the child's non-compliance results in time outs and two-choice commands. Throughout the course of treatment, parents are also asked to initiate daily structured and uninterrupted 5-minute play times with the child to reinforce behaviors and new parenting skills.

Over 30 randomized clinical outcome studies have found PCIT to be useful in treating at-risk families and children with behavioral problems (Child Welfare Information Gateway, 2007). Timmer et al. (2006) reported the efficacy of using PCIT with an aggressive young boy and his foster-adoptive parent. The results from this single case design indicated that PCIT was effective in reducing the child's behavioral problems, decreasing parenting stress, and assisting in preventing a potentially disrupted placement. In addition, the authors asserted that "the foster-adoptive mother's liberal use of praise suggest a positive context for the parent-child relationship" (Timmer et al., 2006, p. 935).

McNeil et al. (2005) conducted research with training foster parents in PCIT. Thirty children exhibiting behavior problems attended a modified 2-day consecutive PCIT training with one of their foster parents. One month after the training 80% of foster parents reported using the skills taught in the workshop most or all of the time. Fricker-Elhai et al. (2005) reported a case study using PCIT with two siblings in the foster care system with severe maltreatment histories. The paternal and maternal ratings on the Eyeberg Child Behavior Inventory (ECBI) were inconsistent. In addition, the caregivers failed to complete the CBCL posttest; therefore,

comparisons could not be made to the CBCL pretest. The authors supported PCIT as a treatment option for maltreated children exhibiting aggressive behaviors, although the results from the assessments used throughout the case study yield mixed results. The preliminary evidence of this research study suggests that intensive 2-day PCIT training may be an effective way to train foster parents to manage disruptive child behavior. Future research is needed involving a randomized control study, increased sample size, and another source of measure to enhance and strengthen these findings.

Child-Centered Play Therapy

The underlying philosophy of child-centered play therapy is that play is the child's language and toys are the child's words (Landreth, 2002). Play itself is spontaneous in nature, is not goal directed, and lacks a prescribed structure. The utilization of play in therapy enables children to communicate their inner world. They have the opportunity to share their self with the therapist without evaluation. Provided with facilitative toys, children bring their feelings to the surface, giving them the opportunity to face their emotional world. They learn self-regulation regarding emotion, contributing to a stronger sense of self. It is at this point that children begin to realize their own ability to think for themselves and make decisions (Axline, 1974).

The goal of a child-centered play therapist is not to converse verbally with the child. A push to have the child talk reveals the therapist's desire to be in control. Children may not have the capacity to verbalize feelings because of their developmental level or as a result of traumatic experiences. The child-centered therapist recognizes this dynamic and understands that children use toys as a way to say what cannot be verbalized (Landreth, 2002). This understanding is also a recognition that play gives the child the ability to be in control. So much of childhood is spent following grown-ups around, doing what they do, and doing what they tell the child to do.

Children are expected always to obey, listen, be quiet, wait, and be still, with little room for self-expression. Allowing children to play in most of the ways they would like opens the window of opportunity to experience control. The child experiences what it is like to be in control and learns responsibility that comes with being in control. Through expressing control the child can find freedom while at the same time learn how to regulate this new sense of personal mastery.

Child-centered play therapy is a therapeutic model based on the work of Carl Rogers, who believed that a therapeutic approach responsive to the client's present needs enables the individual to facilitate their own change. When provided an environment of freedom and unconditional positive regard, clients feel openness to explore incongruence between their self-concept and the ideal self. Virginia Axline (1974), a student of Rogers, explained this as "a powerful force within each individual which strives continuously for complete self-realization. This force may be characterized as a drive toward maturity, independence, and self-direction" (p. 10). The child-centered play therapist believes that this force is present in all children but does not attempt to direct the influence of this force with structured or directive play.

According to the child-centered play therapist, nondirective play promotes decision making, acceptance of responsibility, and enhanced self-esteem (Landreth, 2002). These factors effect change in the child because they teach an internal means of control and independence as opposed to dependence on the external controls often encountered by the child at home and school. A core belief of the child-centered play therapist is that these changes can occur only in the context of relationship that conveys trust in the child's personhood and in the child's innate ability for growth and self-discovery. In the context of this type of interpersonal, therapeutic relationship the child can fully explore his or her negative feelings and more realistically react to the environment (Moustakas, 1955). As in the therapeutic approach of Rogers, child-centered

play therapists understand that the therapeutic relationship is based on the full acceptance of the child. One must have unconditional positive regard for the child in order to facilitate an environment open to change.

The child-centered therapist utilizes a responsive approach in the development of the therapeutic relationship. Landreth (2002) asserted, “This relationship is for most children like no other they have experienced. Here the adult allows the child to be – just that, to be” (p. 79)! This is precisely the goal of child-centered play therapy: that a child can experience full, unconditional acceptance from another person. The therapist unconditionally accepts the personhood of the child, removing the focus from his or her behaviors and symptoms.

Virginia Axline led the way in outlining the basic principles for establishing a relationship, and Landreth (2002) revised and extended the eight basic principles.

1. The therapist is genuinely interested in the child and develops a warm, caring relationship.
2. The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.
3. The therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express self completely.
4. The therapist is always sensitive to the child’s feelings and gently reflects those feelings in such a manner that the child develops self-understanding.
5. The therapist believes deeply in the child’s capacity to act responsibly, unwaveringly respects the child’s ability to solve personal problems, and allows the child to do so.
6. The therapist trusts the child’s inner direction, allows the child to lead in all areas of the relationship and resists any urge to direct the child’s play or conversation.

7. The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.
8. The therapist establishes only those therapeutic limits which help the child accept personal and appropriate relationship responsibility. (pp.84-85)

These principles, if the therapist adheres to them, have a powerful way of creating a welcoming environment in which the child is accepted and the therapist is trusted. O'Conner and Braverman (1997) reported that Axline believed "that it is the permissive, nonjudgmental, warm, and caring relationship that gives the child the courage to delve deeply into his or her innermost world to bring out the real self" (p. 22).

This type of relationship allows children room to utilize their own play. The therapist facilitates an environment for children to express thoughts, emotions, and formulating beliefs without the risk of being judged. This environment is rare in many children's lives; therefore, it may take time for them to trust the therapist. After all, this grown-up talks differently and allows children to express themselves in ways that other grown-ups will not allow. This approach allows the therapist to keep attention on the child, even when the child exhibits many negative behaviors (Landreth, 2002). Limits in this environment are not set until the moment arises. Boundaries and limits are communicated by the therapist if children choose to hurt themselves, the therapist, or intentionally damage materials in the playroom. This can be a difficult endeavor on the part of the therapist. One must be confident in children's ability to self-regulate and trust that they can bring themselves under control when limits are set in a therapeutic way.

While this relationship is not fully permissive, it is free of expectation and evaluation. Change is not measured by predetermined goals set by the therapist, and one does not seek to cure the child. Learning and change arise from one's tendency for self-actualization; therefore,

there is no need to motivate or direct the child. Landreth (2002) exemplified this attitude when he stated, “I trust the child to lead our experience together to where the child needs to be. I am not wise enough to know where a child should be in our relationship or what a child should do” (p. 84). Allowing the child to remain in the lead of the play within certain limits is central to the change process, because it promotes the freedom for the exploration of one’s self-concept as it relates to the ideal self.

Filial Therapy

A Brief Overview of Historical Development of Filial Therapy

Bernard and Louise Guerney are the co-founders of filial therapy. Prior to the Guerneys, there exist few documented occurrences of clinicians directly using parents in their child’s therapeutic process. Sigmund Freud facilitated therapy for a 5-year-old boy, Hans, through the use of Hans’s father: “The treatment itself was carried out by the child’s father...No one else could possibly have prevailed on the child to make such avowals” (1959, p. 149). In addition, Dorothy Baruch (1949), Natalie Fuchs (1957), and Clark Moustakas (1959) also promoted the use of parents as therapeutic change agents with children. The formal development and implementation of filial therapy is credited foremost to the Guerneys’ work in the 1960s (B. Guerney, 1969).

The use of the parent as the primary therapeutic change agent in working with children was revolutionary at the time (Guerney & Guerney, 1989). The Guerneys developed this concept as a way to help children presenting with social, emotional, and behavioral issues (B. Guerney, 1969). This model enabled a change in the current perspective of parents. The Guerneys’ premise for this approach was that children’s problems are often due to the lack of parental knowledge and skill, and parents have more emotional significance in the child’s life

than anyone else (L. Guerney, & B. Guerney, 1989; B. Guerney, 1969; L. Guerney, 2000).

Therefore, directly involving parents in the therapeutic process with their children became the rationale for the development of filial therapy. Until this point, parents were blamed for the child's struggles; the goal of filial therapy is to align the parent and therapist for the benefit of the child.

Filial therapy continues to grow in popularity, and adaptations are implemented for a variety of populations. Rise VanFleet, a former student of Louise and Bernard Guerney, defined filial as "involving parents as partners in the therapeutic process. Parents learn to conduct special play sessions with their own children, harnessing the therapeutic belief of play for their children and their family relationships" (VanFleet, 1998, p. 463). VanFleet emphasized that filial therapy can reduce or eliminate presenting problems and can be used as a preventative intervention (VanFleet, 1994, 1998, 2000, 2003).

VanFleet (1994) developed a model that divides the process into three phases. The early phase contains assessment of social developmental history, family play observation, and pre-measures. In addition, during the early phase, a description and rationale of filial therapy is provided to the parents. Also, parents observe a session facilitated by the therapist that demonstrates child-centered play therapy. The middle phase involves training, play sessions, and transfer of the sessions into the home. During this phase the therapist is responsible for conducting skills-training exercises and mock play sessions with parents. Then parents begin to facilitate the play sessions under the therapist's direct supervision. The filial sessions transfer into the home setting, and the therapist facilitates consultations with parents regarding ongoing concerns, progress, and parenting skills. The closing phase involves assisting parents in generalizing skills throughout therapy, making a plan for discharge from services, and

conducting post-measures. This model is typically carried out within the dynamic of the therapist and the caregiver.

Child Parent Relationship Therapy (CPRT)

After years of experience with children in the playroom, Landreth had a growing belief that parents could be helpful to their children if they gained the same attitude and skills reflecting the environment provided for children in child-centered play therapy sessions (Landreth, 2002; Landreth & Bratton, 2006; Watts & Broaddus, 2002). In addition, the Guerneys' profound influence, Landreth's experience as a group leader, and a desire to reduce the intervention length were factors contributing to Landreth's development of child-parent relationship therapy (CPRT), a 10-session filial therapy model (Landreth & Bratton, 2006). Landreth and Bratton (2006) defined CPRT as follows:

A unique approach used by professionals trained in play therapy to train parents to be therapeutic change agents with their own children through a format of didactic instruction, demonstration play sessions, and supervision in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self esteem, and structuring weekly play sessions with their children using a special play kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent. (p. 11)

CPRT is a 10-session filial therapy model that uses a group format weaving together didactic information and group process (Landreth & Bratton, 2006). The model is designed for an average of 6 to 8 caregivers meeting together in 2-hour groups for 10 weeks. Therapists with

training and experience in group process, child-centered play therapy, and child development lead or co-lead the group. Sessions 1 through 3 focus on the building of group cohesion, safety, communication of the objectives of CPRT and the concepts of child-centered play. In addition, parents receive clear instructions on gathering a filial toy kit, structuring the play session in the home, and learning the basic do's and don'ts of play sessions. After Session 3, each member of the group is expected to begin sessions at home with the child of focus, record the session, and bring the tape to the group to be viewed for support and supervision. During Sessions 4 through 10 a schedule is designed so that home play sessions are viewed and supervision is provided each week. Parent-child play sessions may also be facilitated at the mental health clinic location for parents who are personally struggling with the skills or having difficulty conducting sessions in the home. It is expected that all group participants will bring a tape a minimum of one time throughout this process. Additional skills are taught; modeled, and practiced each week, such as therapeutic limit setting, choice giving, esteem building, and using encouragement versus praise. Discussion of generalizing concerns outside of play sessions and additional parenting concerns are addressed in Sessions 8 through 10. It is also recommended that during Session 10 plans are made for a follow-up meeting to discuss progress and additional concerns.

