THE EFFECTS OF CHILD PARENT RELATIONSHIP THERAPY (CPRT)

FOR ADOPTIVE FAMILIES

Kristie K. Opiola, M.Ed., LPC, RPT

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APPROVED:

Sue C. Bratton, Major Professor
Dee Ray, Committee Member
Leslie Jones, Committee Member
Jan Holden, Chair of the Department of Counseling and Higher Education
Bertina Hildreth Combes, Interim Dean of the College of Education
Victor Prybutok, Vice Provost of the Toulouse Graduate School
Adoptive parents often struggle to understand and meet the social-emotional behavioral needs of their adopted child, particularly when the child's pre-adoption experience lacked a secure relationship with an attuned and responsive caregiver. This randomized controlled study, a replication of Carnes-Holt and Bratton’s 2014 research, investigated the effects of child parent relationship therapy (CPRT) for adoptive families who reported attached-related concerns such as difficulties establishing a mutually satisfying parent-child relationship as well as concerns about the adopted child's behavior and parental stress. Participants were 49 adoptive parents (61% female; 7% couples; 86% European American, 6% Latino, 6% Asian, and 2% Black American) with adoptees between the ages of 2.5 to 9 (50% female; 35% European American, 22% Asian, 12% Latino, 10% Black American, and 21% Biracial or other). Eighty-four percent of children were adopted internationally or from the foster care system. Parents were randomly assigned to CPRT or treatment as usual (TAU). Results from 2 (group) by 2 (time) repeated measures ANOVAs indicated that compared to the TAU control group, parents who participated in CPRT reported statistically significant improvement in child behavior problems, parent-child relationship stress, and parental empathy, with a large treatment effects on all measures. Findings confirmed results from Carnes-Holt and Bratton's study and provided strong support for CPRT as a responsive intervention for adoptive parents and their children.
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By

Kristie K. Opiola
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ADOPTIVE FAMILIES

Adoptive families represent a growing segment of the population in the United States. Approximately 136,000 children are adopted yearly (Child Welfare Information Gateway, 2012), adding to the current estimate of 2 million adopted children (Kreider & Lofquist, 2014). International adoptions and foster care-based adoptions together account for over half of U.S. adoptions (Vandivere, Malm, & Radar, 2009). Children’s pre-adoption experiences vary on a continuum of supportive and nurturing to neglectful and abusive. Early relational experiences lay the foundation for how children interact with others, explore their world, cope with stress, regulate their emotions, and create relationships (Bowlby, 1988; Carnes-Holt & Bratton, 2014; Perry & Szalavitz, 2006; Siegel & Hartzell, 2004). A secure attachment relationship is essential to children’s optimal brain development and overall wellbeing (Siegel & Payne Bryson, 2014). Unfortunately, for many adopted children, their early experiences did not provide a secure bond with an attuned and supportive caregiver. Children whose pre-adoption experience included neglect, frequent changes in caregivers, prolonged periods of isolation, and repeat abuses often exhibit intense emotional and behavioral challenges (Brodzinsky, 2013; Hughes, 2006) and may reject adoptive parents’ efforts to connect and form a close relationship (Lanius, Vermetten, & Pain, 2010; Nelson, Bos, Gunner, & Sonuga-Burke, 2011). Adoptive parents are often confused, discouraged, and hurt by their child’s intense reactions (Hughes, 2006). As a result, up to 25% of adoptions results in disruptions or termination (Child Welfare Information Gateway, 2012).

Loving and responsive adoptive parents can have a major influence on helping adoptees overcome the adverse effects of early interpersonal trauma associated with attachment disruptions (Perry & Szalavitz, 2006; Purvis, Cross, & Sunshine, 2007), yet many adoptive
parents report feeling overwhelmed and ill-equipped to understand and meet the social-emotional and behavioral needs of their children (Hughes, 2006; Brodzinsky, 2013). Although adoptive parents are more likely than the general population to seek mental health services to cope with the stressors related to parenting an adoptee (Brodzinsky, 2013; Howe & Fearnley, 2003), there is a dearth of proven adoption competent services (Brodzinsky, 2013). Adoption and attachment authorities agree that interventions are needed that are responsive to the unique challenges and needs of adoptees and emphasize those parents should play a key role in the therapeutic process (Brodzinsky, 2013; Hughes, 1999; Perry & Szalavitz, 2006; Purvis et al., 2007; V. Ryan, 2007; Siegel & Hartzell, 2004). Recognizing a shortage of adoption competent services, the Donaldson Adoption Institute commissioned a study to better understand the mental health needs of adoptive families and to identify and evaluate empirically supported adoption specific interventions (Brodzinsky, 2013). Brodzinsky identified a handful of promising parent-child interventions and based on a randomized controlled study by Carnes-Holt and Bratton (2014), named child parent relationship therapy (CPRT; Landreth & Bratton, 2006) as the parent-child intervention demonstrating the most robust empirical support for helping adopted children and their parents. However, further research is needed to confirm CPRT as an evidence-based intervention for adoptive families.

Needs of Adoptive Families

Over half of children adopted annually have experienced multiple disruptions in their attachment relationships, and far too often, they have experienced abuse and neglect (Public Broadcasting Station [PBS], 2010; Purvis et al., 2007). The rate is even higher for children adopted internationally and through the foster care system due to greater potential for multiple losses of caregivers (Carnes-Holt & Bratton, 2014; Tan, 2006). Adverse early caregiving
experiences can significantly hinder young children’s ability to form secure attachments, impede their holistic development, and impair their ability to form close emotional connections throughout their lifetime (Brodzinsky, 2013; Perry & Szalavitz, 2006; Purvis et al., 2007). Children who lacked attuned and predictable caregiving early on tend to misattune to their new caregivers and misread the cues of the other. As a result, parents are often confused by their child’s reactive responses as they are unaware of what triggered the child’s behavior. Adoptive parents may feel they are failing as parents as their child rejects their efforts to build a close, nurturing relationship (Purvis et al., 2007). These types of misattuned interactions between child and parent can lead to parent-child relationship stress and overall lack of enjoyment in parenting (Hughes, 2006; Purvis et al., 2007).

Compared to peers, adopted children are at greater risk for impaired day to day functioning including psychological problems (Hussey, Falleta, & Eng, 2012), behavioral problems and poor cognitive functioning (van IJzendoorn & Juffer, 2006; Tan & Marfo, 2016), and diminished social development (Leerkes, Blankson, & O’Brien, 2009). Juffer and Van IJzendoorn investigated the prevalence of behavior problems in adopted and non-adopted children and found greater occurrence of behavior problems for adopted children and higher rate of comorbidity of internalizing and externalizing problems. The high rate of co-occurring behavior problems in children presenting for treatment is supported in literature (Angold, Costello, & Erkanli, 1999; Jensen & Weisz, 2002; Ray, Stulmaker, Lee, & Silverman, 2013; Weisz & Kazdin, 2010). The findings regarding co-morbid presenting issues suggest the need to identify interventions that are responsive to broad spectrum behavior problems, particularly for adoptees.
Understanding the social-emotional and behavioral needs of children who experience early trauma can help adoptive parents provide a relationship that promotes secure attachment and healing (Perry & Szalavitz, 2006; Purvis et al., 2007). Majority of adoptive families are required to participate in pre-adoption preparation to help them understand the risk factors associated with adopting children who may have experienced early traumatic events. Unfortunately, pre-adoption preparation may not be enough as many adoptive parents report feeling ill-equipped to manage their children’s significant behavior problems and high levels of relational stress (Brodzinsky, 2013; Hughes, 2006; Purvis et al., 2007). According to Purvis, Sunshine, and Cross (2007), adoptive parents benefit from mental health services that provide parent skill training that focuses on responsive ways to connect and develop a secure attachment with their adopted child.

Attachment

Infants’ brains are hard-wired to form attachment relationships with their caregivers (Badenoch & Kestly, 2014; Siegel & Hartzell, 2004). Positive early life experiences shape and build children’s abilities to connect with others and form secure attachments to their primary caregivers (Bowlby, 1988; Dozier & Rutter, 2008). Secure attachment with an attuned and responsive caregiver early in life positively impacts children’s holistic development (Siegel & Hartzell, 2004). Secure attachments enable children to seek closeness to their caregivers, pursue comfort from caregivers in time of distress, and internalize the caregiver-child relationship as an internal working model of a secure base (Bowlby, 1988). Caregivers who promote a secure attachment typically display interaction patterns of emotional availability and are characterized as perceptive and responsive (Siegel & Hartzell, 2003, p. 109).
According to Bowlby (1980), insecurely attached children may avoid closeness to their caregivers, experience confusion, have feelings of anxiety and uncertainty when they need to depend on their caregivers, and are unsure what to expect from their caregivers. These children tend to view others and the world as harsh, unreliable, and filled with uncertainty (Siegel & Hartzell, 2003). They create defensive strategies to protect themselves from their desire to attach and connect with those around them.

Although children’s attachment styles are created at the beginning of life, they can be altered by consistent, attuned, and compassionate caregiving (Siegel & Hartzell, 2003; Zilberstein, 2013). Mental health interventions that focus on parent-child relationships and provide core conditions for building a secure relationship are essential for adopted children with a history of attachment disruptions to help them recover from their early adverse experiences (Carnes-Holt & Bratton, 2014; Hughes, 2006; Purvis et al, 2007; Siegel & Hartzell, 2003).

Child Parent Relationship Therapy

Child parent relationship therapy (CPRT; Landreth & Bratton, 2006) is an empirically validated, parent-child mental health intervention grounded in child centered play therapy (CCPT) theory and principles of child development and attachment. CPRT is based on Bernard Guerney’s group filial therapy model in which parents are taught CCPT attitudes and skills as means to becoming the therapeutic agent for their child (L. Guerney & Ryan, 2013). Building on the Guerneys’ work, Garry Landreth (1991, 2002) developed a more structured and condensed 10-session, group filial therapy training format. Landreth and Bratton (2006) formalized the training format and named it CPRT to distinguish it from other filial therapy models. Bratton, Landreth, Kellam, and Blackard (2006) manualized the CPRT protocol to provide researchers and clinicians with a tool for ensuring treatment integrity in delivering the intervention.
CPRT is based on the belief that a secure relationship between a parent and a child is necessary for children’s healthy development and overall well being (Landreth & Bratton, 2006). Using a small, support group training format consisting of didactic, supportive, and supervision experiences, parents are taught CCPT attitudes and skills as means to becoming the therapeutic agent for their child during supervised, weekly parent-child play sessions. Parents use play to enter the child’s world to better understand the child's past experiences and associated feelings (Bratton, Opiola, & Dafoe, 2015). Parent-child playtimes provide a unique and developmentally responsive means to help parents attune to and understand their child’s underlying needs, respond more empathically to their child’s behavioral and emotional difficulties, and facilitate their child’s ability to self-regulate.

CPRT is a child therapy treatment model with over 50 studies investigating its process and outcomes. Thirty-five published, controlled outcome studies involving over 1000 participants have examined the effectiveness of CPRT on increasing parental empathy, decreasing stress in the parent-child relationship, and reducing children’s behavior problems. Previous studies show CPRT’s efficacy across diverse populations, variety of presenting issues, varying age ranges, and its transportability across real-world settings. Comprehensive systematic reviews (Bratton et al, 2010; Lindo, Bratton, & Landreth, 2015) and meta-analyses (Bratton, Ray, Rhine, & Jones, 2005; Lin & Bratton, 2015) conducted over the past decade support and strengthen the findings from individual CPRT studies. Specific to adoption, Carnes-Holt and Bratton (2014) conducted a randomized controlled CPRT study with 61 adoptive families and found that the experimental group demonstrated statistically significant improvement in child behavior problems and parental empathy compared to a wait list control; treatment effects were
moderate to large. In order to move CPRT towards recognition as a well-established treatment for adoptive families, well-designed replication studies are needed.

**Purpose of the Study**

The purpose of this study was to examine the effectiveness of CPRT for adoptive families who reported attachment-related concerns including difficulties establishing a mutually satisfying parent-child relationship and concerns about the adoptive child’s behavior and parental stress. In addition, this study was designed to replicate and add to the methodological rigor of Carnes-Holt and Bratton (2014) study by using a treatment as usual (TAU) condition for the control group rather than no-treatment waitlist. Specifically, this study addressed three primary research questions: 1) do children of adoptive parents who participated in CPRT exhibit a reduction in behavioral problems? 2) do adoptive parents who participated in CPRT report a reduction in stress in the parent-child relationship? and 3) do adoptive parents who participate in CPRT demonstrate an increase in empathic interactions with their children?

**Methods**

I used a randomized control group design to examine the effects of CPRT with adoptive parents who reported child behavior problems and stress in the parent-child relationship. A priori power analysis using G*Power software determined that a minimum sample of 42 participants was necessary to find a statistical difference between two groups over two times of measurement (pre and post-test). I based G* Power calculation on an alpha level of .025, moderate treatment effect size ($f = .25$), and minimum power at .80 (Cohen, 1988). To allow for attrition, I established 50 participants as my target sample.
Participants

Participants were adoptive families recruited from a large metropolitan area in the southwest United States. Adoptive families met the following criteria for inclusion in the study: 1) Parents identified themselves as adoptive parent or foster-to-adopt parent of a child of normal cognitive functioning between the ages of 2½ and 9 years residing in the home; 2) Parents self-referred for attachment-related concerns such as difficulties establishing a mutually satisfying parent-child relationship as well as concerns about the adoptive child’s behavior and parental stress; 3) Parents reported clinical concern regarding child behavior problems or stress in the parent-child relationship, 4) Parents spoke and read English; and 5) Parents consented to participate in CPRT.

Sixty-three parents were recruited, of which 50 met inclusion criteria and were randomly assigned to treatment groups. One parent from the experimental group withdrew midway through the study due to an extended stay outside the U.S. to meet his second adopted child. Dropout demographics and data were examined to determine any difference that might impact outcome. No difference between the non-completer and completers was detected. Thus, 49 parents completed all pre and post assessments and their data was included in data analysis, 25 in the experimental group (E) and 24 in control (C). Overall, 61% of participants were female; 15 (E) and 15 (C), and 39% male, 10 (E) and 9 (C). Overall, 86% of parents reported European American as their ethnicity and 90% were married. The children of the parents that participated in the study ranged in ages 2½ - 9, with a mean age of 5.5; m = 5.7 (E) and m = 5.2 (C). Parents reported that children were adopted at the following ages: 16% < 1 year, 37% 12-23 months, 14% 2-4 years, and 33% were over the age of 5 years old, with 53% of children adopted out of foster care and 31% international adoptions. Parents reported their adopted child’s length of
placement with them as: 12.5% <1 yr, 24% 12-23 months, 51% 2-4 years, and 12.5% for over 5 years. Parents reported children’s ethnicity as 35% European American, 22% Asian, 12% Latino, 10% Black American, and 20% biracial or other. Children’s sex was 51% male. Figure 1. depicts flow of participant recruitment and group assignment as well as detailed participant demographics.
Figure 1. Participants flow chart.
Instrumentation

Two parent report instruments and one direct observation measurement were used to assess the effectiveness of CPRT for adoptive parents. For the purpose of this research, the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000) Total Problem scale was used to operationally define parents’ perceptions of their children’s global behavior problems. The Parenting Stress Index, 4th edition (PSI-4, Abidin, 2012) Total Stress score was used to operationally define stress in the parent-child relationship. Lastly, the Measurement of Empathy in Adult-Child Interaction (MEACI; Stover, Guerney, & O’Connell, 1971) Total Empathy score was used to operationally define parents’ empathic behaviors and responses as observed by blinded raters.

Child Behavior Checklist– Parent Version. The CBCL measures parents’/caregivers’ perception of their children’s behavioral, emotional, and social functioning (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001). The CBCL takes approximately 15 minutes to complete. A decrease in scores indicates improvement in behavior. The CBCL is composed of eight syndrome scales that categorize clinical behaviors on three domains – Internalizing, Externalizing, and Total Problems – and yield T scores in the normative, borderline, and clinical ranges. For the purpose of this study, Total Problems was used to screen for inclusion criteria and to assess children’s global behavior problems pre and post intervention. For Total Problems, T scores below 60 are considered normal, T scores between 60 and 63 are in the borderline range, and scores 64 and above are considered clinical. There are two versions of the CBCL based on the child’s age, CBCL 1½ to 5 years of age and CBCL 6 to 18 years of age; both were used in this study due to age range of child participants. Achenbach and Rescorla (2001) emphasized the continuity and consistency amongst the preschool and school-age CBCL forms.
and items which allows researchers to reliably measure participants’ behavior when the sample’s age range spans across the CBCL versions. The CBCL reports strong psychometrics (Achenbach & Rescorla, 2000, 2001; Njoroge & Bernhart, 2011) including content, criterion-related and construct validity. The CBCL has strong test-retest reliability for both the CBCL 1½-5 and CBCL 6-18 across all tests (r = 0.85). Specifically, the test-retest reliability for Total Problems is $r = 0.90$.

Parenting Stress Index, 4th edition. The PSI-4 (Abidin, 2012), measures parents’ perceptions of their stress related to the parent-child relationship. The PSI-4 is a self-administered instrument and takes approximately 20 minutes to complete. Decrease in score indicates reduction of stress in the parent-child relationship. The PSI contains two domains, child domain and parent domain, and a Total Stress score. The child and parent Domains assess characteristics in the child and parent that contribute to distress in the parent-child relationship. The Total Stress score assesses parents’ overall levels of stress and the impact of stress on their children’s behavior problems and overall dysfunction. For the purpose of this study, Total Stress was used to screen for inclusion criteria and to assess parents’ perceptions of overall stress in the parent-child relationship pre and post intervention. For Total Stress, $T$ scores are categorized as normal, borderline, and clinical based on children’s age. The PSI-4 reports acceptable validity maintained across cultures; it has been investigated in a number of studies with varying populations, including children with attachment disruptions. The PSI-4 reports predictive and discriminative validity. The test-retest reliability coefficients for the PSI is stable for Total Stress score, $r = .96$. The PSI has a high degree of internal consistency, with coefficient alpha scores for total stress reported at .95.
Measurement of Empathy in Adult-Child Interaction. The MEACI (Guerney, Stover, & DeMeritt, 1968; Stover, Guerney, & O’Connell, 1971) is a direct observation instrument that measures a parent’s observable empathic behaviors and responses during unstructured play sessions with his or her child. MEACI has been frequently used in filial therapy/CPRT research to identify parents’ ability to demonstrate empathic skills and attitudes that align with filial therapy goals. When used in outcome research, the MEACI is designed for use by independent raters blinded to the study. The MEACI consists of a Total Empathy score, which is comprised of three subscales that represent key attributes of empathic behavior in parent-child interactions: Communication of Acceptance, Allowing the Child Self-Direction, and Involvement (Stover et al., 1971). Blinded to group assignment and timing of the measurement, trained observers evaluate empathic behaviors on a five-point scale. Lower scores indicate higher levels of empathic responses and behaviors. The MEACI requires raters to achieve acceptable inter-rater reliability ($r=.70$) prior to coding video recorded play sessions (Stemler, 2004). Raters code parents’ behaviors and responses for six cycles of 3-minute intervals on the three subscales. The MEACI scoring system produces a score for each of the subscales and a Total Empathy score. Stover et al. (1971) determined a high inter-rater reliability for the three subscales that comprised the total empathy score, with average reliability correlation coefficients of .88 for Communication of Acceptance, .80 for Allowing the Child Self-Direction, and .88 for Involvement. Bratton and Lin (in progress) examined inter-rater reliability correlation coefficients across seven CPRT studies representing over 600 coded play sessions and reported coefficients ranging from .82 to .99 across studies, indicating a high level of consistency among raters. Stover et al. (1971) also reported construct validity for the MEACI based on its ability to
detect differences in parents’ level of empathic interactions with their children before and after intervention.

Procedure

Upon receiving approval from participating recruitment sites and university institutional review board, I recruited adoptive parents from community clinics, agencies, and ministries serving adoptive families. Parents who reported attachment-related concerns such as difficulties establishing a mutually satisfying parent-child relationship as well as concerns about the adoptive child’s behavior and parental stress were screened for inclusion criteria. Following informed consent, parents with multiple adopted children determined their “child of focus” for study purposes (Bratton & Landreth, 2006) and completed pretest data collection: family background form, CBCL, PSI-4, and MEACI. To ensure integrity of the data collection process, parents completed written assessments without their children present. I provided parents a space free from distractions to assure their answers were thoughtful and aligned with their individual views of their children and the parent-child relationship. Researchers were available to answer questions and childcare was provided while parents completed assessments. To collect MEACI data, parents participated in a 20-minute video recorded play session with their child in a private room set in a traditional CPRT play session format.

I used a random table of numbers to assign parents who met study criteria to the experimental or TAU group. Due to the large number of couples participating in the study, couples (n= 19 pairs) were randomly assigned as a unit, while single parents or parents participating without their spouse/partner (n = 12) were individually randomly assigned. As a result, 26 parents were assigned to the experimental group and 24 to the TAU control group. As
discussed previously, one parent from the experimental group was removed from the study due to inability to complete the training protocol.

At the completion of the study phase, CPRT and TAU participants completed post-test data (CBCL, PSI-4, and MEACI) following the same procedures as pretesting. To obtain MEACI data from the pre and post video recorded parent-child play sessions, a team of independent raters blinded to participants’ assignment to the experimental or TAU control and to whether the video recorded play session was a pretest or posttest session rated participants’ 20-minute play session videos. Eight doctoral level counseling students, independent of the present study and with advanced training in play therapy and CPRT, scored the videos. Raters were required to review the MEACI scoring instructions and participate in intensive training following the coding protocol outlined by Bratton (1993) and Bratton et al. (2006) to ensure an acceptable level of interrater reliability prior to coding the video data. Inter-rater reliability was initially established using recorded parent-child play sessions independent of the present study. Raters viewed and independently scored nine segments of parent-child play sessions. Following the scoring of each segment ratings were discussed to facilitate clarity of scoring criteria. To ensure maintenance of acceptable interrater reliability, checks were performed again at mid and end points of the coding period using video segments that the raters determined “difficult to score.” I 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 96% agreement. For the mid and end point rating sessions, raters achieved 86% and 94% agreement, respectively.

Parents received a small stipend for their participation in the study. Additionally, TAU parents were offered the opportunity to participate in the CPRT intervention immediately following the 11-week study period. To maintain confidentiality, all assessments, treatment notes, and identifying information were coded numerically and stored in a double-locked filing cabinet in the faculty supervisor’s office area.

Treatment Groups

Experimental treatment: CPRT. Parents assigned to the experimental group were divided into small groups of 4 to 6 parents (2 groups of 6; 2 groups of 5; 1 group of 4). Groups were held at convenient sites throughout a large metropolitan area. Consistent with the protocol (Bratton et al., 2006), parents participated in CPRT once per week for 2-hours for 10 weeks (Landreth & Bratton, 2006). Prior to beginning CPRT, parents attended a 2-hour pre-treatment session based on Carnes-Holt’s (2012) recommendation. The session was focused on the specific needs of adoptive parents including time to share their adoption experiences and to provide information related to attachment dynamics and interpersonal trauma. Free childcare, snacks, and age-appropriate activities were provided throughout the study. Childcare providers participated in training and ongoing supervision on the needs of adoptive children and ways to manage challenging behaviors.

CPRT facilitators followed the 10-session CPRT protocol (Bratton et al, 2006) with two overarching objectives in mind: (1) teach and supervise parents in CCPT attitudes and skills, and (2) support and encourage parents as they shared their parenting struggles and began to integrate the CCPT philosophy into their way of being with their child. The 2-hour group structure
allowed time for didactic experiences, emotional support of parents, and supervision of parent-child play sessions. Parents learned and practiced foundational CCPT principles including being with and fully attuning to their child’s needs, empathic listening, following the child’s lead, reflecting the child’s feelings and desires, understanding verbal and nonverbal content of the child’s play, encouragement, and limit setting; as well as the importance of consistency and structuring of playtimes to build a sense of safety and predictability in the parent-child relationship. The balance of teaching and emotional support provided parents with ample opportunities to explore their feelings and perceptions about themselves, their child, and their parenting styles while also ensuring that parents learned the CCPT attitudes and skills necessary to conduct special play times with their children.

The first three sessions focused on teaching parents foundational CCPT attitudes and skills, ways to establish an environment of safety and acceptance, and encourage parents to openly share and normalize their experiences (Bratton et al., 2006). After session 3, parents began weekly 30-minute special playtimes with their “child of focus.” Parents recorded their special play times with their children for the purpose of supervision. Thus, the primary focus of sessions 4 to 6 was skill refinement through supervision of parents’ video recorded play sessions, along with identifying and encouraging parental strengths and normalizing parenting struggles (Landreth & Bratton, 2006).

Sessions 7 to 9 continued the focus on CCPT skills to aid parents’ ability to respond and play with their children in ways that facilitated children’s development of an internal locus of evaluation and self-regulation. Supervision and processing of play sessions continued along with an increased emphasis on parents’ reflection on their feelings and experiences during the special playtimes (Landreth & Bratton, 2006). Parents were encouraged to begin to generalize and apply
their new skills to their daily interactions with their children. In the final session, parents processed their learning experiences, discussed changes in their relationships with their children, and identified any observed changes in their children and themselves. Parents were encouraged to continue their play sessions with their children.