Many similarities and a few differences exist in the approaches utilized to facilitate filial therapy. However, the core objectives and goals are the common thread among models. Filial therapy aims to help parents understand and accept their child, gain insight into self, change perception of their child, increase general understanding of child development, and improve parenting skills. The hope for children is that they will increase the ability to express feelings, enhance self-esteem and self-responsibility, and reduce problematic behaviors (B. Guerney, 1969; L. Guerney, 2003; Landreth & Bratton, 2006; Van Fleet, 1994, 1998, 2000).

Parent's Involvement in the Child's Play during CPRT

It is important to note the distinction between the parent's involvement in the child's play and the parent is joining in the child's play. It is crucial that the parent always remain involved in the child's play. Verbal tracking, reflecting feeling, and maintaining appropriate body language are ways in which the parent communicates involvement. In this way the parent lets the child know, "I'm here, I hear you, I understand, I care" (Landreth & Bratton, 2006, p. 84).

Joining the child's play is done only when the child invites the parent into the play. When joining the play, the parent must take caution not to control the child's play. The parent's role is similar to the role of a child-centered play therapist.

The child-centered play therapist avoids interfering with the child's play, does not offer solutions or suggestions, and above all does not allow himself or herself to be manipulated into becoming the child's teacher or doing things *for* the child. Assistance is provided only in rare circumstances when the child has tried and truly cannot do something by himself or herself. (Landreth & Sweeney, 1997, p. 23)

Landreth and Sweeney highlight the importance of maintaining a certain role with the child. Teaching is an evaluative task, and doing things for the child communicates that the parent believes the child to be incompetent. It is important that the parent maintain good boundaries when entering the child's play, remaining non-evaluative and nonjudgmental and maintaining the relationship.

Evidence-based Research Outcomes

Outcome research with various populations contributes to the belief that CPRT is a well-researched and effective treatment modality. Continued execution of outcome research is needed to maintain and enhance the creditability of filial therapy. Bratton et al. (2005) conducted a

meta-analysis of 93 outcome-controlled research studies examining the efficacy of play therapy. Meta-analytic results on the effectiveness of CPRT indicated an overall large treatment effect size for CPRT ($ES = 1.25$). For Cohen's d an effect size of 0.2 to 0.3 might be a "small" effect, around 0.5 a "medium" effect, and 0.8 to infinity a "large" effect (Cohen, 1988). Practical significance is measured by the effect sizes. Practical significance indicates "the magnitude of the association between the independent and dependent variable" (Sink & Stroh, 2006, p. 402). Effect sizes indicate the strength of the relationship between the two groups; therefore, the large effect size of 1.25 indicates the significant impact of CPRT with participants. Bratton et al. (2005) clearly communicated the effectiveness of play therapy and filial therapy, revealing that when play therapy is delivered to a group of parents who conduct weekly supervised play sessions with their child, the result is a very large effect size in fewer sessions... The results of this research indicate that if a child and a parent are both firm candidates, filial therapy would be the most effective intervention. (p. 386)

A separate analysis within this study was conducted specifically for filial therapy, which resulted in a large treatment effect ($ES = 1.05$). These results indicate that filial therapy provided by parents, mentors, or teachers is effective at decreasing parental stress, reducing children's disruptive behavior, and enhancing parental empathy.

Overall research on CPRT includes 34 studies with a variety of presenting issues; 27 of these studies are controlled-outcome studies involving over 1,000 participants (Landreth & Bratton, 2006). Bratton and Landreth (1995) examined the effectiveness of the CPRT model with 43 single parents of children ages 3 through 7. This research indicated that, when compared to the control group, single parents in the experimental group ($n=22$) made statistically significant gains in increasing their level of empathy in interactions with their children, as

evidenced by a blinded rater's Measurement of Empathy in Adult Child Interaction (MEACI). The MEACI was the result of the rater's observation of 2 videotaped play sessions; recorded both prior to and at the conclusion of the parent's participation in CPRT. In addition, parents in the experimental group increased in their perceived acceptance of their child, reporting statistically significant decreases in parenting stress and in their child's disruptive behaviors.

Landreth and Lobaugh (1998) conducted 10-week filial sessions using the CPRT model with 32 incarcerated fathers of children ages 4 through 9. Research results indicated that incarcerated fathers in the experimental group ($n=16$) scored statistically significantly higher after training when compared to incarcerated fathers in the control group on their attitude, acceptance, and empathic behavior toward their children based on ratings on the Porter Parental Acceptance Scale. Fathers in the experimental group reported statistically significant decreases in their children's behavior problems and in their own stress related to parenting. Children in the experimental group also indicated a statistically significant increase in self-esteem based on results on the Joseph Preschool and Primary Self-Concept Scale.

Costas and Landreth (1999) conducted a CPRT study with non-offending parents of children who had been sexually abused. This research involved a total of 26 subjects, 14 in the experimental group and 12 in the control group. Results from the experimental group indicated statistically significant decreases in problematic behavior and anxiety with children ages 4 through 10 who were sexually abused. Statistically significant increases of acceptance of the child by non-offending parents and reduction in parental stress levels were reported in the experimental group.

Tew, Landreth, Joiner, and Solt (2002) examined the effectiveness of the CPRT model with parents of chronically ill children. This pre-post-randomized control group design involved

23 parents, 12 in the experimental group and 11 in the control group. Parents in the experimental group reported statistically significant decreases in stress related to parenting and decreases in children's disruptive behavior. Parents in the experimental group also reported significant increases in acceptance of their children. Kale and Landreth (1999) randomly assigned 22 parents of children with learning difficulties. Parents in the experimental group ($n=11$) reported statistically significant increases in their acceptance of their child and a significant reduction in parental stress when compared to the control group.

These are only a few of evidence-based research demonstrating the effectiveness of filial therapy with a wide range of populations. Continued execution of outcome research is always needed to maintain and enhance the creditability of filial therapy.

The literature often indicates the effectiveness of filial therapy with adoptive families. However, case studies and articles demonstrating the effectiveness of filial therapy are essential contributions to the field of play therapy (Ginsberg, 1989; S. Ryan & M. Madsen, 2007; V. Ryan, 2007; VanFleet, 2003, 2006). S. Ryan and Madsen (2007) provided a detailed case-analysis of using filial family therapy with an adoptive family and their adopted child with a previous history of maltreatment. The authors of this case study reported that family filial play therapy was helpful in strengthening relationships and increasing parenting strategies such as increases in their ability to therapeutically respond to behavioral difficulties. V. Ryan (2007) reported several vignettes that indicated the effectiveness of filial therapy with adopted children and their families.

Van Fleet (2003, 2006) provided an extensive rationale for the use of filial therapy with adoptive families. Van Fleet reported the benefits of using filial therapy to assist a young child in developing a secure attachment to an adoptive family as he transitioned from foster care. In

addition, VanFleet provided a detailed case study of an adoptive family involved in filial therapy, reporting that the family was able to strengthen relationships, strengthen attachment, and decrease problematic behaviors. Ginsberg (1989) also reported several case studies of adoptive families with comparable themes and outcomes.

While case studies do meet the requirement for evidence-based research, the findings offer support for the need to conduct outcome-based research in the area of filial therapy with adoptive families. However, after a thorough review of literature this researcher found no outcome research indicating the effectiveness of filial therapy with adoptive families.

Rationale and Possible Adaptations of CPRT with Adoptive Families

Rationale of CPRT with Adoptive Families

“Individual child therapy by itself is inadequate for treating attachment problems” (James, 1994, p. 59). Professionals specializing in adoption and attachment challenges agree about the need for dedicated and intense parental involvement (Forbes & Post, 2006; Ginsberg, 1989; Hughes, 1999; James, 1994; Kottman, 1997; Purvis et al., 2007; S. Ryan & Madsen, 2007; V. Ryan, 2007; Siegel & Hartzell, 2004; VanFleet, 1994). Parents serving as therapeutic change agents are an essential component in the healing journey of children from difficult backgrounds. The core of the attachment relationship is a matching and attuned relationship. For children with early interpersonal traumas, healing can take place as adoptive parents engage in a connected relationship with their child (Purvis, Cross, and Pennings, 2009).

James (1994) listed several necessary attributes of therapeutic parenting, such as understanding the child’s need to process and integrate past experiences; recognizing, acknowledging, and witnessing the child’s pain, and having enough self-awareness to seek personal support and therapy (p. 60). Filial therapy empowers parents to be therapeutic

caregivers to their children. “Sensitive understanding of the child occurs to the extent that the parent is able to put aside personal experiences and expectations and appreciate the personhood of the child, as well as the child’s activities, experiences, feelings and thoughts” (Landreth & Bratton, 2006, p. 81). Parents learn the skills in filial therapy to use the child’s language of play to facilitate a healing environment (Landreth, 2002; Landreth & Bratton, 2006).

Filial therapy identifies the relationship as essential to the healing process. “CPRT is based on the rationale that the relationship is the essential and curative therapeutic dimension for improving and correcting children’s problems and preventing the development of future problems” (Landreth & Bratton, 2006, p. 16). Adopted children who struggle with attachment challenges have difficulty maintaining close relationships. Parents have the responsibility to guide children in learning how to be in a mutually satisfying relationship with others (Forbes & Post, 2006; Purvis et al., 2007). Filial therapy is based on child-centered play therapy principles, including a relationship focused on unconditional acceptance, genuineness, warmth, patience, and empathy. These principles are fundamental to developing secure attachments in adoptive families.

CPRT, a 10-session filial therapy model, communicates the importance of four “be with attitudes” for the parent to exhibit during special play times with their children. These healing messages are I am here, I hear you, I understand, and I care (Landreth & Bratton, 2006, p. 84). The acceptance of the child through these four healing messages creates a safe haven for the child to initiate a secure attachment relationship at the unique developmental pace of the child.

The developmental sequence that characterizes a secure attachment contrasts significantly with that of a child who experiences chronic neglect, abuse, and placement with multiple caregivers. Often the maltreated child does not discover that he is special;

does not learn the joy and interest that is elicited from experiences of shared affect with his mother; and does not feel affirmed, identified, or important. (Hughes, 1999, p. 548)

The philosophy of filial therapy is for the parents to prize the unique experience of each child and trust the innate capacity of each child to heal. Relationships that provide experiences of connection, safety, and understanding are essential to the establishment of secure attachments (Siegel & Hartzell, 2004, p. 103).

CPRT is a 10-session filial therapy training model that combines didactic instruction with a supportive group environment. Child-centered play therapy techniques, limit setting, choice giving, and a variety of the skills are taught in an environment that also allows parents to learn and express their current feelings and concerns. The group dynamic of CPRT has the potential to create a supportive atmosphere for adoptive parents. Parents of adopted children often feel depleted and hopeless and experience a lack of support. They may not feel that their needs are met in traditional mental health services. In an exploratory research study conducted by Forbes and Dziegielewski (2003) of adoptive mothers of children with special needs, defined as children with diagnoses indicating significant emotional and behavioral impairments, 77% of mothers agreed or strongly agreed that they had experienced more rage and anger than ever before since the adoption of their child and 14% disclosed thoughts of suicide since the adoption of their child. It is often difficult for outsiders to possess a realistic view of the daily stresses a parent can face when raising an adopted child with demanding emotional needs.

The group experience can help normalize many struggles of raising adopted children while also validating the intense emotions of the parents. Parenting adoptive children requires the ability to relate to the child with affection and empathy, deal with frequent rejection from the child without taking it personally, and regulate intense personal emotions (Hughes, 1999).

Parents can integrate the new skills taught in CPRT only after they are able to process their feelings, emotions, and cognitions connected to parenting the child (Landreth & Bratton, 2006). In addition, connections made among parents in CPRT training sessions often extend to support outside of the weekly sessions, such as respite care and a supportive voice during stressful times throughout the week. The group dimension of the CPRT training model may enhance the benefits of filial therapy with adoptive families.