Video cameras and special toy kits described in the treatment protocol (Bratton et al., 2006) were made available for loan to parents to ensure all parents recorded their sessions and had the appropriate play materials. CPRT facilitators were five advanced level doctoral counseling students and one counseling faculty member with advanced training and clinical experience in CCPT, CPRT, and adoption and attachment issues. Five counselors identified as Caucasian and one identified as biracial. Prior to the study counselors participated in a two-hour training to review the CPRT protocol, emphasize the importance of using clinical judgment in applying the protocol, and discuss issues related to parenting an adopted child. All CPRT sessions were recorded for the purpose of weekly supervision and to ensure treatment integrity. A supervisor with advanced training and clinical experience in CPRT provided weekly supervision to participating counselors and viewed a random selection of 20% of CPRT sessions using the CPRT Therapist Skill Checklist (Bratton, et al., 2006) to verify protocol adherence. One video was randomly selected from each of the ten sessions, with sessions equally drawn from each of the CPRT groups. Sessions were viewed in their entirety. Counselors adhered to the CPRT protocol over 95% of the time, with an average adherence of 94.8% per viewed sessions.

TAU control group. Because 96% of parents were recruited from local adoption agencies and ministries, TAU was based on the typical responsive services offered by the adoption agencies and ministries. Services were described as individual parent consultation regarding child behavior management and crises intervention, conducted by phone or in person (R. North,
personal communication, April 2, 2015; D. Wynne, personal communication, April 29, 2015). Thus, for the purpose of this study, TAU was defined as individual parent consultation and designed for parents to participate in face-to-face or phone consultation, based on parents’ preference, once per week for 30 minute. In practice, 100% of the parents chose phone consults. Although the counselors initially called parents weekly as scheduled, the majority of parents preferred bi-weekly contact and conversations varied from 15-30 minutes per call. Phone consultations typically consisted of parents seeking strategies for managing difficult behavior. TAU counselors were first year doctoral counseling interns specializing in child counseling and who had completed one graduate course in child development and one to two courses in play therapy, which included training in parent consultation but no training in CPRT. Four counselors identified as Caucasian and one identified as Black American. Prior to the study, TAU counselors attended a two-hour training on the common concerns of adoptive parents and helpful strategies for working with adoptive families. Throughout the study, counselors participated in weekly supervision.

Results

I conducted 2 (group) by 2 (times) repeated measures ANOVAs for each dependent variable to evaluate the effectiveness of CPRT for adoptive parents. Dependent variables included PSI Total Stress, CBCL Total Problems, and MEACI Total Empathy. A reduction in scores on the CBCL, PSI-4, and MEACI indicates improvement. Treatment groups served as the between-subjects variable and time (pretest/posttest) served as the within-subjects variable. For each analysis, the assumptions for level of measurement, independence of observations, normal distribution, and homogeneity of variance were reasonably met. Sphericity is assumed for two points of measure. To minimize the risk of a Type I error that can occur from multiple
hypotheses testing, I established a more conservative alpha level of .025 to test for significant mean differences. To test for the practical significance of the CPRT intervention, I calculated partial eta squared effect sizes ($\eta^2_p$) for each dependent variable to determine the magnitude of the difference between the two groups over time. I interpreted effect sizes according to guidelines reported by Cohen (1988), .01 equals a small effect, .06 equals a moderate effect, and .14 equals a large effect.

Research Question 1: Adopted Children’s Problematic Behaviors

Table 1 presents the pre and post mean scores and standard deviations for CBCL Total Problems for the experimental and control groups. Results of analysis of the dependent variable, Total Problems, indicated a statistically significant interaction between treatment group (CPRT/TAU) and time (pretest/posttest), $F(1,47) = 17.006, p < .001$ and partial $\eta^2_p = .266$.

Table 1

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<th>Mean Scores for Each Group</th>
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<td>CBCL Total Problems</td>
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<td>MEACI Total Empathy</td>
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The results indicate that according to parents, adoptive children whose parents participated in the CPRT groups (n=25) demonstrated a statistically significant decrease in global behavior problems as measured on the CBCL Total Problem scale over time compared with children whose parents received TAU (n=24) and that the treatment effect was large, indicating the practical significance of the findings. A visual inspection of the graph of the mean scores for the CPRT and TAU groups supports the greater improvement of the CPRT group compared to the TAU group over time (see figure 2). Children whose parents participated in CPRT demonstrated a 7.04 decrease in their mean behavior problem scores compared to a .59 decrease for the control group.

Figure 2. Means scores on CBCL Total Problem Score.

Research Question 2: Stress in the Parent-Child Relationship

Table 1 presents the pre and post mean scores and standard deviations for the PSI Total Stress scores for the experimental and control groups. Results for the analysis of the dependent
variable, Total Stress, demonstrated a statistically significant interaction effect between treatment group (CPRT/TAU) and time (pretest/posttest), $F(1,47) = 25.204, p < .001$ and partial $\eta^2_p = .349$.

These results indicate that adoptive parents who participated in CPRT reported a statistically significant decrease in stress in the parent-child relationship over the TAU group parents and the treatment effect was large ($\eta^2_p = .349$), indicating the practical significance of the findings. A visual inspection of the graph of the mean scores for the CPRT and TAU group supports the greater improvement of the CPRT group compared to the TAU group over time (see figure 3). Parents who participated in CPRT reported a 5.08 decrease in their mean parent-child relationship stress scores compared to a .375 increase in stress for the TAU group.

![Figure 3. Means scores on PSI-4 Total Stress Score.](image)

Research Question 3: Parental Empathy
Table 1 presents the pre and post mean scores and standard deviations for the MEACI Total Empathy scores for the experimental and control groups. Results of analysis for the dependent variable, Total Empathy, showed a statistically significant interaction between treatment group (CPRT/ TAU) and time (pretest/ posttest), $F (1,47) = 61.554$, $p < .001$ and partial $\eta^2_p = .567$.

These results indicate that, according to reviewers blinded to parents group assignment, CPRT parents demonstrated a statistically significant increase in empathic responses and behaviors compared to the control group and the treatment effect was large ($\eta^2_p = .567$), indicating the practical significance of the findings. A visual inspection of the graph of the mean scores for the CPRT and TAU group supports the greater improvement of the CPRT group compared to the TAU group over time (see figure 4). Parents who participated in CPRT demonstrated a 15.78 decrease (improvement) in their mean empathy score compared to a .469 increase (worsening) for the control group.
Figure 4. Means scores on MEACI Total Empathy Score.

Discussion

The current study aimed to replicate findings from Carnes-Holt and Bratton’s (2014) randomized study to provide further evidence for the effectiveness of CPRT for adoptive families. Replication increases the credibility of research findings and allows clinicians, educators and policy makers to make informed decisions about mental health services that are most beneficial for clients’ presenting issues (Kazdin, 2016). The statistical and practical significance of the findings from the present study confirmed Carnes-Holt and Bratton’s results and indicates that CPRT is an effective early intervention for reducing child behavior problems, reducing stress in parent-child relationship stress and increasing parents’ empathic interactions with their adoptive children. Identifying evidence-based interventions is particularly important for adoptive families due to the dearth of proven treatments for this growing population (Brodzinsky, 2103).

Effectiveness of CPRT on Child Behavior Problems

Children whose adoptive parents participated in CPRT demonstrated a statistically significant decrease in total problem behaviors over children whose parents participated in the TAU control group and the treatment effect was large. This result is consistent, not only with Carnes-Holt and Bratton’s finding, but also with findings from several other controlled studies that showed statistically significant decreases in child behavior problems as a result of CPRT intervention (Bratton, Dafoe, et al., 2015; Bratton, Landreth, & Lin, 2010).

The significant decrease in overall problem behaviors is particularly important for adoptive parents whose children tend to present with co-occurring behavioral problems rather than a single presenting issue (Juffer & IJzendoorn, 2005). As in the Carnes-Holt and Bratton
(2014) study, parents in this study reported a combination of internalizing and externalizing child behavior difficulties. Parents’ inability to manage complex behavior problems can lead to high levels of distress which can potentially lead to disrupted placements for adopted children (Hughes, 2006; Child Welfare Information Gateway, 2012).

Adoption and attachment experts propose that children with a history of neglectful caregiving can catch up emotionally, behaviorally, and developmentally when they are in relationships with emotionally attuned and responsive adults (Brodzinsky, 2013; Purvis et al., 2007; Siegel & Hartzell, 2003; Zilberstein, 2013). CPRT focuses on the primacy of a secure parent-child relationship as the agent of change. CPRT is designed to help parents learn the basic principles, attitudes, and skills of CCPT, initially during weekly, 30-minute supervised play sessions, in order to foster a more attuned, unconditionally accepting, and consistent relationship with their children (Landreth & Bratton, 2006). According to the principles of CCPT and CPRT, when children experience this type of safe and secure caregiving relationship consistently over time, they begin to feel understood and accepted, experience themselves as lovable and capable, and experience others as safe, dependable, and trustworthy. As a result, children are then free to give up behaviors that distance themselves from others, for many adopted children, may have been used as a means of self-protection, and choose more self-enhancing and functional behavior (Bratton, Carnes-Holt, & Ceballos, 2011).

Effectiveness of CPRT on Parent-Child Relationship Stress

Adoptive parents who participated in CPRT reported a statistically significant decrease in stress in the parent-child relationship over parents who participated in the TAU control group and the treatment effect was large. This result is consistent with findings from numerous controlled studies that showed statistically significant decreases in parent-child
relationship stress as a result of the CPRT intervention (Bratton, Dafoe, et al., 2015; Bratton, et al., 2010;).

The noteworthy reduction in parent-child relationship stress is important because familial stress related to attachment and behavioral issues is the most common reason that adoptive parents seek help from professionals (Barth et al., 2005; Howe & Fearnley, 2003; Hughes, 2006). Furthermore, high levels of relationship stress is a major factor in parents placing their adopted child in residential care or relinquishing their rights (Brodzinsky, 2013; Child Welfare Information Gateway, 2012). CPRT aims to enhance the parent-child relationship, and because relationships are reciprocal with both parent and child contributing to stress in the relationship, CPRT focuses on the needs of both the parent and child.

Landreth and Bratton (2006) emphasized the significance of the CPRT group process component in helping parents feel supported, accepted, and understood. Parents in both the CPRT and TAU groups shared feeling isolated in their role as an adoptive parent and feeling misunderstood and discounted by others including family members and parents of biological children. Thus, the opportunity to connect and share with parents with similar experiences may have been especially meaningful for parents in this study. Landreth and Bratton described creating a safe, reassuring, and nonthreatening environment in which parents can share their experiences as well as “explore feelings, attitudes, and perceptions of themselves, their adopted children, and their parenting struggles” (p. 47). These therapist offered conditions along with a supportive group atmosphere in which parents’ concerns and fears could be normalized may have contributed to parents’ report of decreased stress in the parent-child relationship.
The required weekly, parent-child playtimes are a cornerstone of the CPRT model. Parents in the present study consistently reported on the importance of this one-on-one time for themselves and for their children. The required playtimes are structured to allow parents to focus on being with and enjoying their child (Landreth & Bratton, 2006). It is possible that this special time between parent and child provided an oasis in their week where both felt free from the constraints and stress of daily interactions; thereby contributing to parents’ perception of improved stress levels in the parent-child relationship.

Effectiveness of CPRT on Parental Empathy

Parents who participated in CPRT demonstrated a statistically significant increase in their empathic interactions with their children over parents in the TAU control group and the treatment effect was large. This result is consistent with the Carnes-Holt & Bratton’s (2014) study as well as several other controlled studies that found statistically significant increases in parental empathy as a result the CPRT intervention (Bratton, Dafoe, et al., 2015; Bratton, et al., 2010). As further evidence of CPRT’s effect on parental empathy, 24 of the 25 parents in the experimental group increased in their empathic interactions with their children as indicated by their mean change score on the MEACI; one parent stayed the same. These results are particularly noteworthy because the MEACI ratings were obtained through direct observation by independent coders who were blinded to participants’ group assignment and time of measurement (pre or post).