It is reasonable to assume that the consistent implementation of CPRT has long-term effects for the health of the child and overall family unit. Research studies focusing on the effects of adoption identify several key factors in the long-term mental health of the adoptee. According to their study of the mental health of adolescents who were adopted as infants, Benson, Sharma and Roehlkepartain (1994) identified six factors as essential to the well-being of adopted adolescents, including “a strong emotional attachment of child to parent and parent to child and the use of positive approaches to the issues unique to adoptive families” (p. 3). In addition, McCormick and Kennedy (1994) identified key factors between parent-child attachments and the self-esteem of adolescents. Their research indicates that those adolescents who classified their parent-child attachment as secure rated their parents as encouraging and accepting. Encouragement and acceptance are vital elements in filial therapy (B. Guernsey, 1969; Landreth & Bratton, 2006; Van Fleet, 1994). J. Smith (2001) reported that the adoption status is not the main risk factor contributing to behavioral and emotional difficulties in youth “but rather the feelings of parent toward child, whether positive or negative, that lead to feelings of being desirable or undesirable” (p. 497). The limited research available on the mental health of adults who were adopted at a young age identified similar key factors for secure attachment, including unconditional acceptance, open expression of thoughts and feelings, affectionate relationships,

and quality of parental bonding (Feeney, Passmore, & Peterson, 2007; Baldwin & Kay, 2003). It seems apparent, therefore, that the philosophy and interventions promoted in CPRT training support the potential long-term emotional health of adopted individuals.

Possible Adaptations of CPRT with Adoptive Families

Adaptations for the CPRT model of filial therapy developed by Landreth and Bratton (2006) are explored in the context of meeting the special needs of adoptive families. As previously discussed, the group format seems potentially effective for providing filial therapy training with this population. An extensive review of the literature indicates possible adaptations regarding CPRT protocol for some of the material in weekly sessions to specifically meet the needs of adoptive families.

This model is designed for 10 sessions; however, additional sessions may be added if needed. The adoption process is commonly associated with intense emotions, struggles, and surprises. Parents may need an additional session prior to the beginning of the 10-session training to have time to share their family's unique journey of adoption in a supportive and understanding environment. In addition, follow-up sessions are an option with the CPRT model. The difficult journey of establishing secure attachments in an adoptive family is time consuming, and follow-up sessions may have far-reaching benefits. Parents raising adopted children can benefit from ongoing support, resources, and words of encouragement.

Generally, it is important that the group leaders take into account the unique needs of the population present in the filial group. Material in each session should be adapted to fit the context of the group and should be applicable to the unique needs of parents. For example, in the first session the leader could show a video clip from NOVA's, *Life's First Feelings*, (WGBH, 2006). The leader could enhance the insight of the adoptive parents regarding struggles

connected to their child and the attachment disruption the child may have experienced as an infant. In session 1, the leader assigns parents the task of noticing one physical characteristic of the child they have not seen before. Adopted children often have to master the fear that they are unlovable, that the adoptive parents may send them back, or that they will always feel different than others (Kottman, 1997, p. 351). Therefore, an adaptation of this assignment could be to find a physical characteristic or positive behavior that the adopted child has in common with the parents. For example, the child and the parent laugh at the same jokes, or they both have a freckle on their right hand. This provides an opportunity to find a new connection in the relationship between parent and child.

Session 3 focuses on the do's and don'ts of the play sessions and preparation for the first in-home play session. A discussion of the possible play that may take place during the special playtime needs exploration. Children with a history of attachment disruptions and trauma can manifest intense play that may be disturbing and emotionally painful for the parent. The leader should normalize the need for personal counseling to deal with unresolved issues regarding the parent's own emotional triggers and traumas. Deeper self-understanding provides parents with the inner resources to increase emotional availability when connecting to their children (Forbes & Post, 2006; Hughes, 1999; Purvis et al., 2007; Siegel & Hartzell, 2004). It may be helpful to have a video demonstration or case example of play therapy with an adopted child to help parents prepare for the first play session. The option of having play sessions directly supervised at the clinic for at least the first few sessions may be offered to some parents based on the filial leader's use of clinical judgment and should strongly recommended for families in which the child is exhibiting severe behaviors.

In the majority of sessions the leader presents the option to end the group with a motivational poem, story, or rule of thumb. Several suggestions are provided in the manual; however, the therapist may want to explore resources that are specifically applicable to this population. Session 4 may be an appropriate time to introduce additional skills because the basics of the in-home play sessions have been covered. Children's book specifically addressing adoption, ideas for family rituals, calming exercises for the parents, or simple encouraging mantras to repeat during the week could be integrated into the closing portion of the group.

Choice-giving is introduced in session 6. During this session, the therapist should explore specific needs of each child.

Often, it is necessary to begin an adoptive placement by keeping the child in close proximity to his new parents so they can make many of his choices for him and provide him with a sense of safety. This child can begin to rely on his parents to decide which behaviors represent the best choice for him in the new setting. This results in fewer consequences for misbehavior because there are fewer misbehaviors, and the child is not repeatedly engaged in experiences of failure and shame. (Hughes, 1999, p. 562)

It may be recommended that some parents use only basic, positive, and empowering choice-giving skills for a while before progressing to choice-giving as a method of discipline. It is essential that the leader reiterate repeatedly that empathy and patience are the key factors in experiencing success with choice giving. It is common that children will initially make poor choices, exhibit increased opposition, or display angry outbursts. The use of advanced choice giving provides the parents the empathy for the child's choices without rejecting the child and perpetuating the insecure attachment. In addition, the concept of close proximity instead of time-out as a consequence for misbehavior should be discussed (Hughes, 1999; Purvis et al., 2007;

Forbes & Post, 2006). The concept of choice giving, close proximity, and the developmental needs of the child should be woven into the discussion for several sessions.

CPRT leaders introduce the concept of structured doll play in session 9; this is a way of storytelling for parents to help children who feel anxious or insecure. This skill could have numerous benefits for adoptive families, and CPRT leaders may want to introduce the technique in an earlier session. Adoptive parents may or may not have shared with their child that they are adopted or the story behind the creation of their family. Structured doll play can be one way of communicating the family's adoptive journey to the child.

By telling stories about the child's life before he or she came to live with the adoptive family, stories about the family's life before he or she came to live with the adoptive family, and stories about how the parents decided to adopt the child and the process of adoption can build a shared history that will make claiming occur more smoothly.

(Kottman, 1997, p. 348)

In addition, trauma creates a fragmented and disordered memory (Forbes & Post, 2006; James, 1994; Purvis et al., 2007). Constructing a coherent narrative for the child can have numerous healing benefits. Structured doll play can enhance communication between the parent and child, and additional emphasis may be beneficial when facilitating filial therapy with adoptive families. During the group training times therapists and parents could work together to develop the story and practice this new skill.

CPRT leaders may also need to make adaptations to the homework in session 9. Assignments for this week include counting the number of times the parent touches the child outside of play sessions and play-wrestling with the child. The parent may experience feelings of defeat if the child rejects physical interactions. Many children who have a past history of

trauma often resist physical contact with the caregiver as a way to protect self or sensory processing difficulties. The child's world is "easily distorted and social cues are often misread. Some children react by seeking out more of a particular sensation; others avoid that sensation at all cost" (Purvis et al., 2007, p. 39). The assignment may be rephrased to ask the parent to reflect on the child's change in physical contact since the beginning of the CPRT. In addition, the parent could be asked to explore the times or situations in which the child is more receptive to touch at home. CPRT leaders could facilitate this discussion with parents during feedback time of the weekly videotaped play sessions.

Adoptive families encompass unique characteristics that enable a filial leader to use creativity in developing adaptations. Being responsive to the needs of the population is an indication of sensitive insight and awareness on behalf of the filial leader. New skills are more readily integrated when one can assign personal meaning to the material being presented. CPRT provides a flexible yet structured format to meet the needs of a wide variety of populations.

CHAPTER 3

METHODS AND PROCEDURES

This experimental study used a repeated measures, control group design to investigate the effectiveness of child-parent relationship therapy (CPRT; Landreth & Bratton, 2006) with adoptive parents and their children who were identified as experiencing behavioral problems, compared to a wait list control group. A sample of adoptive families in the southwestern United States was randomly assigned to participate in CPRT, a 10-session filial therapy model developed originally by Landreth (1991, 2002). In CPRT, parents learn child-centered play therapy principles and procedures to use in play sessions with their children in order to enhance the parent-child relationship. In this chapter the definition of terms, hypotheses, instrumentation, participant selection, details of treatment, data collection, and analyses of data are discussed.

Research Question

Is child-parent relationship therapy effective in decreasing child behavior problems, reducing parent-child stress, and increasing parental empathy of adopted children and their parents?

Definition of Terms

For the purpose of this study, the following terms are operationally defined:

Adoptive parents. For the purpose of this study, an adoptive parent is operationally defined as the legally adoptive mother or father who is also the primary caregiver of the child.

Child-parent relationship therapy (CPRT). Landreth and Bratton (2006) defined this term as:

a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision

in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent. (p. 11)

A protocol for CPRT can be found in the treatment manual *Child-parent relationship therapy (CPRT) Treatment Manual: A 10-session Filial Therapy Model for Training Parents* (Bratton, Landreth, Kellam, & Blackard, 2006).

Empathy. The degree to which the adult can attend to the child's behavior, genuinely accept and verbally reflect the child's expression of feelings, and clearly demonstrate that the child is fully permitted to engage in current activity. For the purpose of this study, empathy is operationally defined by the parent's total scores on the Measurement of Empathy in Adult – Child Interaction (MEACI; Stover et al., 1971).

Externalizing behaviors. For the purpose of this study, externalizing behavior is operationally defined as the overall score on the Externalizing Problem scale on the Child Behavior Checklist for ages 1½-5. These behaviors include (a) Attention Problems, (b) Aggression, (c) Affective Problems, (d) Anxiety, and (e) Pervasive Developmental Problems (CBLC; Achenbach & Rescorla, 2000).

Internalizing behaviors. For the purpose of this study, internalizing behavior is operationally defined as the overall score on the Internalizing Problem scale on the Child Behavior Checklist for ages 1½-5. These behaviors include (a) Emotional Reactions, (b)

Anxious/Depressed, (c) Somatic Complaints, (d) Withdrawn, and (e) Sleep Problems (CBCL; Achenbach & Rescorla, 2000).

Parent-child relationship stress. Degree of reported parental stress based upon characteristics of both the child and the parent. For the purpose of this study, parent-child relationship stress is operationally defined as the total stress of the two domains of the Parenting Stress Index (PSI; Abidin, 1995): Child Domain and Parent Domain.

Research Hypotheses

The following hypotheses were formulated for this study:

1. From pretest to posttest, the treatment group will report a statistically significant decrease on the Total Problems scale of the CBCL when compared to the control group.
2. From pretest to posttest, the treatment group will report a statistically significant decrease on the Total Stress Domain of the PSI when compared to the control group.
3. From pretest to posttest, the treatment group will report a statistically significant lower mean total score on the MEACI when compared to the control group.

Instrumentation

Child Behavior Checklist – Parent Version (CBCL)

The CBCL 1½-5 measures parents' reports of children's behavioral and emotional problems based on children's social relationships, activities, and school performance. This instrument uses a Likert scale that gives respondents three possible answers (0) *not true*, (1) *sometimes true*, and (2) *very true* on a total of 99 items that describe children's different behaviors. The CBCL takes approximately 15 minutes to complete. The CBCL is composed of seven syndrome subscales. The syndrome subscales are categorized into one of the

following two categories: Internalizing Problems or Externalizing Problems. Internalizing Problems refers primarily to problems within the self, and it is measured through the Internalizing Problems syndrome subscales: (a) Emotionally Reactive, (b) Anxious/Depressed (c) Somatic Complaints, and (d) Withdrawn. Externalizing Problems refers to behaviors that are expressed outwardly and are in conflict with adults' expectations of children. The Externalizing Problems syndrome subscales include (a) Attention Problems and (b) Aggressive Behavior. Sleep Problems is an additional syndrome scale that is not included in either the Externalizing Problems scale or the Internalizing Problems scale, but is included under the Total Problems scale. A decrease in scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2000).

The normative population for the CBCL was based on a diverse sample, including children referred for clinical and special education services and children enrolled in various preschool, prekindergarten, and childcare settings. Children were residents of the United States, Canada, Australia, and Jamaica. The mean score of the test-retest reliability for the CBCL is strong ($r = .85$). The test-retest reliability for each syndrome subscale of the CBCL is as follows: emotionally reactive ($r = .87$); anxious/depressed ($r = .68$); somatic complaints ($r = .84$); withdrawn ($r = .80$); sleep problems ($r = .92$); attention problems ($r = .78$); aggressive behavior ($r = .87$); internalizing problems ($r = .90$); externalizing problems ($r = .87$); and total problems ($r = .90$). The content validity of the problem scales was strong, as was supported by research that determined that all but two items discriminated between referred and nonreferred children. The criterion-related validity of the problem scales was also supported by the differentiation between referred and nonreferred children (Achenbach & Rescorla, 2000).

Parenting Stress Index (PSI). The PSI is designed to identify parent-child systems that are under significant stress and at-risk for problematic parent and/or child behavior. The PSI can be used with parents of children ranging from 1 month to 12 years. This instrument uses a Likert-type scale on a total of 120 items. The PSI is divided into two domains, the Child Domain and the Parent Domain. In addition, the PSI offers a Total Stress score that combines Child Domain and Parent Domain scores.

Abidin (1995) explained high scores on the PSI Child Domain as being associated with children's qualities that contribute to difficulties in the parent-child relationship. The Child Domain measures a parent's perception in the following areas:

Distractibility/Hyperactivity: This subscale measures the parent's perception of a child's behaviors associated with ADHD. In addition, high scores could indicate that a parent cannot keep up with the child's energy level, older parents who are having difficulty adjusting to the child, and/or parents who have unreasonable expectations of their children's behaviors.

Adaptability: This subscale measures the parent's perception of the child's ability to adjust to changes in his or her social environment.

Reinforces Parent: This subscale measures parent ability to experience his or her child as a source of positive reinforcement.

Demandingness: This subscale measures the parent's perception of the child's demandingness level upon him or her. It is measured through the parent's perception of behaviors such as crying, physically hanging onto the parent, frequently requesting help, or having a high frequency of minor problem behaviors.

Mood: This subscale measures the parent's perception of the child's affective functioning by looking at behaviors such as crying and/or displaying signs of happiness.

Acceptability: High scores are produced in this area when the child possesses physical, intellectual, and emotional characteristics that do not match the parent's expectations.

Abidin (1995) indicated that high scores on the Parent Domain indicate that parents feel "overwhelmed and inadequate to the task of parenting" (p. 10). The Parent Domain measures a parent's perceived parental competency by measuring the following subscales:

Competence: This subscale measures the parent's self-perception of his or her level of parental competency. High scores in this subscale might be the result of parents lacking developmental knowledge about their child, and/or parents who do not find the parenting role as rewarding as they had expected. This subscale also measures parents' perceived level of acceptance and criticism from their child.

Isolation: Parents who score high in this area are often socially isolated from their peers, relatives, and emotional support systems.

Attachment: This subscale measures the parent's level of emotional closeness to the child and the parent's perceived ability to observe and understand the child's feelings and/or needs accurately.

Health: High scores are suggestive of deterioration in parental health that may be the result of either parenting stress or an additional independent stress in the parent-child system.

Role Restriction: This subscale measures the extent to which the parent experiences the parental role as restricting his or her freedom and ability to maintain own identity.

Depression: This subscale measures the presence of depression in the parent.

Spouse: Parents who earn high scores on this subscale are those who are lacking the emotional and active support of the other parent in the area of child management.

The PSI takes less than 30 minutes for parents to complete. The norm sample for the PSI included 2,633 mothers, with an average age of 30.9 years. The participation of ethnic groups in the sample was as follows: 76% White, 11% African American, 10% Hispanic, and 2% Asian. The children of focus for the sample varied in age from 1 month to 12 years. Coefficients for test-retest reliability were obtained from four different studies. For the Parent Domain, coefficients ranged between .69 and .91. For the Child Domain, coefficients ranged between .55 and .82. For total stress score, coefficients ranged from .65 to .96. The instrument has been validated with diverse populations in the United States as well as in other countries. The instrument has also been validated with at-risk populations including battered women, negligent mothers, parental drug exposure, teenage parents, and families at risk for parenting problems.

Measurement of Empathy in Adult-Child Interaction (MEACI). The MEACI was adapted by Bratton (1993) from a scale developed by Stover et al. (1971) to operationally define empathy as related to parent-child interactions. This direct observational scale measures three specific parental behaviors identified as major aspects of empathy in adult-child interactions: communication of acceptance, allowing the child self-direction, and involvement. The scale also provides a total empathy score. Lower scores indicate higher levels of positive behavior in each subscale and the total score.

The Communication of Acceptance subscale measures the adult's verbal expression of acceptance-rejection of the child's feelings and behaviors during the adult-child play sessions. The dimension of acceptance is viewed as a necessary condition for optimal development of the child's self-worth and the major element in the communication of empathy (Stover et al., 1971). The Involvement subscale measures the adult's attention to and participation in the child's play. Stover et al. (1971) found that high scores on the Involvement subscale may or may not be

related to high levels of empathy. Bratton and Landreth (1995) found that adults who exhibited high levels of communication of acceptance and allowing the child self-direction also demonstrated high levels of involvement.

The MEACI is a 5-point bipolar scale utilized to rate the three dimensions of adult-child interactions at 3-minute intervals for six consecutive rating intervals. The scale ranges from a high rating of 1 to a low rating of 5. Each point on the scale is followed by typical responses obtained from coding of the direct observations of parent-child interactions. Considering all three subscales together as components of empathic behavior, the highest levels of empathy are evident when the adult is frequently commenting on the child's expression of feeling or behaviors in a genuinely accepting manner; is clearly demonstrating that the child is fully permitted to engage in self-directed activity; and is attending fully to the child's behavior.

Reliability coefficients were established for the three subscales. After attending 4 training sessions for collaborative rating, six pairs of coders independently rated 7 to 10 twenty-minute parent-child play sessions. The average reliability correlation coefficient for the Communication of Acceptance was .92. The Allowing the Child Self-Direction had a median correlation coefficient of .89, and the Involvement subscale had an average of coefficient of .89 (Stover et al., 1971).

Construct validity for each subscale and the total empathy scores was demonstrated in a study with 51 mothers who participated in filial therapy training (B. Guernsey, & Stover, 1971). The validity of these scales was demonstrated through filial therapy training because it involved training parents in empathic skills that closely relate to the behaviors that the skills are intended to measure. The parents' levels of empathic interactions with their children were measured three times: (a) a pretraining play session; (b) the first posttraining play session; and (c) the third

posttraining play sessions. Highly significant increases, at the .005 level, between the first and third posttraining play sessions demonstrated that the scales are extremely sensitive measures of empathic behaviors. Concurrent validity was established by demonstrating a .85 correlation at the .005 level between the MEACI and a previously developed empathy measure for adult-child interaction (B. Guerney, Stover, & DeMerrit, 1968).

Participants

Human subjects approval from the University of North Texas Institutional Review Board was obtained prior to contacting potential participants. The investigator met with directors of adoption agencies and adoption support organizations in a large metropolitan area in the southwest region of the United States to discuss the project and obtain their support. Flyers with a brief description of CPRT and the investigator's contact information were provided to directors for distribution to their clientele of adoptive families. The investigator met individually with interested parents to discuss details of the study and to obtain consent prior to collecting data. These individual meetings took place in a confidential setting. Parents met the following criteria to participate in the study:

1. Parent identified himself/herself as the adoptive parent or foster-to-adopt parent of a child of normal cognitive functioning residing in the home
2. Parent identified concerns about his/her adoptive child's behavior
3. Parent consented to participate in CPRT
4. Parent spoke and read English

Consenting parents filled out the family background form (see Appendix B), and were interviewed individually to ensure that they met criteria for participation. Parents, who met criteria filled out the CBC, PSI, and for the purpose of obtaining data for the MEACI, completed

a 20 minute recorded play session with their adoptive child of focus for this study. Parents who expressed interest in the training but did not meet requirements for this study were offered the opportunity to participate in CPRT after completion of the study.

A total of 72 volunteer parents qualified for this study. I utilized a table of random numbers to randomly assign qualifying participants to the experimental and wait-list control group. Participants participating with their spouse/partner were randomly assigned as a unit. Initially 37 participants were randomly assigned to the experimental group and 35 to the wait list control group. Over the course of the study eight parents dropped from the study; two dropped from the experimental group due to life events that prevented their continued involvement, and six dropped from the control group due to moving or failure to complete post-test data. An additional three experimental parents were dropped from data analysis; one for missing more than 3 sessions and two due to extreme life events that interfered with validity of data. Thus, a total of 61 parents completed the study and were included in data analysis; 32 in the experimental condition and 29 in the control condition.

Because participants were recruited from a large metropolitan area, the CPRT intervention was held in four locations evenly spread across the area. Participants were allowed to select from the four locations. Meeting times were established based on parent feedback. Five parents met on Monday evenings from 6:30-8:30 and another group of five parents met on Tuesday evenings. A group of 10 parents met on Saturday afternoons from 4:30-6:30. Two groups were held on Sundays, eight participants met from 2:00-4:00 and seven participants met from 5:00-7:00. According to traditional CPRT methodology suggested group size is six to eight participants (Bratton, Landreth, et al., 2006). Due to the large response of this study and to allow parents to attend the location most convenient to them, co-leaders were used to accommodate for

the groups with larger than recommended numbers. The investigator, a licensed professional counselor-supervisor and registered play therapist-supervisor with extensive training in play therapy and the CPRT protocol, led all the CPRT groups. All co-leaders had also completed at least two graduate level courses in play therapy and one graduate-level course in the CPRT. Free childcare was provided for all training sessions. Childcare providers were specially-trained in skills to help them respond to children with acting-out behaviors.

Experimental Treatment

Parents of children assigned to the experimental treatment group participated in CPRT training and supervision. Consistent with CPRT methodology, parents met weekly in a 2 hour group format to facilitate small-group interactions. CPRT facilitates the enhancement of the child-parent relationship by training parents to become therapeutic agents in their children's lives. The curriculum content and procedures used during treatment followed the CPRT 10-session treatment protocol (Bratton et al., 2006). In order to assure adherence to the protocol, the primary CPRT facilitator was supervised by an expert in the CPRT protocol. To further ensure treatment integrity, all CPRT treatment sessions were video-recorded and the same expert viewed randomly selected videos to assess that the CPRT protocol was followed. As part of the CPRT protocol designed to ensure parents adherence to CPRT skills, parents are required to video-record their weekly play sessions with their children during which they apply the skills they are learning and then receive direct supervision. To facilitate the special parent-child play sessions, parents are provided a list of toys to collect before week 3 of CPRT. For the purpose of this study, play kits and video cameras were loaned to parents who expressed a need for these materials to complete the course.

Whereas the CPRT treatment protocol (Bratton et al., 2006) was used throughout the training, CPRT facilitators remained flexible to allot time for group members to engage in conversations regarding their adoption story including successes and struggles. Following CPRT protocol for Sessions 1-3, parents were taught essential CPRT skills. To accommodate to the unique experiences of adoptive families, the leader spent additional time processing the DVD clip from *Life's First Feelings* (WGBH, 2006) in light of the early experiences of children prior to adoption. The CPRT facilitator spent time helping parents grasp the relationship based philosophy of this program and the basic philosophy of play therapy. Parents practiced basic child-centered play therapy skills such as reflecting the child's feeling, reading non-verbal behaviors more accurately, tracking the child's behavior, reflecting the content of the child's play, using encouragement, therapeutic limit setting, and esteem building responses. Parents were taught the importance of structure and security for the adopted child and the need to facilitate special playtimes at the same time, day and location in order to establish an atmosphere of safety and predictability for the child.

CPRT protocol for Sessions 4-10 outlined in the CPRT treatment manual focuses on supervising and supporting parents as they facilitate weekly, 30-minute play sessions with their child during the last 7 weeks of the program. Each week, two parents were assigned to show segments of their videotaped sessions during group meetings for supervision purposes. The CPRT facilitator, as well as parents, used the CPRT skills checklist (Bratton et al., 2006) to provide feedback on parent skills while viewing parent-child play sessions. This procedure provided assurance of treatment integrity and reinforced learning by helping parents recognize and assess skills that were being taught. During Sessions 4 and 5, the leader taught parents the basics of therapeutic limit setting using the ACT model. The leader focused on choice giving

strategies in the 6th session training and the difference between praise versus encouragement in session 7 and 8. During the last two sessions, the leader taught advanced CCPT skills such as choice-giving and helped parents generalize the use of learned skills outside of their play session time. All parents videotaped their home-sessions in order to ensure completion of required play sessions. Parenting strategies taught in sessions 4-10 were explained by the CPRT leader with examples of behavioral struggles and emotional needs that many adopted children demonstrate such as controlling behaviors, difficulty regulating emotions, and struggles with appropriate peer and adult interaction. Detailed outlines of content and procedures for CPRT sessions 1-10, as well as required and supplemental handouts, are contained in the CPRT treatment manual (Bratton et. al, 2006).