The significant increase in adoptive parents’ empathic interactions with their children as a result of CPRT is especially noteworthy for this population of parents. Adopted children with a history of interpersonal trauma are often hypersensitive to parents’ attempts to connect and discipline in traditional ways, which cause adoptees to feel threatened and fearful.
(Bowlby, 1980; Cozolino, 2006; Siegel & Hartzel, 2003). According to Zilberstein (2013) and Siegel and Hartzel (2003) adopted children can overcome early attachment hardships when they receive emotionally attuned and responsive caregiving in their new family. Fostering an attuned, responsive, and secure relationship is at the heart of CPRT. A major goal of CPRT is to teach parents CCPT attitudes and skills designed to create an atmosphere of safety, consistency, warm acceptance, and empathic understanding in their family (Landreth & Bratton, 2006). The structure of the CPRT group offers parents a balance of didactic, supportive, and supervision experiences intended to enhance learning through opportunities to observe, practice (role play), and directly apply CCPT skills including empathy with their children under the direct supervision of the CPRT facilitator. CPRT is a “do as I do” approach. Facilitators’ role model the relational skills they want parents to learn with the objective that parents feel heard, understood, and accepted as they learn and apply the new skills.

A major feature of the CPRT model is the requirement for parents to video record their required weekly, playtimes with their children for the purpose of supervision, feedback, and parents increased awareness of themselves and their children. Consistent with the CPRT protocol, play sessions were limited to 30-minutes once per week to avoid overwhelming parents. Moreover, playtimes were structured to foster parents’ success in applying CCPT attitude and skills. Weekly supervision of video recorded play sessions allowed parents to receive feedback from the CPRT facilitator as well as parents in the group, with a focus on self-awareness, skill development, increased understanding of children’s underlying needs, and processing parents’ reactions and feelings. Over the course of the present study, parents remarked on their increased self-awareness and their ability to differentiate their own
emotional response from their child’s emotional state, which may have allowed them to respond with greater empathy, understanding, and acceptance.

Limitations and Recommendations for Future Research

The present findings are promising and add further information for mental health providers working with adoptive families. I have noted several limitations that need to be taken into account. First, the generalizability of results is limited by sample size and isolated geographic location. Although the study had adequate sample size, a larger study would advance the findings of this study. A multi-site study could address both the sample size and geographic limitations and expand the evidentiary support and generalizability of CPRT; as well as advance CPRT being recognized as an evidenced based treatment for young adoptive children. In addition there are no follow-up studies for CPRT. Carnes-Holt and Bratton (2014) and this study looked at the immediate results. A longitudinal study could help researchers and clinicians recognize the long-term impact of CPRT with adoptive families.

The use of parent report assessment instruments was a limitation of this study. Both the CBCL and PSI-4 utilized parents’ self-report and may have evaluated parent perception instead of actual changes in stress levels and child behavioral problems. The inclusion of another source of measurement for the same dependent variable, such as a teacher report or a direct observation tool, would address this concern. Another limitation to the study was the lead researcher (LR) heavy involvement in the recruitment and intervention process. The LR co-facilitated all the groups, which has the potential to impact treatment decisions and introduce researcher bias. LR met weekly with an expert in CPRT and co-facilitators for weekly supervision to ensure adherence to CPRT protocol, explore biases and how personal
biases may interfere with treatment delivery and outcomes, and help minimize the chance for prejudicing the findings.

To address the limitations from Carnes-Holt and Bratton’s (2014) study the addition of TAU was added to resemble services typically offered by adoption agencies and ministries. TAU was not manualized, thus treatment integrity could not be ensured. To address the lack of a manualized treatment, individual parent consultation guidelines were created and provided to counselors. Although weekly face-to-face or phone consultations were preferred, parents chose bi-weekly conversations. This changed the intended dose of intervention, possibly weakening the comparability of the two groups. A study comparing group CPRT to individual CPRT may help confirm the benefits of the group component. Similarly, a study comparing group CPRT and another group parenting model, preferably an evidenced-based model, would add to the confidence of the findings and firmly establish CPRT as an evidence-based treatment.

Implications for Practice

CPRT is an empirically supported therapeutic parenting intervention that has been shown effective with a range of social, emotional, and behavioral concerns (Bratton & Lin, 2015; Landreth & Bratton, 2006). Specific to this study, CPRT shows promise as an early mental health intervention for adoptive families who present with attachment related concerns. The results of this replication study have several implications for practice with adoptive families who reported child behavior problems and stress in the parent-child relationship.

Adoptive parents in this study presented with a high need for emotional support and required time to process their day-to-day challenges. They reported feeling overwhelmed by
their adopted child’s behavior problems and were unclear on how to respond when their child was having both behavioral and emotional difficulties. The findings indicate that the 11 sessions for the intervention group was effective in helping parents learn skills to approach their children’s emotional and behavioral struggles. Although the 11 sessions were enough to find effectiveness, parents’ verbal and behavioral feedback suggested a desire for further support. Additional sessions or follow-up session may be needed to provide adoptive parents support and opportunities share new challenges.

The group CPRT model appeared to have greater appeal for adoptive parents than TAU design. Few parents in the TAU group participated in consultation session on a weekly basis; instead preferring periodical phone calls. The results from this study indicate that individual parent consults via phone did not reduce parent-child relationship stress, reduce child’s behavior problems, or improve parental empathy, possibly suggesting adoptive parents need more support than TAU provided. In addition, the lack of face-to-face contact could have plausibly contributed to parents sporadic involvement with TAU. Parents may need the personal connection and belonging that occurs with face-to-face interventions, such as CPRT. Parents in the CPRT groups were committed to weekly meetings and vast majority rarely missed a meeting. Mental health providers may want to consider face-to-face interventions and group interventions for adoptive parents. Additionally, when delivering direct contact services for adoptive families, providers may need to consider offering childcare. Parents in this study expressed appreciation for childcare because their babysitters and other family members were reluctant to watch their adopted child due to the child’s unpredictable and challenging behaviors.
Conclusion

Adoptive parents can have a major influence on helping adoptees overcome adverse effects of early attachment disruptions and relational trauma (Perry & Szalavitz, 2006; Purvis et al., 2007). Unfortunately not all adoptive parents feel well equipped to manage their child’s socio-emotional and behavioral needs potentially leading to further disrupted placements for adopted children (Hughes, 2006; Child Welfare Information Gateway, 2012). Brodzinsky (2013) emphasized the need for adoption competent interventions that are responsive to the unique challenges and stressors of adoptees and focus on the parent-child relationship. The present study responds to the call for evidenced based interventions that focus on the parent-child relationship. The parent-child relationship is at the heart of the CPRT approach. In CPRT, parents learn to be therapeutic agents of change for their children and how to foster a more attuned, unconditionally accepting, and consistent relationship with their children (Landreth & Bratton, 2006). The present study’s findings are particularly important for adoptive parents who feel ill prepared to respond when their adopted child is exhibiting intense emotions and challenging behaviors.

The statistical and practical significance of the findings regarding improvement in child behavior problems, parent-child relationship stress, and parental empathy provide support for CPRT’s utility with adoptive families. In addition, the findings from this replication study confirm and expand the results of Carnes-Holt and Bratton’s (2014) study. Replication research enhances the credibility of previous results and helps clinicians, researchers, educators and policy makers make informed decisions about effective interventions for those seeking mental health services (American Psychological Association, 2006; Kazdin, 2016). And lastly, the findings from this study, together with the findings from...
the Carnes-Holt & Bratton study can serve to advance CPRT towards being recognized as an effective and well-established treatment for adoptive families.

Acknowledgments

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References


APPENDIX A

EXTENDED LITERATURE REVIEW
The review of literature includes the following topics: (a) needs of adoptive families, (b) attachment, (c) early mental health interventions for adoptive families, and (d) child-parent relationship therapy (CPRT).

Needs of Adoptive Families

Adoptive families represent a growing segment of the population in the United States. Approximately 136,000 children are adopted yearly (Child Welfare Information Gateway, 2011), adding to the current estimate of 2 million adopted children (Kreider & Lofquist, 2014). International adoptions and foster care-based adoptions together account for over half of all U.S. adoptions (Vandivere, Malm, & Radar, 2009). Many more children need a secure and permanent family placement but are either left in the foster care system in the U.S. or remain in international institutions, where they are at risk for attachment difficulties and delays in their holistic development (Brodzinsky, 2013).

Children in the foster care system spend, on average, three years awaiting permanent placements and have three or more temporary placements before finding a permanent home. Placement of internationally adopted children typically begins in the first two years of life, but the adoption process takes 1-3 years before the child is placed in the care of the adoptive parents (Congressional Coalition of Adoption Institute [CCAI], 2014). Long waits for placements, inconsistent caregivers, and associated adverse experiences increase adopted children’s risk of interpersonal trauma and insecure attachment (CCAI, 2014; Perry & Szalavitz, 2006). Abuse, neglect, and deprivation have damaging effects on children, and the earlier children experience physical or relational harm, the greater the impact on their overall development (Perry & Szalavitz, 2006; Siegel & Hartzell, 2004).
Perry and Szalavitz (2006) suggest loving and responsive adoptive parents can have a major influence on preventing long-term damage to young adopted children. Understanding the needs of children who experience early relationship trauma can help adoptive parents care for their adopted children and provide needed support to assist children heal. Additionally, adoptive parents need care and attention for themselves in order to care for their at-risk children (Purvis et al., 2007). All members of an adoptive family are impacted by adoption, due to changes in the family system and additional stress on family members. Post-adoption support and services from family, friends, and professionals are vital to helping adoptive families navigate the ever-changing needs of adopting a child (Gray, 2007).

Adopted Children

Children’s pre-adoption experiences vary on a continuum of supportive, nurturing care to neglectful and despondent caregiving. Children who received loving and supportive care early in their lives have a greater chance for creating secure and successful attachments with their adoptive parents (Dozier & Rutter, 2008). Children who experienced neglect, frequent changes in caregivers, prolonged periods of isolation, and repeat abuses are at risk of developing an insecure attachment style; thus, they often struggle to attach to new caregivers (Lanius, Vermetten, & Pain, 2010; Nelson, Bos, Gunner, & Sonuga-Burke, 2011). Neurobiology experts propose that based on an insecure attachment schema, children may unconsciously react to their adoptive parents’ relational overtures as threatening, causing them to want to flee, fight, or freeze (Cozolino, 2006; Perry & Szalavitz, 2006; Siegel & Hartzel, 2003). Perry and Szalavitz (2006) posited that children with attachment disorders have overactive autonomic nervous system that leads to difficulty regulating their emotions and impulses and exhibiting heightened fear responses, hypervigilance, high levels of stress, and chronic fears. Cozolino (2006) hypothesized that people in an activated autonomic state cannot
focus, reason, listen to feedback, or find solutions to their current problem. In order to regulate and calm children in a reactive state, such as adopted children, they require a calm, attentive, and attuned caregiver that can comfort and support them (Perry & Szalavitz, 2006; Siegel & Hartzel, 2003).

Compared to peers, foster and adopted children are at greater risk for developing psychological disorders (Hussey, Falleta, & Eng, 2012), behavioral problems and poor cognitive functioning (van IJzendoorn & Juffer, 2006; Tan & Marfo, 2016), and diminished social development (Leerkes, Blankson, & O’Brien, 2009). Juffer and Van IJzendoorn investigated the prevalence of behavior problems in adopted and non-adopted children and found greater occurrence of behavior problems for adopted children and higher rate of comorbidity of internalizing and externalizing problems. The high rate of co-occurrence of behavior problems in children presenting for treatment is supported in literature (Angold, Costello, & Erkanli, 1999; Jensen & Weisz, 2002; Ray, Stulmaker, Lee, & Silverman, 2013; Weisz & Kazdin, 2010). The findings regarding co-morbid presenting issues suggest the need to identify interventions that are responsive to broad spectrum behavior problems, particularly for adoptees.

In addition, foster and adopted children are at greater risk for developing psychological disorders than their peers (Stinehart, Scott, & Barfield, 2012; Wilson, 2001). Reactive attachment disorder (RAD), conduct disorder, and oppositional-defiant disorder are a few of the more common diagnoses associated with this population of children. RAD is the most severe form of attachment-related psychopathology and is characterized by infants or childrens inability to form relationships with people and other significant delays in their social development. Adopted children who exhibit disturbing attachment-related behaviors place additional pressure and stress on adoptive parents.

Early relational trauma can negatively impact adopted children’s brain development (Hodel, Hunt, Cowell, Van Den Heuvel, Gunnar, & Thomas, 2015). Children who experience
adverse experiences in utero or in the first few months of life have a greater risk of problems with their executive functioning, learning, emotional regulation, attachment security, and social engagement and interactions (Lanius, Vermetten, & Pain, 2010; Nelson, Bos, Gunner, & Sonuga-Burke, 2011). Without a nurturing environment and proper interventions, adopted children can experience long-term consequences including behavioral and socio-emotional problems that can persist into adulthood (Sroufe, 2005; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Fortunately, adopted children can catch up emotionally, behaviorally, and socially when they receive consistent and loving care from an emotionally attuned and supportive caregiver (Brodzinsky, 2013; Purvis et al., 2007; Siegel & Hartzell, 2003; Zilberstein, 2013).