Wait List Control Group

Parents of children assigned to the wait list control group were offered CPRT upon completion of the study. The same procedures followed for parents in the experimental group were followed for parents in the control group.

Data Collection

Parents who consented to participate in the study were interviewed by the investigator. Following the interview, the following data was obtained from parents: Family Demographics form, CBCL, PSI, and the MEACI. To ensure integrity of data collection, parents completed questionnaires in a controlled environment, free from distractions, and in the presence of the investigator who was available to clarify any questions. Parents were provided free childcare while they completed the CBCL and the PSI.

During the intake session parents were videotaped playing with their child for 20 minutes for the purpose of collecting pre-test data for the MEACI. Research assistants provided the

parent and child a room with toys traditionally used in filial sessions. The parent and child were provided with the following explanation: “This is a room where children and parents can play together. I’ll be back in 20 minutes to let you know that you have 1 minute left to play.”

Following the study, CBCL, PSI, and MEACI data was collected following the same procedures used at pretesting. To ensure confidentiality, participants were assigned random code numbers for use on all data. Data were stored in a locked filing cabinet in a secure location.

Analysis of Data

Data were obtained from the pretest and posttest scores of the CBCL, PSI, and MEACI completed by parents. Data were statistically analyzed in order to examine the effects of the experimental treatment on children’s behaviors, parents’ stress, and parental empathy when compared to the control group over time. The investigator consulted a qualified statistician to ensure the validity and appropriateness of all statistical analysis.

To ensure accuracy on the CBCL, a research assistant scored the assessments using computer software that requires all data to be entered twice. Pretest and posttest for PSI scales were scored twice by hand in order to ensure accuracy. Before conducting statistical analyses, a research assistant verified all data for accuracy a final time.

Statistical Package for the Social Sciences (SPSS 17) was utilized to analyze each dependent variable, using a two-factor (treatment group x time) repeated measures analysis to determine whether the CPRT group and the wait-list control group preformed differently over time. Specifically, a split-plot factorial analysis of variance (ANOVA) was performed on each dependent variable to analyze group differences, changes across time, and possible interaction effects which were of particular interest in this study. Dependent variables included parents’ ratings on the CBCL Total Problems scale and the PSI Total Stress domain and the blinded

raters' scores on MEACI Total Empathy. A reduction in scores on the CBCL, PSI, and MEACI indicates improvement. To avoid a Type I error that can result from the testing of multiple hypotheses, a .025 alpha level was established to either reject or accept hypotheses.

As previously stated, three participants in the experimental group were dropped from the study at the time of data analysis; one parent failed to complete the training protocol by missing four sessions, and two cases were identified as outliers due to extreme life events that could confound results. One case in the wait-list control group was removed for the analysis of the PSI Total Stress and Parent Domain due to not completing all questions regarding parent domain. Therefore data for 32 participants in the experimental group and 29 in the wait list control were utilized for the CBC and 28 in the wait list control for the PSI analysis. Due to technical difficulties with three recorded parent-child play sessions, there were 31 experimental videos and 27 wait-list control videos (total n=58) scored for the MEACI.

A team of raters blinded to participants' assignment to the experimental or wait-list control and to whether the play session was a pretest or posttest session scored the MEACI's. The pretest and posttest videos of parent-child play sessions were not rated until the completion of the study. Seven graduate counseling students with advanced training in play therapy and CPRT scored the videos. Prior to coding the video data, raters were required to review the MEACI scoring instructions and participate in a 2-hour training session. The training session included discussions and rating sessions following the original procedures outlined in Stover et al. (1971) and refined by Bratton (1993) and Bratton et al. (2006). Inter-rater reliability was established using recorded parent-child play sessions independent of the present study. Raters viewed and independently scored nine 3-minute segments of parent-child play sessions. Following the scoring of each 3-minute segment ratings were discussed to facilitate clarity of

scoring criteria. Inter-rater reliability was checked again at mid and end points following the same procedures used during the pre-rating training session.

The investigator used Stemler's (2004) 70% benchmark and procedure for calculating and interpreting consensus estimates of interrater reliability (i.e. percentage agreement estimates). Percentage agreement scores were calculated through dividing the total number of agreements by the total number of observations and multiplying by 100. Agreements were defined as ratings that fell within one point of the mode or most frequently occurring rating. For the pre-rating training session, raters attained 94% agreement across all data. For the mid and end point rating sessions, raters achieved a 96% and 100% agreement, respectively. Hence, raters demonstrated a high level of interrater reliability throughout the rating period.

Table 2 presents demographic information of the parents in the experimental and control group. Table 3 presents demographic information of the children of parents assigned to the experimental and control group.

Table 2

Demographics of Parents in the Experimental Group (n=32) and wait-list control group (n=29).

		experimental	control
Sex	Male	13	9
	Female	19	20
Age	26-29	2	0
	30-39	13	6
	40-50	16	17
	51-60	1	5
	61+	0	1
Mean Age		39.3	45.2
Ethnicity	European American	26	28
	Black American	2	1
	Hispanic/Latino	3	0
	Other	1	0
Participating in the study as:	Single	6	9
	Spouse/Partnered	13 couples	10 couples

Table 3

Demographics of Children in the Experimental Group (n=32) and wait list control group (n=29).

		experimental	control
Current Age of Child	2-4 years	11	9
	5-7 years	13	14
	8-10 years	8	6
Mean age		5.8	5.6
Age of Child when Adopted	<1 month	2	1
	1-6 months	3	1
	7 months-1 year	3	4
	1-3 years	10	16
	4-5 years	7	5
	5-7 years	5	2
	8+ years	2	0
Ethnicity	European American	14	15
	Black American	4	1
	Hispanic/Latino	6	3
	Other	8	10
Child Adopted by Means of:	Foster Care	18	11
	Private	1	2
	Domestic/Agency	4	3
	International/Agency	7	13
	Other	2	0

CHAPTER 4

RESULTS

This chapter includes the results of this study. Results of data analysis are presented in the order in which the hypotheses were tested.

Results

For each dependent variable, a two (group) by two (repeated measures) split-plot ANOVA was conducted to examine group differences, changes across time, and the possible interaction of change with group membership, which was of particular interest in this study. All assumptions for running split plot ANOVA were met. Dependent measures included the CBCL Total Problems (Achenbach & Rescorla, 2000), PSI Total Stress (Abidin, 1995), and the MEACI Total Empathy (Stover, Guerney, & O'Connell, 1971).

CBCL, PSI, and MEACI data were collected prior to and following treatment. CBCL and PSI data were gathered through parent report, whereas MEACI data were collected through direct observation of parent-child play sessions by raters blinded to the study. A reduction in scores on the CBCL, PSI, and MEACI indicates improvement in the targeted behavior. Wilks's Lambda was utilized to interpret results. Partial eta squared (η_p^2) effect sizes were calculated to assess the magnitude of difference between the two groups and to better understand the practical significance of findings (Kazdin, 1999). In the absence of prior CPRT outcome research with the target population investigated, and in keeping with previous CPRT research, Cohen's (1988) guidelines were used to interpret η_p^2 results: .01= small, .06= medium, and .14 = large.

Although participants were randomly assigned, a visual inspection of pretest means revealed that the experimental and control groups appeared to start out differently on the CBCL and PSI. One-way ANOVAs were conducted for CBCL and PSI to examine between group differences at pre-

test. The experimental groups reported higher levels of concern regarding Externalizing Problems on the CBCL and higher levels of stress on the Child Domain of the PSI at pre-test. Results from the 1-way ANOVA indicated the groups were not statistically significantly ($p = .077$) different regarding scores on the CBCL. However, results from the 1-way ANOVA for the PSI indicated that groups did start out statistically significant ($p = .026$). Therefore the PSI results should be interpreted with caution. The possibility that the experimental group's higher pretest mean score impacted the results and regression to the mean is plausible. Whereas this finding is a concern, it is important to note that the experimental group contained more parents working with children adopted through the foster care system and had children adopted at older ages. It is probable that these children may have had more breaks in primary caregivers and traumatic events that contributed to the adoptive parents' higher concerns regarding Externalizing Problems on the CBCL and stress related to child's characteristics on the PSI.

Hypotheses 1

From pretest to posttest, the treatment group will report a statistically significant decrease on the Total Problems scale of the CBCL when compared to the control group.

Table 4

Mean Scores on the Total Problems scale on the Child Behavior Checklist (CBCL)

	Experimental Group $n=32$		Control Group $n=29$	
	Pretest	Posttest	Pretest	Posttest
Total Problems				
Mean	64.03	57.44	59.00	57.62
<i>SD</i>	9.379	10.429	9.856	11.229

Note: A decrease in mean scores indicates an improvement in behavior.

Results for the dependent variable, Total Problems, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/ control); Wilks's

Lamda = .867, $F(1, 59) = 9.037$, $p < .004$, $\eta_p^2 = .133$. Post hoc power analysis revealed a robust power of .841. These results indicate that parents who participated in the experimental group reported a statistically significant decrease in children's Total Problems from pre-test to post-test when compared to parents in the control group. On the basis of these results, Hypothesis 1 was retained. Results further indicate that CPRT demonstrated a medium to large treatment effect ($\eta_p^2 = .133$) on children's behavior problems.

Hypotheses 2

From pretest to posttest, the treatment group will report a statistically significant decrease on the Total Stress Domain of the PSI when compared to the control group.

Table 5

Mean Scores on the Total Stress on the Parent Stress Index (PSI)

	<i>Experimental Group n=32</i>		<i>Control Group n=28</i>	
	Pretest	Posttest	Pretest	Posttest
Total Stress				
Mean	265.22	245.69	236.07	237.93
SD	44.371	39.509	31.220	39.854

Note: A decrease in mean scores indicates an improvement in behavior.

Results for the dependent variable, Total Stress, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Wilks's Lamda = .871, $F(1, 58) = 8.561$, $p < .005$, $\eta_p^2 = .129$. Post hoc power analysis revealed a robust power of .820. It is important to note that the control group sample is missing one participant due to incomplete data reported on Parent Domain. These results indicate that parents in the experimental group who received CPRT reported a statistically significant decrease in the Total Stress Domain from pre-test to post-test when compared to parents in the control group. On the

basis of these results, Hypothesis 2 was retained. Results further indicate that CPRT demonstrated a medium to large treatment effect ($\eta_p^2 = .129$) on parent-child relationship stress.

Hypotheses 3

From pretest to posttest, the treatment group will report a statistically significant lower mean total score on the MEACI when compared to the control group.

Table 6

Mean Scores on the Measurement of Empathy in Adult-Child Interaction (MEACI)

	<i>Experimental Group n=31</i>		<i>Control Group n=27</i>	
	Pretest	Posttest	Pretest	Posttest
Total Empathy				
Mean	44.06	27.355	45.35	43.370
SD	10.182	8.0117	10.080	10.8394

Note: A decrease in mean scores indicates an improvement in behavior.

Results for the dependent variable, Total Empathy, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Wilks's $\Lambda = .542$, $F(1, 56) = 47.351$, $p < .000$, $\eta_p^2 = .458$. Post hoc power analysis revealed a robust power of 1.000. It is important to note that one participant is missing from the experimental group and two participants from the control group due to recording failures of the parent-child play sessions. These results indicate that parents in the experimental group who received CPRT reported a statistically significant decrease in the Total Empathy score from pretest to post-test when compared to parents in the control group. On the basis of these results, Hypothesis 3 was retained. Results further indicate that CPRT demonstrated a large treatment effect ($\eta_p^2 = .458$) on parental empathy.

Post Hoc Analysis

Post hoc analyses were calculated to examine treatment impact on variables that seem of particular relevance to the caregiver population in the present study: the Externalizing Problems Scale of the CBCL and the Parent and Child Domains of the PSI. Because externalizing behaviors such as aggression, tantrums, and oppositional behavior were major concerns reported by parents at the initial parent intake, and throughout the study for the experimental group, it seemed important to examine this variable directly. In addition, at initial intake and throughout the study parents continually expressed experiencing high levels of stress and uncertainty in response to addressing the child's behavioral and emotional struggles. Parent comments indicated that they perceived the stress that they were experiencing in the parent-child relationship was primarily a result of child characteristics. Hence, post hoc analyses of the Parent and Child Domains of the PSI were conducted to examine each domain's contribution to parents' perceived stress and to determine if CPRT impacted these variables differently.