Adoptive Parents

Parenting adopted children can be both rewarding and challenging (Carnes-Holt & Bratton, 2014). Adoptive parents take on the responsibilities of nurturing their adopted child’s normal growth and development while struggling to overcome parenting challenges related to their adopted child’s negative early experiences (Gray, 2007; Hughes, 2006). Adoptive parents are often placed in the role of helping repair their children’s early relationship experiences; supporting their adopted children through recovery, grief, and loss; and creating their children’s adoptive identities (Brodzinsky, 2013). Providing love, support, and guidance to adopted children throughout their lifetimes requires a compassionate environment where adopted children can heal and develop (Hughes, 2006; North American Council on Adoptable Children [NACAC], 2007; Perry & Szalavitz, 2006). Children with a history of interpersonal trauma, including disruptions in their attachment relationships, tend to misread and misattone to the cues from their caregivers. Purvis, Cross, and Sunshine (2007) found common patterns in adoptive parents and children’s interactions
that can lead to increased parental stress and behavior problems for adopted children. In addition, many adoptive parents are dealing with their own losses, such as infertility or loss of a biological child, which can impact their ability to emotionally respond and attune to their adopted child (Brodzinsky, 2013).

Research into the impact of early trauma on children (von der Kolk, 2005) identify that children who experience trauma tend to be reactive; this makes forming relationships challenging for adoptive parents because the child is easily triggered (Perry & Szalavitz, 2006; Purvis et al., 2007). Hughes (2006) noticed parents often reported feeling confused and surprised by their child’s responses as they were unaware of what triggered the reaction, thereby causing increased stress and less joy in the parent-child relationship. In addition, adoptive parents find it hard to reason, support, or help their adopted child problem solve due to the child’s reactive or defensive responses. Adoptive parents may feel they are failing as parents as their adoptees continue to reject and sabotage their efforts to build a safe and trusting environment (Purvis et al., 2007). Their interactions with their adopted children can be challenging, unfulfilling, and lack pleasure potentially causing them to feel discouraged, withdrawn, and unresponsive to the child’s needs (Carnes-Holt & Bratton, 2014).

Ayling and Stringer (2013) proposed that adoptive parents need joyous and engaging interactions with their adopted children to help children learn to trust and find pleasure within supportive relationships. Adoptive parents can enhance their connections and bonds with their adoptee through play. Adopted children with early trauma and relational disruptions may be hesitant to play as they explore their early life relationships and re-experience difficult emotions and memories (Gil, 2006). Play is children’s natural medium of communication, and helps them organize and make sense of their world and experiences (Landreth, 2012). Through play, children
make difficult experiences more manageable, gain a sense of mastery and control, and develop coping skills. Adoptive parents can help by being present, aware, and receptive to their adopted children as they share their past experiences (Ayling & Stringer, 2013). Not all adoptive parents feel prepared to manage these difficult experiences and may need further training and support to help their children feel heard, understood, and not alone.

Understanding the social-emotional and behavioral needs of children who experience early trauma can help adoptive parents provide a relationship that promotes secure attachment and healing (Perry & Szalavitz, 2006; Purvis et al., 2007). Majority of adoptive families are required to participate in pre-adoption preparation to help them understand the risk factors associated with adopting children who may have experienced early traumatic events. Unfortunately, pre-adoption preparation may not be enough as many adoptive parents report feeling ill-equipped to manage their children’s significant behavior problems and high levels of relational stress (Brodzinsky, 2013; Hughes, 2006; Purvis et al., 2007). According to Purvis, Sunshine, and Cross (2007), adoptive parents benefit from mental health services that provide parent skill training that focuses on responsive ways to connect and develop a secure attachment with their adopted child.

For some parents, their adopted child’s needs are overwhelming and add considerable stress to the parent-child relationship (Howe & Fearnley, 2003). Parent-child relationships are the central reason most adoptive parents seek mental health services (Barth, Crea, John, Thoburn, & Quinton, 2005, p. 264). Interventions that involve parents in the therapeutic process are necessary for this population (Barth et al., 2005; Carnes-Holt & Bratton, 2014; Landreth & Bratton, 2006; Perry & Szalavitz, 2006; Purvis et al., 2007; Siegel & Hartzell, 2004; VanFleet & Sniscak, 2003). Therefore, researching and identifying evidenced-based, early mental health interventions for adoptive families
that focus on the parent-child relationship is crucial for mental health providers and adoptive families.

Attachment

Attachment is an important and well-recognized tenet to emotional and social development. Bowlby (1988) proposed that all humans are born with an innate attachment behavioral system that activates the infant to attach to caregivers in order to protect the self and alleviate distress. In addition, Siegel (2001) expanded and identified attachment as an adaptive motivational system that propels people to connect with others. Early attachment typically occurs with a primary caregiver (Field, 1996) and helps infants learn and interpret their own needs as well as the behaviors and feelings of others (Beijersbergen, Jeffer, Bakermans-Kranenburg, & van IJzendoorn, 2012). Infants’ early attachment experiences impact many other domains in children’s development (Siegel, 2001).

A secure attachment refers to consistent and predictable communication patterns and interactions between caregiver and child that provides a base of safety and security from which the child can explore their world and other relationships (Berk, 2007; Siegel, 2012). Secure attachments enable children to seek closeness to their caregivers, pursue comfort from caregivers in time of distress, and internalize the caregiver-child relationship as an internal working model of a secure base (Bowlby, 1988). Caregivers who promote a secure attachment typically display interaction patterns of emotional availability and are characterized as perceptive and responsive (Siegel & Hartzell, 2003, p. 109).

Children with secure attachment have confidence in the predictability of their caregivers’ responsiveness and availability to meet their needs, causing them to feel safe to explore their environment and take risks (Bowlby, 1980). Children in a secure parent-child relationship exhibit curiosity about their world, display flexibility, and have the ability to organize their
thoughts, emotions, and behaviors (Siegel & Hartzel, 2003). Together, the child and caregiver form strategies to maintain closeness and assess the child’s physical and emotional safety. If a break in the parent-child relationship occurs, the caregiver seeks to repair the break by recognizing the child’s emotional state, helping the child understand what happened, and soothing the child back to an emotionally balanced and secure state.

Insecure attachment refers to unresponsive or unpredictable communication and behavior patterns between caregivers and child that leaves the child experiencing confusion and doubt in the parent-child relationship, thereby causing distress and dysregulation (Berk, 2007; Siegel, 2012). There are three forms of insecure attachment: avoidant, ambivalent, and disorganized. Siegel and Hartzell (2003) discussed the unique parental characteristics of each style and how children experience their parents’ attempts to connect with them. Parents who foster an avoidant style of attachment are typically emotionally unavailable, imperceptive, unresponsive, and rejecting towards the child (p. 109). Parents who cultivate an ambivalent attachment style are typically characterized as inconsistent, responsive, and intrusive. Parents who promote a disorganized style of attachment typically display characteristics that are frightening, disorienting, and alarming to the child.

According to Bowlby (1980), insecurely attached children may avoid closeness to their caregivers, experience confusion, have feelings of anxiety and uncertainty when they need to depend on their caregivers, and are unsure what to expect from their caregivers. Children with insecure attachments tend to view others and the world around them as harsh, unreliable, and filled with uncertainty (Siegel & Hartzell, 2003). They create defensive strategies to protect themselves from their desire to attach and connect with those around them.
Although children’s attachment styles are created at the beginning of life, they can be altered or changed when new, compassionate, and consistent people are in their life (Siegel & Hartzell, 2003; Zilberstein, 2013). Mental health interventions that focus on parent-child relationships and provide core conditions for building a secure relationship are essential for adopted children with a history of attachment disruptions to help them recover from their early adverse experiences (Carnes-Holt & Bratton, 2014; Hughes, 2006; Purvis et al, 2007; Siegel & Hartzell, 2003).

Early Mental Health Interventions for Adopted Families

Adoption and attachment authorities agree that mental health providers need specialized training in interventions that are responsive to the unique needs of adopted and malattached children and emphasize that parents should play a key role in the therapeutic process (Brodinsky, 2013; James, 1994; Perry & Szalavitz, 2006; Purvis et al., 2007; V. Ryan, 2007; Siegel & Hartzell, 2004). Children with early relationship trauma may struggle to attune and connect with their caregivers, thus adoptive parents often seek attachment and adoption specific services to help them form a secure attachment with their adoptee (Purvis, Cross, & Pennings, 2009). Both Barth, Crea, John, Thoburn, and Quinton (2005) and Weir, Lee, Canosa, Rodrigues, McWilliams, and Parker (2013) encouraged mental health services that focus on attachment based treatment modalities to provide mental health services that are non-coercive and responsive in nature.

Brodzinsky (2013) completed a thorough review of the adoption literature, reports and interviews and found there is a shortage of counselors who are competent in providing interventions that are responsive to adoption issues. Approximately 20% of university mental health programs offer education and training in interventions focused on adoption and attachment difficulties. To address the shortage of adoption competent services, the Donaldson Adoption Institute (DAI)
published a major report in 2013 that included an evaluation of the empirical support for existing adoption specific interventions. The report identified CPRT, Dyadic Developmental Psychotherapy (DDP; Hughes, 1997), and Theraplay (Booth & Jernberg, 2009) as the most promising parent-child interventions and named CPRT as demonstrating the most robust empirical support for helping adopted children and their parents. All three interventions focus directly on the attachment relationship between caregiver and child and incorporate play or playfulness into treatment (Booth & Jernberg, 2009; Hughes, 1997; Landreth & Bratton, 2006). The primary difference in the three models is seen in their theoretical foundation and the methods parents are taught to enhance the parent-child relationship and form a secure attachment with their child. CPRT, further explained in the next section, teaches parents the foundational attitudes and skills of the non-directive CCPT approach to help parents attune to and understand their child’s underlying needs and respond to their child with empathy and unconditional acceptance (Landreth & Bratton, 2016). Whereas, Theraplay and DDP teach parents more directive approaches to encourage the adoptee to engage in more intimate interactions with their caregivers (Booth & Jernberg, 2009; Hughes, 1997; Hughes, 2007; Weir et al., 2013).

Similar to CPRT, Theraplay is a play-based approach that teaches parents specific relational skills to use with their child to build trust and a secure attachment (Booth & Winstead, 2015). Theraplay differs in that activities are structured to simulate parent-infant interactions that encourage and challenge the child to make contact with the parent or therapist in order to meet the child’s relational needs. According to the DAI report (Brodzinsky, 2013), Theraplay has less empirical support than CPRT for its use with attachment-disordered and traumatized children, but the California Evidence-Based Clearinghouse for Child Welfare has recognized it as a promising practice for this population (CEBC, 2014). DDP has similar goals of helping
parents develop a safe, trusting, and secure relationship with their adopted child (Hughes, 1997). In this approach, therapists encourage playfulness in the parent-child dyad and teach parents a mix of verbal and non-verbal strategies to help them attune to their child’s emotional state and co-regulate the child’s state of arousal (Becker-Weidman & Hughes, 2008). The CEBC (2014) also identified DDP as a promising approach for helping children with an adoption history, yet the 2013 DAI report concluded that DDP has less empirical support than CPRT (Brodzinsky, 2013).

According to Barth and colleagues (2005), adoptive parents seek mental health services due to challenges in the parent-child relationship. Experts agree that effective intervention for adoptive families includes parents directly in the treatment with their children and focuses on the parent-child relationship (Brodzinsky, 2013). A review of literature on adoption specific interventions in the United States resulted in the conclusion drawn by Brodzinsky in the 2013 DAI report regarding evidence-based treatments. As the only parent-child intervention with a randomized controlled study to support its effectiveness with adoptive families (Carnes-Holt & Bratton, 2014), CPRT appears to uphold the distinction as the parent-child treatment with the most robust empirical support for adoptive families.

CPRT

CPRT is an empirically validated, manualized mental health intervention for children presenting with a range of social, emotional, and behavioral concerns (Bratton, Landreth, Kellam, & Blackard, 2006; Landreth & Bratton, 2006). Rooted in the theoretical assumptions of CCPT, the relationship---in this case between caregiver and child---is viewed as the primary mechanism for change and the foundation for children’s overall well-being. Using a small, support group training format consisting of didactic and supervision experiences, parents are
taught CCPT attitudes and skills as means to becoming the therapeutic agent for their child during supervised, weekly parent-child play sessions. CPRT offers a unique and a developmentally responsive approach to help parents attune to and understand their child’s underlying needs, respond more empathically and effectively to their child’s behavioral and emotional difficulties, and facilitate their child’s ability to self-regulate.

Essential to the successful and ethical application of CPRT is the requirement that treatment providers are mental health professionals who are first trained and supervised in CCPT theory and skills (Landreth, 2012; Ray, 2011), and then trained and supervised in the 10-session CPRT protocol (Bratton et al., 2006). Landreth and Bratton (2006) are clear that CPRT is not intended for use without formal training and supervision.