Externalizing Problems Outcomes

Table 7 presents the pretest and posttest means and standard deviations for the experimental group ($n=32$) and control group ($n=29$) on the Externalizing Problems scale.

Mean Scores on the Externalizing Problems Scale of the CBCL

	<i>Experimental Group n=32</i>		<i>Control Group n=29</i>	
	Pretest	Posttest	Pretest	Posttest
Externalizing Problems				
Mean	64.03	57.06	56.31	55.90
SD	9.966	10.500	10.167	10.682

Note: A decrease in mean scores indicates an improvement in behavior.

Results for the dependent variable, Externalizing Problems, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Wilks's Lamda = .827, $F(1, 59) = 12.37$, $p < .001$, $\eta_p^2 = .173$. Post hoc power analysis revealed a robust power of .933. These results indicate that parents in the experimental group who received CPRT reported a statistically significant decrease in the Externalizing Problems from pre-test to post-test when compared to parents in the control group. Results further indicated that the effects of CPRT treatment on the experimental group when compared to the control group were large ($\eta_p^2 = .173$).

PSI Child Domain Outcomes

Table 8 presents the pretest and posttest means and standard deviations for the experimental group ($n=32$) and control group ($n=29$) on the Child Domain of the PSI.

Mean Scores on the Child Domain of the PSI

	<i>Experimental Group n=32</i>		<i>Control Group n=29</i>	
	Pretest	Posttest	Pretest	Posttest
Child Domain				
Mean	129.13	115.97	114.14	114.31
SD	23.376	18.410	18.647	23.359

Note: A decrease in mean scores indicates an improvement in behavior.

Results for the dependent variable, Child Domain, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Wilks's Lamda = .813, $F(1, 59) = 13.605$, $p < .000$, $\eta_p^2 = .187$. Post hoc power analysis revealed a robust power of .952. These results indicate that parents in the experimental group who received CPRT reported a statistically significant decrease in the Child Domain subscale from pre-test to post-test when compared to parents in the control group. Results further indicate that the effects

of CPRT treatment on the experimental group when compared to the control group were large ($\eta_p^2 = .187$).

Parent Domain Outcomes

Table 9 presents the pretest and posttest means and standard deviations for the experimental group ($n=32$) and control group ($n=28$) on the Parent Domain of the PSI.

Mean Scores on the Parent Domain of the PSI

	<i>Experimental Group n=32</i>		<i>Control Group n=28</i>	
	Pretest	Posttest	Pretest	Posttest
Parent Domain				
Mean	136.28	129.72	121.50	122.79
<i>SD</i>	25.895	25.750	16.281	20.734

Note: A decreased in mean scores indicates an improvement in behavior.

Results for the dependent variable, Parent Domain, did not reveal a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Wilks's Lamda = .950, $F(1, 58) = 3.040$, $p < .087$, $\eta_p^2 = .050$. Post hoc power analysis revealed a low power of .403. It is important to note that the control group sample size is missing one participant due to incomplete data reported on Parent Domain. These results indicate that parents in the experimental group who received CPRT did not report a statistically significant decrease in the Parent Domain subscale from pre-test to post-test when compared to parents in the control group. Results further indicate that the effects of CPRT treatment on the experimental group when compared to the control group were small ($\eta_p^2 = .050$).

CHAPTER 5

Discussion

This study was designed to investigate the effects of child-parent relationship therapy (CPRT) with adoptive parents. Specifically this study examined the effects of CPRT treatment on reducing children's behavioral problems and parent-child relationship stress as reported by parents on the Child Behavior Checklist (CBCL) and Parenting Stress Index (PSI). In addition, the study examined the effect of treatment on increasing parental empathy as measured by the Measurement of Empathy in Adult Child Interaction (MEACI) scores obtained from raters blinded to the study. All three hypotheses were retained at the .025 level of significance, indicating an improvement in the experimental group when compared to the wait-list control group.

Additionally, the practical significance of the findings was examined through effect size calculations to better understand the magnitude of treatment effects on the dependent variables studied. Thompson (2002) stated that "effect sizes are particularly important because statistical tests are so heavily influenced by sample sizes" (p. 65). Practical significance indicates "the magnitude of the association between the independent and dependent variable" (Sink & Stroh, 2006, p. 402). Following Cohen's (1988) guidelines for interpreting effect sizes the CPRT treatment demonstrated a medium to large treatment effect on children's behavioral problems and parent-child relationship stress, and a large treatment effect on parents' empathic behavior. Researcher observations and caregivers' personal accounts are included to provide additional insight of the impact of CPRT with adoptive families.

CPRT Effects on Child Behavior Problems

Achenbach and Rescorla (2000) defined the Total Problems scale on the CBCL form as consisting of a combination of children's internalizing and externalizing behavioral problems. In addition, Total Problems includes sleep problems for the 1 ½ -5 year old version of the CBCL. For the 6-18 year old version of the CBCL, Total Problems also includes concerns related to social interaction, attention, and negative self talk. Results of Hypothesis 1 indicated that from pretest to posttest, parents who participated in the CPRT treatment group reported a statistically significant decrease on the Total Problems scale of the CBCL when compared to the control group. Based on the mean scores from pretest to posttest on the Total Problems scale of the CBCL, the experimental group demonstrated a 6.41 decrease in their mean score when compared to a 1.38 decrease for the control group. These results are consistent with findings from other controlled studies that showed statistically significant decreases in child behavior problems as a result of the CPRT intervention (Bratton & Landreth, 1995; Landreth & Lobaugh, 1998; Sheely-Moore & Bratton, 2010; Ceballos & Bratton, in press; Morrison & Bratton, in press).

The statistically significant decrease in overall behavior problems is particularly meaningful for adoptees, as this population of children demonstrates more total behavior problems than non-adopted children and is overrepresented in mental health referrals as reported by Juffer and Ijzendoorn in a meta-analysis (2005). In addition, Purvis and Cross (2005) reported that they have often seen that adopted/foster children with externalizing behaviors respond to the same interventions used for internalizing behaviors. Further, literature indicates that young children often present with co-morbid symptoms (Achenbach & Rescorla, 2000). Therefore focusing on a single diagnosis may not be in the best interest of young children, particularly young adoptees. Whereas this view appears to be antithetical to current trends in

mental health to utilize treatment interventions based on diagnosis, findings from the present study give credence to the view that young children often present with a wide range of behavioral concerns and provide support for the use of CPRT as an effective intervention to treat a combination of internalizing and externalizing behaviors exhibited by adopted children.

Post hoc analysis was conducted for the Externalizing Problems scale of the CBCL due to risk factors associated with unresolved externalizing behavior problems. Hinshaw (1992) reported that externalizing behaviors in children and adolescents appears to remain stable over time. In addition, children presenting with externalizing behaviors are resistant to most interventions and are considered to carry a worse prognosis than their peers. Children with externalizing behaviors have additional risk factors such as depression, substance abuse, and violence (Webster, Stratton, & Reid, 2003). Given that adopted children are over-represented in mental health referrals, parents reporting higher concern regarding externalizing problems than internalizing problems, and the risk factors associated with children with externalizing behaviors it seemed appropriate to conduct further analysis regarding the Externalizing Problems scale on the CBCL.

Achenbach and Rescorla (2000) defined the Externalizing Problems scale on the CBCL as consisting of behaviors that affect children's relationship with others. Behavioral difficulties in this subscale include aggression, rule breaking behavior, and attention problems. Parents reported throughout the study high concerns regarding externalizing behaviors such as tantrums, oppositional behavior, and aggression. Purvis and Cross (2005) found similar results from a survey of adoptive families with parents reporting tantrums as one of the highest behavioral concern at the time of their child's adoption. A close visual inspection of the group means at pretest revealed that externalizing problems were of greater concern than internalizing problems

for adoptive parents in both the experimental group and the wait-list control group. The Externalizing Problems scale also showed the greatest group difference between the experimental and wait list control group. The parents in the experimental showed higher level of externalizing behavior concerns.

Results of the post hoc analysis indicated that from pretest to posttest, parents who participated in the CPRT treatment group reported a statistically significant decrease ($p < .001$) on the Externalizing Problems scale of the CBCL when compared to parents who did not participate in CPRT. The findings regarding CPRT's large treatment effect when compared to the control group demonstrates the practical therapeutic value of this intervention. These results also indicate that the CPRT intervention addresses many parents' most pressing concerns regarding parenting their adopted child.

CPRT Effects on Parent-Child Relationship Stress

Results of the study indicate that from pretest to posttest parents in the CPRT treatment group reported a statistically significant decrease in parent-child relationship stress, as measured by the PSI Total Stress score (Abidin, 1995), when compared to the control group. Mean change scores from pretest to posttest revealed that the CPRT treatment group demonstrated a 19.53 point decrease in stress related to parenting, whereas the control group showed a slight increase in stress. These results are consistent with other CPRT controlled studies that showed a statistically significant decrease on scores for the Total Stress Domain of the PSI (Bratton & Landreth, 1995; Costas & Landreth 1999; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Sheely-Moore & Bratton, 2010; Ceballos & Bratton, in press).

Many adoptive parents report increased feelings of stress related to caring for adopted children who often present with emotional and behavioral struggles (Forbes & Dziegielewski,

2003). In addition, these parents report feeling un-equipped and unprepared for the aftermath of institutional care and its effect on their adopted child (Purvis & Cross, 2005). Parents struggling to connect, discipline, and understand can perpetuate heightened stress in the parent-child relationship. Higher levels of parenting stress are associated with negatively impacting the parent-child relationship and children presenting with disruptive behaviors (Deater-Deckard, 1998; Kazdin & Whitely, 2003). Parents' pretreatment scores reported on the CBCL and PSI indicated significant concerns, providing support for a reciprocal relationship between parenting stress and children's behavioral problems. Barth et al. (2005) contended that "it is the parent-child relationship that is the central reason adoptive parents come to therapy" (p. 264). CPRT training is a relationship-based approach empowering parents as the therapeutic change agent in the child's life. Parents participating in CPRT training gain skills to connect, respond, and strengthen the relationship with their child. The results of the study demonstrate that CPRT training can positively impact the parent-child relationship and decrease stress. However, to better understand contributing factors to parent-child relationship stress post hoc analysis was conducted on the Child and Parent Domains.

The Child Domain includes questions associated with children's qualities that contribute to stress in the parent-child relationship as reported by the parent. Abidin (1995) recommended that when scores are high in the Child Domain that professionals utilize treatment interventions geared towards positively impacting children's behaviors. Results from the post hoc analysis indicate that from pretest to posttest parents who participated in the CPRT training reported a statistically significant improvement ($p < .000$) on the Child Domain of the PSI when compared to the control group. Taking into consideration parents' high concern regarding Externalizing Behaviors on the CBCL, it appears that a relationship may be present between parents reporting

a decrease in externalizing behaviors and a decrease on the Child Domain of the PSI. In interpreting the results, it is important to take into account that the parents in the CPRT training reported higher levels of parent-child relationship stress at pretest. Therefore, it is possible that that regression to the mean may have been a factor in these results.

The finding regarding CPRT's large treatment effect ($\eta_p^2 = .187$) demonstrates its practical significance as a treatment intervention for addressing parent-child relationship stress. Leaders of CPRT focus on helping parents understand children's emotional needs through the use of basic child-centered play therapy skills. Hughes (1999) discussed that parental attitudes need to include empathy, unconditional acceptance, and playfulness. Hughes acknowledged how difficult it can be for parents to regulate their own emotions in the midst of continued opposition and emotional outbursts by the adopted child. CPRT leaders spend time each week helping parents increase in their ability to be responsive as opposed to reactive to the child's behavioral and emotional difficulties. It is possible that the statistically significant decrease on the Child Domain score is a reflection of parents' ability to perceive the child's behavioral struggles within a new framework with enhanced responsive strategies.