History and Development

CPRT is grounded in the CCPT-based parent training model originally developed by Bernard Guerney in the early 1960s (L. Guerney & Ryan, 2013). Although there were a few isolated reports of parents working therapeutically with their children in the first half of the 20th century (Baruch, 1949; Freud, 1909; Fuchs, 1957; Moustakas, 1951), Guerney was the first to develop a systematic model for training parents to be therapeutic agents for their children (B. Guerney, 1964). Guerney named the model filial therapy to reflect the significance of the parent-child bond in this innovative treatment. Louise Guerney joined her husband in the early research and development of filial therapy and has continued to refine and advance the model into the 21st century (L. Guerney & Ryan, 2013).

The Guerneys, both practicing child-centered play therapists, relied on their clinical experience and knowledge of the research on CCPT to develop the content and structure of filial therapy training (L. Guerney & Ryan, 2013). CCPT is based on the assumption that children have an inherent propensity to strive towards growth and fulfillment of their potential when in a
nurturing and supportive environment (Axline, 1947; Landreth, 2012; Rogers, 1951). The Guerneys theorized that training parents in CCPT principles, attitudes and skills to use with their own children in weekly, supervised parent-child play sessions could effectively reduce their children’s social, emotional and behavioral problems (L. Guerney, 2000; L. Guerney & Ryan, 2013). Moreover, based on the emotional significance parents hold for their children over their lifetime, the Guerneys believed that this approach had the potential for greater success and longer lasting effects than play therapy delivered by a professional. By taking on the therapeutic role prescribed by CCPT, parents would learn positive ways of relating and responding to their child in the required weekly play sessions that they then could generalize to day-to-day parent-child interactions. In the earliest publication on filial therapy, B. Guerney (1964) suggested that “every bit of success the parent achieves in filling the prescribed role should have an effect many times more powerful than that of a therapist doing the same thing” (p. 307).

In the original model (B. Guerney, 1964), a small group of parents met weekly for an unspecified length of time that could extend beyond one year. Over time, the Guerneys continued to refine and adapt the group model to include shorter versions of the training format specifying as few as 20 sessions (L. Guerney & Ryan, 2013). Practical considerations for use with single families and parents resulted in the model’s further adaptation for individual filial therapy (VanFleet, 2013).

Building on the Guerneys’ work, Garry Landreth (1991, 2002) developed a more structured and condensed 10-session, group filial therapy training format. Based on Landreth’s experiences in the 1970s using the Guerneys’ model, he began to experiment with modifying the training structure in order to reduce the number of sessions. Landreth posited that reducing parents’ time and financial commitment would result in increased parent participation and make the intervention available to more families (Landreth & Bratton, 2006). Landreth and Bratton further refined the model and
formalized the 10-session training format in their 2006 text, Child Parent Relationship Therapy (CPRT), to distinguish the model from other filial therapy approaches. Landreth and Bratton pointed out that although the training structure and delivery of CPRT varies from the Guerneys’ model, CPRT’s underlying philosophy, including the benefits of the group training format, is fundamentally the same. Bratton, Landreth, Kellam, and Blackard (2006) manualized the CPRT protocol to provide researchers and clinicians with a tool for ensuring treatment integrity in delivering the intervention.

Theoretical Assumptions

CPRT is predicated on the theoretical foundations of CCPT and person-centered philosophy and incorporates principles of child development and attachment theory. In CCPT (Landreth, 2012; Ray, 2011), children are believed to have an innate drive within themselves towards health and optimal functioning, e.g., Rogers’ (1951) self actualizing principle. Thus, in CPRT, the focus is on the child and his or her capability, not on the child’s problematic behaviors (Landreth & Bratton, 2006). Another major assumption of CCPT is that children possess the capacity to solve their own emotional problems satisfactorily, given the opportunity and a favorable environment. Axline (1947) described the growth process in play therapy as one in which the child is free to play out feelings as they emerge and either “learns to control them, or abandon them” (p. 16). CPRT facilitators share the above assumptions with parents as a rationale for the child-led play sessions and to encourage them to grow in their acceptance and trust in their children’s capabilities.

In CCPT, the child’s experience within the therapeutic relationship is the factor that is most meaningful and growth producing. Rogers (1957) posited that if the child experiences a relationship characterized by genuineness, unconditional positive regard, and empathy, then the child is free to move towards more mature and self-enhancing behaviors. Likewise, CPRT is based on the belief that this type of relationship between parent and child promotes a secure
attachment and is fundamental for children’s healthy development and overall well-being. Landreth and Bratton (2006) referred to the parent-child relationship as the “agent of change” and curative factor for children. CPRT emphasizes that when parents provide a consistent, nurturing, and non-judgmental relationship during the required parent-child play times, children will play out their feelings, experiences, and needs symbolically, and sometimes literally, through the toys and materials they choose, what they do with the materials, and the stories they act out.

Axline (1947) established eight basic principles essential to the process and success of CCPT. Axline emphasized the role of the therapist is to: (a) develop a warm, friendly relationship with the child; (b) accept the child unconditionally, without wishing the child were different in some way; (c) establish a feeling of permissiveness in the relationship so that the child feels free to express self; (d) attune to and reflect the child’s feelings to create within the child a feeling of being understood; (e) respect the child’s innate ability to solve his or her own problems; (f) avoid directing the child’s actions or conversation; rather, allow the child to lead the way; (g) recognize the gradual nature of the child’s process and thus be patient with the process; and (h) establish only those limits that are necessary to anchor the child’s play therapy experience to the world of reality (Axline, 1969, pp. 73-74). These principles serve as a guide for current day CCPT practice and have been distilled into the attitudes and skills taught to parents in CPRT (Landreth & Bratton, 2006).

Developmentally, children have difficulty verbalizing their concerns, feelings, and needs. Play is children’s natural way to learn, express themselves, communicate, and understand their world (Axline, 1969; Landreth, 2012). The CPRT parent-child play sessions provide a window through which the parent can enter the child's world as the child plays out past experiences and
associated feelings (Bratton, Ray, & Landreth, 2008) and become more sensitive, understanding, and attuned to their child’s needs and world view. Play provides children the developmentally responsive means to resolve problems and develop a sense of control and mastery over difficult and confusing experiences. Play is also used to promote relational experiences that foster joy in the parent-child relationship and create opportunities for parents to take greater delight in simply being with their children (Bratton, Opiola, Dafoe, 2015). Children’s development and health are enhanced when they experience a relationship with an affectionate, empathic, and non-judgmental adult who can relate to them on their level through play (Landreth & Bratton, 2006; Ginsburg, 2007; Ray & Landreth, 2015).

Lastly, CPRT incorporates the basic tenets of attachment theory with the objective to strengthen and enrich the attachment bond between parent and child (Bratton et al., 2015). Parents are encouraged to attune to and understand their children’s underlying emotional needs in order to respond more empathically to their children. Attuned caregivers are perceived as emotionally responsive, predictable, consistent, and flexible (Ainsworth & Bell, 1970; Bowlby, 1980; Siegel & Hartzell, 2003)---qualities promoted in CPRT. A parent’s ability to communicate empathy, understanding, and acceptance fosters a secure bond between child and parent that provides a strong foundation for the child’s optimal development and ability to form satisfying relationships in the future.

Overview of Structure, Format and Content

CPRT uses a small, support group format that consists of didactic and supervision experiences (Landreth & Bratton, 2006). This dynamic and interactive process distinguishes CPRT and other group filial therapy models (Guerney & Ryan, 2013) from the majority of parent training programs that tend to be primarily educational in focus. In CPRT, a group of five to
eight parents typically meet two hours weekly for ten weeks, although CPRT has been successfully used in more intensive formats, and in some cases, the treatment time has been extended to meet families’ needs (Landreth & Bratton, 2006). In addition to the group meetings, parents conduct supervised, 30-minute video-recorded child-led play sessions on a weekly basis typically beginning after the third CPRT training session. During these special play times, parents set up a specific group of toys in a designated area of their home. The parent-child play sessions are at the heart of CPRT and the primary means by which parents learn to apply the CCPT attitudes and skills considered essential to the success of the model.

Initial treatment objectives include creating a training structure that promotes an environment of safety, acceptance, and encouragement in order that parents begin to connect and share their parenting struggles with other group members. Parents are given information about child development and taught CCPT attitudes and skills to positively influence the parent-child relationship (Bratton et al., 2015). Essential skills taught include “being-with” (i.e., attunement), reflective listening, following the child’s lead, limit setting, and responding to children’s verbal and nonverbal feelings, thoughts, and behavior (Bratton et al., 2006). CPRT emphasizes the significance of parents being fully attuned with their child and communicating the be-with attitudes: I am here. I hear you. I understand. I care. Parents’ ability to express the attitudinal qualities of unconditional acceptance and empathic understanding while demonstrating the required skills is foundational to the success of CPRT. Training is structured so that parents learn, see, and practice skills through demonstration and role-play prior to implementing skills with their children. The CPRT group format requires a skillful balance of didactic and support group experiences on the part of the therapist in order to maximize parents’ confidence and success.
Arguably the most critical element of the CPRT model is the supervision component of parents’ video recorded play sessions with their children (Landreth & Bratton, 2006). Parents view video recordings and receive feedback from the therapist and the group members during weekly group meetings typically beginning in the fourth session. Ryan and Bratton (2008) emphasized the importance of both sides of the attachment relationship, arguing that effective CPRT/filial therapy addresses the emotional needs of caregivers and children. Thus, sensitive support of parents’ emotional needs is essential to the supervision process. The therapist intentionally links parents and works to deepen a felt sense of safety and acceptance among group members. As parents receive emotional support and directly experience the interpersonal relationship skills that they are learning to apply with their own children (Landreth & Bratton, 2006), they are more willing to explore their feelings and experiences. Increased open communication and sharing in the group allows parents to express their fears and needs and receive support from other parents as well as the therapist. The experience of sharing similar difficulties with other group members can reduce feelings of isolation, promote parents’ self-acceptance, and foster group cohesion.

Empirical Support

CPRT is a child therapy treatment model with more than 50 studies investigating its process and outcomes. The considerable body of CPRT research rests firmly on the empirical foundation laid by the Guerneys and their colleagues in the 60s and 70s (Guerney & Ryan, 2013). Although early filial therapy studies lacked the methodological rigor of contemporary studies, the encouraging findings from the Guerneys’ groundbreaking research provided the catalyst for the significant production of CPRT research over the past two decades (Landreth & Bratton, 2006).
Since Bratton & Landreth published the first CPRT outcome study in 1995, the
evidentiary-base for CPRT has grown as studies’ methodological rigor increased. Thirty-five
studies involving over 1000 participants employed a control group design to examine CPRT’s
effects (Baggerly & Landreth, 2001; Bratton & Landreth, 1995; Carnes-Holt & Bratton, 2014;
Ceballos & Bratton, 2010; Chau & Landreth, 1997; Cornett & Bratton, 2014; Costas & Landreth,
1999; Crane & Brown, 2003; Glover & Landreth, 2000; Harris & Landreth, 1997; Helker & Ray,
2009; Hess, Post, & Flowers, 2005; Jang, 2000; Jones, Rhine & Bratton, 2002; Kale & Landreth,
Morrison & Bratton, 2010; Morrison & Bratton, 2011; Post, McAllister, Sheely, Hess, &
Flowers, 2004; Robinson, Landreth, & Packman, 2007; Sheely & Bratton, 2010; Smith &
Landreth, 2004; Smith & Landreth, 2003; Tew, Landreth, Joiner, & Solt, 2002; Yoder, Carter,
Yuen, Landreth & Baggerly, 2002). Of these 35 studies, 19 employed experimental designs
considered the “gold standard with regards to questions of treatment efficacy” (Baggerly &
Landreth, 2001; Bratton & Landreth, 1995; Carnes-Holt & Bratton, 2014; Ceballos & Bratton,
2010; Chau & Landreth, 1997; Cornett & Bratton, 2014; Costas & Landreth, 1999; Glover &
Landreth, 2000; Harris & Landreth, 1997; Helker & Ray, 2009; Jones, Rhine & Bratton, 2002;
Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Morrison & Bratton,
2010; Morrison & Bratton, 2011; Nezu & Nezu, 2008, p. vii; Sheely & Bratton, 2010; Smith &
Landreth, 2004; Yuen, Landreth & Baggerly, 2002). The remaining 16 studies used quasi-
experimental designs primarily due to challenges in conducting research in community settings
that interfered with random assignment (Crane & Brown, 2003; Hess, Post, & Flowers, 2005;
Jang, 2000; Kidron & Landreth, 2010; Kim, 2009; Post, McAllister, Sheely, Hess, & Flowers,
2004; Robinson, Landreth, & Packman, 2007; Smith & Landreth, 2003; Tew, Landreth, Joiner, & Solt, 2002; Yoder, Carter, Way, Swan, & Allison, 2014; Yoder, Larson, Washburn, Mills, Cater, Bausch, & Lee, 2013). As an indicator of the high level of treatment fidelity in CPRT research, 32 of the 35 controlled studies were conducted by investigators that were directly trained and supervised in the CPRT protocol (Bratton et al., 2006). The majority of studies showed statistically significant results and moderate to large treatment effects for CPRT over control groups. Although the majority of outcome studies focused on the effects of training and supervising parents as therapeutic agents, the benefits of CPRT delivered by teachers and mentors was investigated in approximately one-third of the controlled studies (Baggerly & Landreth, 2001; Crane & Brown, 2003; Helker & Ray, 2009; Hess, Post, & Flowers, 2005; Jones, Rhine & Bratton, 2002; Morrison & Bratton, 2010; Morrison & Bratton, 2011; Post, McAllister, Sheely, Hess, & Flowers, 2004; Robinson, Landreth, & Packman, 2007; Smith & Landreth, 2004; Yoder, Carter, Way, Swan, & Allison, 2014; Yoder, Larson, Washburn, Mills, Cater, Bausch, & Lee, 2013).