The Parent Domain includes subscales related to the roles and responsibilities of parenting such as competency, spousal support, and isolation. Abidin (1995) stated that "individuals who earn high scores feel overwhelmed and inadequate to the task of parenting" (p. 10). Results from the post hoc analysis indicated that from pretest to posttest parents who participated in the CPRT training did not report a statistically significant improvement ($p < .087$) on the Parent Domain of the PSI when compared to the control group. These results are particularly noteworthy given that there was a statistically significant decrease on Total Stress (p

< .005) and Child Domain ($p < .000$) for participants in the experimental group when compared to the control group.

It seems plausible from the results of this study that parents attribute more stress in the parent-child relationship to the child's behaviors as opposed to the role of parenting. Abidin (1995) supported this interpretation by stating "when Child Domain score is elevated in comparison to the Parent Domain score and Life Stress scale scores, the interpretation may be made that child characteristics are major factors in contributing to the overall stress in the parent-child system"(p. 8). Adoption literature often includes research regarding parenting stress in the parent-child relationship; however, this study provides possible insight as to the perceived source of the stress (Forbes & Post, 2006; Hughes, 1999; James, 1994; Perry, B. & Szalavitz, M., 2006; Purvis, Cross, & Sunshine, 2007). These findings indicate that parents attribute more stress connected to the child's emotional and behavioral characteristics than to the role of being a parent.

Many parents who participated in the study were raising both biological and adopted children and expressed increased stress regarding parenting their adopted child. Throughout the training parents reported feeling reasonably competent in the role of parenting; however, they felt unsure of how to handle the unique struggles of their adopted children. CPRT focuses on strengthening the parent-child relationship. Therefore, it would be expected that as parents experience a closer relationship with their children increased feelings of acceptance and understanding would occur resulting in decrease of stress in the parent-child relationship.

CPRT Effects on Parental Empathy

Results of the study indicate that from pretest to posttest parents in the CPRT treatment group reported a statistically significant increase in parental empathy, as measured by the

MEACI (Stover et al., 1971) when compared to the control group. The Total Empathy Score is comprised of the mean scores of three subscales of the MEACI: 1) communication of acceptance; 2) allowing the child to lead; and 3) involvement with the child. A decrease in the mean score indicates an increase in the desired behavior. The MEACI was scored by blinded raters' direct observation of pre and post parent-child play sessions. Based on the mean change Total Empathy scores from pretest to posttest, the CPRT treatment group demonstrated a 16.7 mean decrease, indicating a marked improvement in empathic skills, to a negligible 1.98 point decrease for the control group. All parents who participated in CPRT training increased in empathic behavior as evidenced by their individual mean change scores. The results are particularly noteworthy due the use of raters blinded to the study. The use of a direct observation measure also provides another source of measurement of treatment effect beyond parent report to support study findings. Given the statistically significant increase in parental empathy combined with the statistically significant reported decrease of child behavior problems and parent-child relationship stress it appears reasonable to consider a reciprocal relationship. Taking into account the results of all three hypotheses it is plausible that an increase in parental empathy is a significant factor that positively impacts children's behavioral problems and parent-child relationship stress.

CPRT is rooted in the philosophy of person-centered counseling developed by Carl Rogers. The communication of empathy is one of the core conditions essential for therapeutic change according to person-centered theorists (Fall, Holden, & Marquis, 2004). In addition, researchers have also hypothesized about the relationship between a lack of parental empathy and child maltreatment (Kilpatrick, 2005). Therefore, parents' significant increase in empathic behavior with their children is of particular note. Parental empathy is also believed to positively

impact children's development of pro-social behavior, social competencies, and ability to communicate empathy to others (Valiente et al., 2004). Conversely, children who are unable to empathically respond to others appear socially insensitive and display difficulty in self regulating their feelings and behaviors (Liew et al., 2003).

Researchers support creating parenting programs that focus on teaching parents to express a range of positive and negative emotions to their children in order to facilitate their children's ability to appropriately express emotions (Kilpatrick, 2005; Valiente et al., 2004). "Positive child-focused parent emotions have been well established as important in healthy parent-child relationships" (Kilpatrick, 2005, p. 609). A major goal of CPRT is teaching parents skills that communicate empathy and understanding to their child. Reflective responding, esteem building, and encouragement statements are skills that parents utilize to enhance the parent-child relationship and respond to their child's emotional world. The results of the study support CPRT as a promising parent training program to increase empathy present with interactions between parent and child.

Researcher's Observations

Throughout providing this intervention, I observed several seemingly important considerations for providing CPRT to adoptive families: 1) adoptive parents desire for additional training; 2) normalization and social support; and 3) significance of researcher/therapist understanding the impact of early trauma and attachment for children in relationship to parenting struggles/stress. These observations are supported by written and verbal feedback that parents shared with the investigator throughout the study. During the participant recruitment process, I observed an increased interest in participating in CPRT training when I shared with parents that I was also an adoptive parent. Many parents shared with me throughout the training that this was

the primary reason they agreed to participate in the training. In addition, adoptive families often know many other adoptive families; therefore, potential participants were recruited by word of mouth, adoption agencies, and faith-based adoption support ministries.

Adoptive Parents Desire for Additional Training

The response to offering training for adoptive families was overwhelmingly positive. Parents repeatedly reported the lack of post-adoption services and support. The lack of services is acknowledged by adoption researchers (Child Welfare Information Gateway, 2004a; Forbes & Dziegielewski, 2003; Purvis & Cross, 2005). One of the most powerful dynamics observed was the gratitude expressed by the parents for the CPRT training. One parent shared:

I got a huge kick out of hearing you apologize for having no gift cards (in reference to incentives often offered to research participants). I guess some people have grants to reward their participants. Improved parenting should be enough of a reward.....This type of training is worth thousands of dollars.”

Perhaps one of the most heart-felt expressions was expressed by this adoptive mom:

THIS IS JUST NOT 10 WEEKS IT’S A LIFESTYLE... thanks for saving our family.

I’m a better mom and my spouse is a better dad. I’m so completely grateful...I’m incredulous that you and (co-leader) would donate your time and effort. When I screw up I no longer wallow in it. I pick myself up and get back on track.

Many families expressed throughout the training that they wished they would have had this training prior to adopting or as part of foster parent training. Brazelton and Greenspan (2000) echo the same belief stating that incentive and higher remuneration should be given to foster parents based on the training and experience and their ability to stay with children until adopted. In addition, professionals working in the field of adoption reported a struggle to offer

quality services to adoptive families. Many professionals at adoption agencies expressed excitement and eagerly shared with parents this opportunity for training and support.

Normalization and Social Support

Adoptive parents shared throughout the training the personal healing and benefits of being able to share parenting struggles with other parents who really ‘understood’ and did not think they were ‘crazy’. Group members communicated that whereas many of their extended family were supportive of the adoption, they lacked understanding of the unique challenges of raising adopted children. Parents reported that family and friends are quick to offer ‘parenting advice’ that lacked empathy and insight to their specific parenting challenges.

Themes that parents often shared were that ‘no one can really understand what we are going through unless they have adopted themselves’ and ‘it feels so freeing and healing to know that other families are struggling with the same issues as I am with their adopted child’. In response to the question “what was most helpful about the training?” parents reported “the information was most valuable, but I also enjoyed hearing others experiences and giving voice to my own.” “Face to face contact with other parents who are struggling like we are/did was so helpful....so to be able to hear the stories, success and struggles, of other families was so encouraging.” “I liked finding someone else who had a very similar child. I no longer felt crazy when describing my controller child.” Group cohesion and safety appeared to happen quickly as parents shared their success/struggles along the adoptive journey.

Significance of researcher/therapist understanding the impact of early trauma and attachment

Although CPRT is not designed specifically for adoptive families the CPRT leader was able to utilize the content of each session to make connections to the needs of adoptive families. For example, the use of *Life First Feelings* (Nova, 2006) in the first training session was utilized

by the CPRT leader to enhance understanding of the effects of the early attachment process. Parents reported that this video clip provided new insight into their child's early experience and the connection to current behavioral struggles of the child. Many parents shared that this 'describes my child's experience'. In addition, the CPRT leader used this clip as the foundation for a teaching moment about the formation of the amygdala during 0-36 months, flight/fight/freeze responses, and implications for the child's struggles to self-regulate behaviors and emotions. Many parents reported that this information was one of the most valuable pieces of information that they learned and enabled them to create new insight and empathy for their child.

Often parents needed additional time to process regressed behavior that their adopted children presented within special playtimes as well as outside special playtimes. The CPRT leader spent additional time to discuss the impact of disrupted attachment and early trauma regarding child development. Differences between emotional age and developmental age were explored throughout the training. In the book, *The Boy Who Was Raised as a Dog*, Bruce Perry (2006) communicated this difficulty when talking with the adoptive parents of a young child:

The challenge is that, in one moment, you will need to have expectations and provide experiences that are appropriate for a five-year-old, for example, when teaching him a specific cognitive concept. Ten minutes later, however, the expectations and challenges will have to match those for a younger child, for example, when you are trying to teach him to interact socially. He is, developmentally, a moving target. That is why parenting these children is such a frustrating experience. One moment you are doing the correct thing and the next you are out of sync. (p. 223)

Parents reported that although ‘regressed’ behavior was often difficult to witness in their child’s play behavior, it also increased their empathy, understanding, and responsiveness to their child’s emotional needs.

Adoptive parents who also have biological children acknowledged the differences and the struggles of raising an adopted child when compared to their biological children. Consistently these parents shared feeling challenged and incompetent when discipline strategies that ‘worked with their biological children’ did not work with their adopted child. Parents raising both biological and adoptive children acknowledged the significant implications and differences of parenting children with early trauma and attachment breaks. Continually these parents shared that traditional parenting strategies such as time-outs, behavior charts, and reward-based systems were not effective with their adopted child. Often parents shared about their frustration with many of the traditional parent programs. One couple shared that one-day they finally ‘gave up’ and took all of “‘those’ parenting books that do not work to the used book store.” These parents reported that learning more about the implications of trauma and attachment decreased their feelings of incompetence when parenting their adopted child. Parents raising both biological and adoptive children reported that as a result of the training:

I seem to be more aware of her and her needs. I would try to redirect her. There was a power struggle between her and I, and I was quick to let her know that I was in charge. But I believe I backed off from that quite a bit and enjoyed being her dad. Now I feel closer, more connected to her. I have always loved her but I finally feel like I’m her dad and not just a caregiver.

Another parent shared:

One of the greatest things for me was the ability to allow my children to be who they are and respecting the experiences of their past. I'm no longer trying to make them like every other child and getting frustrated when I fail in that pursuit. They are incredible individuals who are such warriors to be where they after such pain in their lives.

Another parent raising both biological and adopted children shared with the CPRT

leader/researcher shared this account of an interaction with her 2-year-old adopted daughter:

I have to share something with you...yesterday she went into a full-blown meltdown. I picked her up and put her in my lap and reflected her feelings of frustration. She said 'Yeah Mommy. Need special play time.' I almost passed out! It was literally impossible to do it at that moment but I promised her that our special playtime was the very next day. She smiled, said 'OK Mommy!' and hopped out of my lap and went on playing sweetly. I can't tell you how grateful I am that we found our way to this CPRT group. This is radically changing our baby girl and our entire family!

Because of early trauma, frequent caregivers, and attachment breaks the majority of adoptive parents quickly connected to the philosophy of the strengthening the parent-child relationship as one of the vehicles for behavioral changes. The CPRT leader frequently reiterated this rationale during the training. Parents reported that this reminder helped increase responsiveness as opposed to reactivity to the adopted child's resistance to traditional discipline strategies.

Additional Observations

I observed that it was difficult to cover all of the material for each session in the CPRT protocol. Many of the parents appeared to need additional time to process personal feelings

regarding parenting their child. Several times parents shared how this class was more about changing themselves as opposed to changing the child. Therefore, personal processing of this shift in perception was time consuming; however, it was essential to the process. Parents also verbalized that this was the first time they felt really understood and connected to others regarding the joys and struggles of adoption. Time in the group was spent allowing participants time to share their personal adoption journey and connect with others.

Because of this observation I believe that follow-up groups would enhance this training for adoptive families. I was surprised at the minimal attrition that occurred while offering this training. For the experimental group 95% of the participants completed the training. One of the two participants discontinued training because the children she was planning to adopt in the next few weeks were surprisingly court ordered by the judge to a kinship placement, the other parent discontinued for personal reasons. I shared with participants this high commitment level to the training demonstrated by this dedication and high rate of completion. However, many participants minimized this accomplishment by verbalizing that it was driven out of their desperation for post-adoption support and services. A mother with several adopted children who attended the CPRT training with her husband wrote the following as the training was approaching the end:

I cannot tell you how much this training has meant, how much better I understand my kids and just being accepting of where they are at. Also, this is about the only time I've seen (spouse) move from his views to being able to accept a different perspective on how to help our traumatized kids. I'm VERY sad that our 'life-line' is ending. Would love a way to stay connected. We will continue the play sessions as it's almost as important to my kids as oxygen.