Several conclusions can be drawn from reviewing the findings from the body of research. Overall results indicate CPRT is effective on increasing parental empathy, decreasing stress in the parent-child relationship, and reducing children’s behavior problems. Specifically, studies show CPRT’s efficacy across multiple populations and issues including: adopted/fostered children with attachment difficulties, children whose mothers or fathers were incarcerated, children who were sexually abused, children living in domestic violence shelters, children living with chronic illness, at-risk children of teenage parents, and children diagnosed with learning differences, pervasive developmental disorders, speech problems, adjustment difficulties, and various behavior problems. CPRT’s transportability is demonstrated by its successful use in
variety real-world settings including community agencies, churches, public and private schools, Head Start programs, shelters, prisons/county jails, and hospitals.

The effectiveness of CPRT with diverse populations is a strength of the treatment model. Multiple studies show CPRT’s efficacy across ethnic, socioeconomic and cultural groups, including African American, Native American, Israeli, Korean, immigrant Korean, immigrant Latino, second generation Latino, and immigrant Chinese populations. In addition, study participants ranged in age from 2-11 years, indicating CPRT’s responsiveness to a range of developmental needs. With a participant mean age of 5 years, CPRT appears particularly sensitive to the treatment needs of young children and, as such, responds to the dearth of evidence-based treatments for young children (Bratton, Dafoe, et al., 2015; Chorpita, et al., 2011; Weisz & Kazdin, 2010).

Five published studies examined the effectiveness of CPRT specific to children who have experienced interpersonal trauma in their primary relationships (Carnes-Holt & Bratton, 2014; Costas & Landreth, 1999; Harris & Landreth, 1997; Landreth & Lobaugh, 1998; Smith & Landreth, 2003). For the purpose of this study, interpersonal trauma is defined as an experience that overpowers an individual beyond his or her ability to effectively cope and adapt and may negatively impact the individual in the moment and in the future (Siegel, 2012, p. AI-82). Two studies explored the effectiveness of CPRT with incarcerated parents. Harris and Landreth (1997) examined the effects of CPRT with 22 incarcerated mothers with children 3 to 10 years old. The CPRT protocol was adapted to match the mother’s length of stay in county jail such that mothers received 2 hours of CPRT training twice a week for five weeks. Landreth and Lobaugh (1998) investigated the effectiveness of 10 week CPRT at a federal prison with 32 incarcerated fathers of 4- to 9-year-olds. Both studies randomly assigned incarcerated parents to the CPRT treatment group or
waitlist control group. Parents conducted their special play times with their children during scheduled visitations. Results of both studies indicated statistically significant improvement in child behavioral problems and parental acceptance compared to no treatment. Landreth and Lobaugh also investigated CPRT’s effect on child self-esteem and found statistically significant improvement for children in the CPRT group over the control. Harris and Landreth included a measure of parental empathy and reported that CPRT-trained mothers demonstrated an increase in empathic responses and behaviors as directly observed by independent raters.

Costas and Landreth (1999) conducted a study utilizing 10 week CPRT with 26 non-offending parents of children ages 5- to 9-years old who had been sexually abused. Parent assignment to the experimental and waitlist control was based on random assignment and geographic location. Between group differences indicated that CPRT-trained parents reported statistically significant improvement in acceptance of their children and stress in the parent-child relationship. Additionally, CPRT-trained parents demonstrated statistically significant increases in empathic interactions with their children compared to parents in the control group. Costas and Landreth also reported a notable, but not statistically significant, improvement in children’s behavioral problems, anxiety, emotional adjustment, and self-concept.

In a companion study to two studies examining the effects of play therapy on child witnesses of domestic violence, (Kot, Landreth, & Giordano, 1998; Tyndall-Lind, Landreth, & Giordano, 2001), Smith and Landreth (2003) investigated the effects of an intensive CPRT model with 11 mothers residing in a domestic violence shelter with their 4 to 10 year olds. The CPRT protocol was adapted to twelve sessions over 2-3 weeks to accommodate the shelter setting. Study outcomes were compared to intensive individual CCPT (Kot et al., 1998) and intensive sibling group CCPT (Tyndal- Lind, 2001). Mothers in all 3 studies were recruited in the identical manner from the same
shelter populations, and the 3 interventions were delivered over a 2-3 week period. Smith and Landreth used the wait list control group (n = 11) from Kot et al. to analyze the effects of intensive CPRT. The findings revealed that CPRT-trained mothers reported statistically significant improvement in their children’s problem behaviors and self-esteem compared to the no treatment control group. According to independent raters, the CPRT-trained mothers displayed a statistically significant increase in their empathic behaviors and responses with their children following treatment. In addition, comparisons between the treatment groups did not reveal a statistically significant difference between interventions indicating equal effectiveness for CCPT, Sibling CCPT, and CPRT.

Carnes-Holt and Bratton (2014) conducted the only study examining the responsiveness of CPRT specific to adoptive parents. Sixty-one parents were randomly assigned to treatment or waitlist control to investigate if CPRT was an effective intervention for adopted families self-referred for parent-child relationship concerns and child behavior problems. Compared to the waitlist control group, parents who participated in 10-week CPRT reported statistically significant decreases in their children’s externalizing and total problems. Between group differences also indicated that parents demonstrated statistically significant gains in their empathic interactions with their adopted children according to direct observation by raters blinded to the study. CPRT demonstrated moderate to large treatment effects across outcomes. Carnes-Holt and Bratton concluded that CPRT was responsive to the mental health needs of adoptive families and emphasized the need for replication studies using active control and comparison groups to increase confidence in CPRT’s treatment effects. A recent report issued by the Donaldson Adoption Institute evaluated the empirical support for adoption-related interventions and recognized the Carnes-Holt and Bratton study in its conclusion that among
parent-child interventions CPRT demonstrated the strongest empirical support for helping adopted children and their parents (Brodzinsky, 2013).

Comprehensive systematic reviews (Bratton et al., 2010; Lindo, Bratton, & Landreth, 2015) and meta-analyses (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015) conducted over the past decade support and strengthen the findings from individual CPRT studies. Bratton, et al. and Lin and Bratton conducted meta-analyses on play therapy outcome studies including CPRT/filial therapy and found stronger outcomes for studies in which caregivers were trained and supervised in CPRT/filial therapy methodology to use with their children, than play therapy studies in which professional play therapists provided treatment. Landreth & Bratton (2006) used the meta-analytic data from Bratton et al. (2005) to analyze only those studies using the CPRT model and calculated an overall effect size. CPRT demonstrated a large treatment effect size of 1.25 (Cohen, 1988). These results indicate the average child-caregiver dyad receiving CPRT performed one and a quarter standard deviations better on outcome measures compared to the average child/caregiver dyad not receiving the treatment (Bratton, Landreth, & Lin, 2010).

In summary, the evidence base for CPRT establishes the model as an effective child therapy intervention for a variety of presenting issues. According to criterion established by the American Psychological Association, CPRT can be considered a “promising treatment” for several presenting issues and populations including adoptive families (Baggerly & Bratton, 2010; Chorpita et al., 2011). CPRT research has increased in methodological rigor over its relatively short history by investigating clearly defined populations and target behaviors, the use of a manualized protocol and treatment fidelity checks, and the use of randomized controlled studies. In order to move CPRT towards recognition as a well-established treatment for specific
disorders, researchers need to continue to focus on the above mentioned areas, as well as replicate existing well-designed studies using active control and comparison treatments.
APPENDIX B

EXTENDED METHODOLOGY
Methodology

I used a randomized control group design to examine the effects of CPRT with adoptive parents who reported attachment-related concerns such as difficulties establishing a mutually satisfying parent-child relationship as well as concerns about their adopted child’s behavior and parental stress. I compared the experimental condition, CPRT, to treatment as usual control group, which received Individual Parent Consultation. In this chapter, I included definition of terms, research questions, instrumentation, participant selection, procedures, data collection, data analysis, and limitations of the study.

Purpose of the Study

The purpose of this study was to examine the effectiveness of CPRT for adoptive families who reported attachment-related concerns including difficulties establishing a mutually satisfying parent-child relationship and concerns about the adoptive child’s behavior and parental stress. In addition this study was designed to replicate and add to the methodological rigor of Carnes-Holt and Bratton (2014) study by using a treatment as usual (TAU) condition for the control group rather than no-treatment waitlist.

Definitions of Terms

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

*Adoptive Parents.* Adoptive parents are the primary caregivers of the child, who have legally adopted a child from another person, institution, or foster care system. For the purpose of this study, *parents* and *caregivers* are used interchangeably.

*Foster to Adopt Parent.* Foster to adopt parents are parents who are in the process of adopting a child from the foster care system.

*Child-Centered Play Therapy (CCPT).* CCPT is a developmentally responsive and therapeutic approach for children to help them with an array of emotional, behavioral, and social
concerns (Axiline, 1969; Ray & Landreth, 2015). CCPT is based on the belief that the therapist-child relationship is the key factor for healing and growth in therapy. Landreth (2012) defined CCPT as the interpersonal relationship between a child and trained play therapist who utilizes the child’s natural medium of communication--play--to facilitate the development of a safe relationship for the child to express fully and explore his or her feelings, thoughts, experiences, and behaviors (p. 11).

Child-Parent Relationship Therapy (CPRT; Landreth & Bratton, 2006). CPRT, a Filial Therapy Model (Guerney, 1969), is a manualized parent-child intervention grounded in the attitudes and principles of CCPT. Landreth and Bratton (2006) defined CPRT as follows:

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 non-judgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for the child and parent. (p.11)

The CPRT protocol can be found in the Child-Parent Relationship Therapy (CPRT) Treatment Manual: A 10-Session Filial Therapy Model for Training Parents (Bratton et al., 2006).

Treatment as Usual (TAU). TAU was based on the typical responsive services offered by the adoption agencies and ministries. TAU refers to one-to-one consultations between caregivers and a child counselor to provide caregivers with an opportunity to share concerns, needs, and emotional reactions to their child. For the purpose of this study, child counselors provided emotional support to caregivers, taught parenting skills and strategies to resolve current problems, and helped caregivers understand their children’s needs and developmental level.
Child of Focus: Child of focus refers to an adopted or foster to adopt child between the ages of 2 and 9 years identified by the parent as exhibiting behavior problems. The child of focus received weekly playtime with an adoptive parent for the study period. For the purpose of this study, the parent focused on one adopted child for all playtimes.

Attachment. Attachment refers to a bond between a child and primary caregiver that leads to varied emotions and experiences when interacting with each other, particularly around stressful times (Bowlby, 1988). Repeated patterns of communication between caregivers and children help to form a basis for how children view themselves, relationships, others, and the world. Attachment is understood on a continuum from securely attached to insecurely attached.

Empathy. Empathy refers to a process through which caregivers enter into the world of their child with sensitivity to gain understanding and value without judgment (Rogers, 2007). Empathy is operationalized by the degree to which caregivers can fully attend to their child’s behavior, respond to their child’s feelings and behaviors in a genuine and accepting manner, and fully permit their child to engage in an activity of the child’s choosing. For the purpose of this study, empathy was evaluated using the Total Score on the Measurement of Empathy in Adult-Child Interactions (MEACI; Stover, Guerney, & O’Connell, 1971).