Therefore, I believe that many adoptive families need, and would eagerly participate in, follow-up groups for ongoing support and personal processing.

I also observed that most parents preferred the groups to be conducted in the evening or on the weekends. Most parents worked full-time and/or drove significant distances to be part of the training. Sunday afternoon/evenings and Saturday evening appeared to be a favorable time for the majority of families.

In addition, the need for well-trained childcare providers is essential. Many of the children that participated in childcare presented with high levels of externalizing behaviors. All childcare providers were trained in the same discipline strategies taught to the parents in the CPRT training. Many parents reported the struggle to find childcare/babysitters they could trust with their adopted children. Parents expressed relief at the quality of childcare provided while they attended the training. Childcare workers also shared how much they enjoyed being with the children and personal growth they experienced. Several of the college students that provided childcare have future career goals of being a teacher or therapist. They expressed how grateful they were for this opportunity and how it will directly impact how they interact with children in their future profession. Several times individuals providing childcare reported the changes they were seeing in the children such as responding to limits, increased self expression, and maintaining appropriate play interactions with peers.

It also appears that children being in childcare with other adopted children may also have therapeutic benefits. One parent shared that her daughter struggles with accepting her adoption, making friends, and continues to grieve about leaving her birth country. Through the duration of attending weekly childcare she made friends with another adopted child. The parent reported at the last session that her daughter shared with her that this little girl was her best friend. When

questioned as to why the child reported “because she is the only one who really understands me”. The parents of both of these children were able to exchange phone numbers and arrange additional play dates for the two children.

Limitations of the Study

This is first study to empirically explore the effects of CPRT with this population and provides valuable information for mental health professionals working with adoptive families. However, several limitations to this research study need to be taken into account. First, the subjects involved in this research were volunteers; therefore, their motivation to participate could be a factor that differentiates them from the general population. A limitation for this study is that to qualify for the study scores on the CBCL or PSI were not required to be in the clinical or even borderline ranges. Many of the adoptive families reported scores in these ranges; however, some parents reported concerns with their adopted child, yet scores did not fall in the borderline or clinical range. In addition, a limitation of the study is the use of a wait-list control group. The statistical difference found between the experimental group and the wait-list control group could have been caused by the fact that the experimental group was receiving a treatment intervention while the control was not.

In the future a research design comparing CPRT with adoptive families to an evidence-based parent treatment program for adoptive families would be increase confidence that finding are more directly connected to the CPRT treatment intervention. Perhaps, the most significant limitation is the use of only one source of measure, parent report, to assess change in the child. However, the utilization of the MEACI provides another source of measure to this study contributing to the validity of these results. Also, I led or co-led all CPRT groups. While I believe this strengthened treatment integrity and internal validity, it also could have introduced a

degree of personal bias. In addition, this preliminary study does not account for distinctions between international and domestic adoptions or the child's age at the time of adoption. This may limit generalizability to unique adoptive situations and implications for issues concerning foster care.

Recommendations for Further Research

Based on the limitations and findings of this study, several recommendations for future research can be made:

1. The present study is limited to reporting the immediate effects of CPRT on children's behavior, parenting stress, and parental empathy. A follow-up study to investigate long-term effects of treatment is needed.
2. A multi-site study to increase generalizability of results.
3. The utilization of multiple sources of measure for a single dependent variable.
4. Conduct a comparison study of CPRT to a well-researched intervention for this population.
5. In effort to gain additional information related to the effectiveness of CPRT with adoptive families, comparisons between CPRT protocol and other parent programs designed for adoptive families should be researched.
6. The current study did not distinguish between international adoption, foster care, and child's age of adoption. Future research should be conducted focusing on specific adoptive populations to validate the use of CPRT treatment with this population.
7. The present study had a relatively small sample size of 61 participants. Replicating the study with a larger sample size is necessary to allow for greater generalizability of

findings and move forward to establishing CPRT as an evidence-based treatment for adoptive families.

8. Explore altering the format of the CPRT training. Traditionally training sessions are offered once a week for ten weeks. This is a substantial time commitment for families. While maintaining the use of the treatment protocol, variations such as intensive weekend training with additional follow-ups or trainings twice a week for five weeks with additional follow-up sessions should be explored.
9. Conduct a qualitative study to provide greater insight and understanding of the CPRT process and experience with adoptive families.

Conclusion

Creating healthy and secure relationships for parents and adopted children is an essential therapeutic need for adoptive families. Children who lack secure parent-child relationships are at greater risk for exhibiting disruptive behaviors, poor social adjustment, and inability to self regulate feelings and behaviors (Van Fleet & Sniscak, 2003). Children in adoptive and foster placements are at particular risk for forming insecure attachments due to a variety of factors including changes in primary caregivers as well as exposure to repeated traumas such as neglect, abandonment, and abuse. Thus, researching and identifying early mental health interventions for adoptive families that target the parent-child relationship is critical to the long-term welfare of children.

CPRT is a developmentally responsive intervention utilizing full involvement of the parent in the child's treatment. In addition, CPRT is a relationship-based therapeutic model with the philosophy that the parent-child relationship is the vehicle for change. The findings of the study are noteworthy as results indicate that CPRT can significantly decrease parent-child

relationship stress, reduce children's problem behaviors, and increase parental empathy. Further, the results of this study are in opposition to claims by researchers that non-directive and/or child-centered approaches are not effective with adopted children and/or children with attachment challenges (Purvis, Cross & Sunshine, 2007; Van Fleet & Sniscak, 2003). Because adoptive families are seeking to establish a secure relationship with their adopted child and existing literature indicates that adopted children often demonstrate disruptive behaviors and increased parent-child relationship stress, the present findings support CPRT as a well suited intervention for this population.

With over 129,000 children available for adoption in the United States foster care system combined with the thousands of children available internationally and through private adoption, the need for evidence-based mental health services for this population is imperative (Evan B. Donaldson Adoption Institute, 2007). Based on an extensive review of literature, this present study represents the largest randomized controlled CPRT/filial study to date and appears to be the first study utilizing CPRT with adoptive families. In addition, this present study also appears to be the largest randomized controlled CPRT study to date involving the participation of couples and fathers. As such, this study contributes to the field of play therapy by adding to its evidence-base as an effective mental health intervention for children. More specifically, these findings provide positive support for the use of CPRT/filial therapy methodology as well as for interventions using child-centered play therapy principles and procedures. The use of a manualized treatment protocol provides a means of ensuring treatment integrity and allows mental health practitioners and researchers to easily and responsibly replicate this intervention. Potentially, as a result of this study, the use of CPRT with adoptive families will continue to be explored and researched.

APPENDIX A
CONSENT FORM

University of North Texas Institutional Review Board

Informed Consent Form

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

Title of Study: The Efficacy of Child Parent Relationship Therapy (CPRT) with Adopted Children and Their Parents: Effects on Child Behavior, Parent-Child Relationship Stress, and Parental Empathy.

Principal Investigator: Kara Holt, PhD candidate at University of North Texas (UNT) Department of Counseling and Higher Education. Dr. Sue Bratton, Associate Professor at University of North Texas (UNT) Department of Counseling and Higher Education, is the faculty advisor for this research study and can be contacted at (940) 565-3864.

Purpose of the Study: You are being asked to participate in a research study which involves measuring the effectiveness of a parent training model called Child Parent Relationship Training (CPRT). The goal of CPRT is to help parents build a stronger relationship with their children. CPRT aims to help parents connect with their adopted child by understanding their children's concerns and helping them learn developmentally appropriate responses that foster healthy social-emotional development.

Study Procedures: The entire project should take approximately **twenty-nine hours**. There will be **twenty-four** hours of training plus time to complete paperwork for pre and post-tests. You will meet **weekly** with the trainer for **two hours** in a group with other parents. You will also do **seven weekly** play sessions with your child at home. Each play session will be about **thirty minutes**. You will also be videotaped playing with your child to help you better understand your child's needs and to help you learn responses that can help your child feel closer to you, while facilitating your child's communication with you through play. Through play, children can more comfortably communicate their world, especially when they have experienced events outside of their cognitive understanding. The ten-week training will include the following:

Before the ten-week training you will be asked to answer some basic questions about yourselves, your child, and your relationship with your child. This will be done in written form using two standard assessment forms: the Parent Stress Index (PSI) and the Child Behavior Checklist (CBC). The PSI asks questions about your level of parenting, and the CBC asks questions about your child's behavior. Before beginning CPRT you will also be videotaped playing with your child.

During the ten-week CPRT training, you will learn skills that are designed to strengthen your relationship with your child, understand your child's needs, help you know how to respond to your child in difficult situations, and help your child feel understood and loved. Video and live demonstrations, live practice sessions, role-plays and group discussion will be used to help you apply CPRT skills. The weekly group sessions will be videotaped. You will also be videotaped

playing with your child throughout the 10 week session to assist you in learning the CPRT skills. Your identity will not be revealed and all video tapes will be destroyed at the end of the project.

After the ten-week training, you will be asked to complete a PSI and CBC and participate in a final **thirty minute** videotaped play session with your child.

Foreseeable Risks: There are no foreseeable significant risks to participating in this study. The investigator will attempt to minimize discomfort by ensuring that you do not feel pressured to disclose information that would cause discomfort.

Benefits to the Subjects or Others: Potential benefits of being in this project may include a stronger parent-child relationship, increased confidence in parenting and reduced problem behaviors of your child. You may also benefit from being with other parents who are experiencing similar experiences with their child.

Procedures for Maintaining Confidentiality of Research Records: You will be assigned a code and only that code will be used on any stored information you provide, including videos. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study. No one will view your group or play session recordings, look at your assessment responses or see your videotaped play sessions other than the investigator. Your recordings will be kept for no more than two years beyond the end of data collection and then the recordings will be destroyed by the investigator. All recordings and assessments will be securely locked in a secure location in Stovall Hall Room 114 at the University of North Texas, Denton, TX.

Questions about the Study: If you have any questions about the study, you may contact *Kara Holt* or my faculty advisor Dr. Bratton.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

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

- The researcher, Kara Holt, has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
 - You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
 - You understand why the study is being conducted and how it will be performed.
 - You understand your rights as a research participant and you voluntarily consent to participate in this study.
 - You have been told you will receive a copy of this form.
-

Printed Name and Signature of Participant

Date

For the Principal Investigator or Designee:

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

Signature of Principal Investigator or Designee

Date

APPENDIX B
FAMILY BACKGROUND FORM

FAMILY INFORMATION FORM

Your name: _____ Your relationship to child: _____
How old are you? _____ What is your race? _____
Contact number: _____ Best time to call you: _____
Your child's name: _____ Child's age: _____ Child's race: _____
What age was your child when adopted? _____
Did the child live with you prior to being adopted? _____ If yes, how long? _____
Was your child adopted through (check one)
____ foster care
____ privately
____ agency, if yes, please check the following:
 ____ Domestic
 ____ International, if yes, which country? _____
____ other (please specify): _____

BASIC INFORMATION

Is your child in counseling now? No____ Yes____
Is your child receiving special education or other services (physical, speech, occupational therapy, etc.)? No____ Yes____
If yes, explain _____
Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? No____ Yes____
If yes, please provide the name and address of the previous mental health professional or agency:

Your child's current household (check one):
____ Adoptive mother only
____ Adoptive Father only
____ Adoptive Parents/Partners
____ Blended Family (both spouses/partners with children from previous relationships)
____ Other (specify _____)

Including yourself and your child, how many children and adults live in your home? _____

What is the highest grade you completed in school? (circle one)

Grades: 1 2 3 4 5 6 7 8

High school: 9 10 11 12 GED

College: 13 14 15 16 17+

Are you currently employed? Yes No

If yes, what is your current job? _____

Are you currently taking a parenting class? Yes____ No____

Any concerns you have about this child?

Is there a diagnosis or medication that your child is now receiving or has received?

Anything else you would like to share about this child?

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