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

Problem Behaviors: Problem behaviors refer to internalizing and externalizing problematic behaviors for the child. Internalizing behaviors refers to problems that occur within
one’s self. Typical internalizing behaviors include emotional reactions, anxiety, somatic complaints, withdrawal, and sleep problems. Externalizing behaviors refers to problems that occur with other people and deficiencies in expectations for the child. Externalizing behaviors include attention problems, aggression, affective problems, anxiety, and pervasive developmental problems. For the purpose of this study, I operationally defined Problem behaviors as the overall score on the Total Problems scale on the Child Behavioral Checklist ages 1 ½-5 and 6-18 (CBCL; Achenbach & Rescorla, 2000, 2001).

Research Questions

This study addressed three research questions:

1) Based on parent report, do children of adoptive parents who participated in CPRT exhibit a reduction in behavioral problems compared to a TAU control group?  
2) Based on parent report, do adoptive parents who participated in CPRT exhibit a reduction in stress in the parent-child relationship compared to a TAU control group? And  
3) Do adoptive parents who participate in CPRT exhibit an increase in parents’ empathic interactions with their children compared to a TAU control group?

Participants

Participants were recruited from local university counseling clinics, churches, adoption ministries and agencies, and mental health providers who specialize in working with adoptive children and families in the southwest region of the United States, as well as emails and social media. I met with local agency employees and mental health providers to discuss the purpose of the study and answer any questions they may have about the study. The target population was parents of adopted children between the ages of 2½ and 9, who reported concerns for their children’s problematic behaviors and/ or stress in the parent-child relationship. Mental health
providers and agency employees distributed flyers to target parents they identified as needing additional assistance. Interested parents called the researcher and an informal assessment was completed to ensure interested participants understood the purpose, qualification criteria, and possibility of placement in either of the two treatment models, CPRT or TAU. I met with each interested parent to answer any questions and review informed consent.

A G* Power a priori power analysis was used to determined that a minimum sample of 34 participants was necessary to find a statistical difference between two groups over two times of measurement (pre and post-test). I based G* Power calculation on an alpha level of .025, moderate treatment effect size ($f = .25$), and minimum power at .80. To allow for attrition and account for busy family lives and other commitments that may prevent parents from completing the groups, I recruited 50 adoptive parents/caregivers for this study. Parents who met the following criteria were invited to participate in this study: 1) Parents identified themselves as adoptive parent or foster-to-adopt parent of a child of normal cognitive functioning between the ages of 2½ and 9 years residing in the home; 2) Parents self-referred for attachment-related concerns such as difficulties establishing a mutually satisfying parent-child relationship as well as concerns about the adoptive child’s behavior and parental stress; 3) Parents reported clinical level of concern regarding child behavior problems or stress in the parent-child relationship, 4) Parents spoke and read English; and 5) Parents consented to participate in CPRT.

Sixty-three parents were recruited; of which 50 met inclusion criteria. Parents were randomly assigned to treatment groups, with 26 parents assigned to the experimental group and 24 to the treatment as usual control group. One parent from the experimental group withdrew midway through the study due to an extended stay outside the U.S. to meet his second adopted child. 49 parents completed all pre- and post-test written assessments (PSI and CBCL) and their
data was included in the data analysis, 25 in the experimental group and 24 in the active control group. Overall, 61% were female. The parents’ ages ranged from 25 to 59 years old with a mean age of 39.46 years old. Of the participants, 85.7% were European American, 2% was African American, 6.1% were Asian, and 6.1% were Latino. 90% of the participants were married. The distribution of gender, age, ethnicity, and marital status across the two groups is displayed in Table B.1.

Table B.1.

Demographic Information for Parental Participants in the Experimental CPRT Group (n=25) and TAU Group (n=24)

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Experimental Group</th>
<th>TAU Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>15</td>
</tr>
<tr>
<td>Age</td>
<td>20-29</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>30-39</td>
<td>11</td>
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<tr>
<td></td>
<td>40-49</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>50-59</td>
<td>1</td>
</tr>
<tr>
<td>Mean Age</td>
<td></td>
<td>39</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>European American</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>African American</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Hispanic/ Latino</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>0</td>
</tr>
<tr>
<td>Participating in the Study as</td>
<td>Single</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>1</td>
</tr>
</tbody>
</table>

The 49 adoptive parents focused on one adopted child throughout the 11-week study. 49 children were the focus of their parents’ attention, 25 from the experimental group and 24 from
the active control group. Of the 49 children, 51% were male and 49% were female. The age range of children was 2½ to 9 years old, with 39% 2-4 year olds, 39% 5-7 year olds, and 22% 8-9 years old. The ethnicity for the children of focus were 35% Caucasian children, 10% African American children, 12% Hispanic/Latino children, 22% Asian children, 16% Biracial children, and 4% children were African. Of the 49 focus children, 53% were adopted through the foster care system, 31% were internationally adopted, 6% were privately adopted, and 10% were adopted domestically. The distribution of age, gender, ethnicity, and adoption related demographics across the two groups are displayed in Table B.2.

Table B.2

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Experimental Group</th>
<th>TAU Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Age of Child</td>
<td>2-4 years</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>5-7 years</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>8-10 years</td>
<td>6</td>
</tr>
<tr>
<td>Age of Child When Adopted</td>
<td>&lt;1 month</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1-6 months</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>7 months-1 year</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1-2 years</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>2-4 years</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5-6 years</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>7+ years</td>
<td>5</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>16</td>
</tr>
<tr>
<td>Ethnicity</td>
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</tr>
<tr>
<td></td>
<td>Black American</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Hispanic/ Latino</td>
<td>4</td>
</tr>
<tr>
<td>Demographics</td>
<td>Number</td>
<td>5-6</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
<td>-----</td>
</tr>
<tr>
<td>Asian</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Biracial</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>African</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Adoption Source:</td>
<td>Foster Care</td>
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<tr>
<td>Private</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Domestic/ Agency</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>International</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Length of Placement with Parents</td>
<td>&lt; 1 year</td>
<td>3</td>
</tr>
<tr>
<td>12-23 months</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>2-4 years</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>5+ years</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Figure B.1 depicts the flow of participant recruitment, group assignment, and detailed participant demographics.
PARTICIPANTS
Assessed for eligibility (n=63)

Excluded (n=13)
Did not meet inclusion criteria

Random Assignment to Groups (n=50)

Assigned to CPRT group (n=26)
Completed CPRT (n=25)
Completed post-test (n=25)

Assigned to TAU group (n=24)
Completed intervention (n=24)
Completed post-test (n=24)

Parent Demographics
Age: 20-29 (n=1), 30-39 (n=11), 40-49 (n=12), 50-59 (n=1), M= 39
Gender: Male (n=10)  Female (n=15)
Ethnicity: Caucasian (n=24), African American (n=1),
Hispanic/Latino (n=0), Asian (n=0);
Marital Status: Single (n=2), Married (n=22), Divorced (n=0), Widowed (n=1)

Child Demographics
Age: 2-4 (n=9), 5-7 (n=10), 8-9 (n=6), M= 5.70
Gender: Male (n=9), Female (n=16)
Ethnicity: White (n=4), Black American (n=4), Hispanic/Latino (n=4), Asian (n=5), Biracial (n=6), African (n=2)
Age at Adoption: < 1m (n=2), 1-6m (n=0), 7-11m (n=1),
12-23m (n=11), 2-4y (n=2), 5-6 y (n=4), 7+ y (n=5)
Adoption Source: Foster Care (n=15), International (n=8),
Domestic Agency (n=2), Private (n=0);
Length of time with Adoptive Parent: < 1 yr (n=3),
12-23m (n=5), 2-4y (n=13), 5+ y (n=4)

Parent Demographics
Age: 20-29 (n=0), 30-39 (n=15), 40-49 (n=6), 50-59 (n=3), M= 39.92
Gender: Male (n=9)  Female (n=15)
Ethnicity: Caucasian (n=18), African American (n=0),
Hispanic/Latino (n=3), Asian (n=3);
Marital Status: Single (n=1), Married (n=22),
Divorced (n=1), Widowed (n=0)

Child Demographics
Age: 2-4 (n=10), 5-7 (n=9), 8-9 (n=5), M= 5.23
Gender: Male (n=16), Female (n=8)
Ethnicity: White (n=13), Black American (n=1),
Hispanic/Latino (n=2), Asian (n=6), Biracial (n=2),
African (n=0)
Age at Adoption: < 1m (n=1), 1-6m (n=4), 7-11m (n=0),
12-23m (n=7), 2-4y (n=5), 5-6 y (n=5), 7+ y (n=2)
Adoption Source: Foster Care (n=11), International (n=7),
Domestic Agency (n=3), Private (n=3);
Length of time with Adoptive Parent: < 1 yr (n=3),
12-23m (n=7), 2-4y (n=12), 5+ y (n=2)
PARTICIPANTS
Assessed for eligibility (n=63)

Excluded (n=13)
Did not meet inclusion criteria

Random Assignment to Groups (n=50)

Assigned to CPRT group (n=26)
Completed CPRT (n=25)

Completed post test (n=25)

Analyzed (n=25)
Excluded from analysis due to not completing intervention (n=1)

Assigned to TAU group (n=24)
Completed intervention (n=24)
Completed post-test (n=24)

Analyzed (n=24)
Excluded from analysis (n=0)

Parent Demographics
Age: 20-29 (n=1), 30-39 (n=11), 40-49 (n=12), 50-59 (n=1), M= 39
Gender: Male (n=10)Female (n=15)
Ethnicity: Caucasian (n=24), African American (n=1), Hispanic/Latino (n=6), Asian (n=0),
Marital Status: Single (n=2), Married (n=22), Divorced (n=0), Widowed (n=1)

Child Demographics
Age: 2-4 (n=9), 5-7 (n=10), 8-9 (n=6), M= 5.70
Gender: Male (n=9), Female (n=16)
Ethnicity: White (n=8), Black American (n=4), Hispanic/Latino (n=4), Asian (n=6),
African (n=2)
Age at Adoption: < 1m (n=2), 1-6m (n=0), 7-11m (n=1)
12-23m (n=11), 2-4y (n=2), 5-6 y (n=4), 7+ y (n=5)
Adoption Source: Foster Care (n=15), International (n=8), Domestic Agency (n=2), Private (n=0)
Length of placement with Adoptive Parent: < 1 yr (n=3), 12-23m (n=5), 2-4y (n=13), 5+ y (n=4)

Parent Demographics
Age: 20-29 (n=0), 30-39 (n=15), 40-49 (n=6), 50-59 (n=3), M= 39.92
Gender: Male (n=9)Female (n=15)
Ethnicity: Caucasian (n=18), African American (n=0),
Hispanic/Latino (n=3), Asian (n=3),
Marital Status: Single (n=1), Married (n=22), Divorced (n=1), Widowed (n=0)

Child Demographics
Age: 2-4 (n=10), 5-7 (n=9), 8-9 (n=5), M= 5.23
Gender: Male (n=16), Female (n=8)
Ethnicity: White (n=13), Black American (n=1), Hispanic/Latino (n=2), Asian (n=6),
Biracial (n=2), African (n=0)
Age at Adoption: < 1m (n=1), 1-6m (n=4), 7-11m (n=0),
12-23m (n=7), 2-4y (n=5), 5-6 y (n=5), 7+ y (n=2)
Adoption Source: Foster Care (n=11), International (n=7),
Domestic Agency (n=3), Private (n=3)
Length of placement with Adoptive Parent: < 1 yr (n=3),
12-23m (n=7), 2-4y (n=12), 5+ y (n=2)

Figure B.1. Participants flow chart
Instrumentation

I utilized two parent report instruments and one direct observation measurement to assess the effectiveness of CPRT compared to TAU for adoptive parents. The three assessment tools helped identify differences between the experimental and TAU groups to identify if one intervention is more effective than the other. I utilized the Child Behavior Checklist, (CBCL; Achenbach & Rescorla, 2000) to measure parents’ report of children’s total behavior problems and qualified participants for the study. I used the Parenting Stress Index, 4th edition (PSI-4, Abidin, 2012), to measure the parents’ perception of stress in the parent-child relationship and qualified participants for the study. Lastly, I used the Measurement of Empathy in Adult-Child Interaction (MEACI; Stover, Guerney, & O’Connell, 1971), a direct observation assessment, to measure the empathic behaviors and responses parents demonstrate with their adopted children.

Child Behavior Checklist – Parent Version

The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001) measures the parent’s perception of their children’s behavioral, emotional, and social functioning problems. Two versions of the CBCL exist and are based on the child’s age, CBCL for children 1½ to 5 years of age and CBCL for children 5 to 18 years of age (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001). The CBCL is one of the most frequently used screening and assessment tools (Njoroge & Bernhart, 2011), and is commonly used in play therapy research (Lin & Bratton, 2015).

The parent version of the CBCL is completed by parents, but can also be completed by parent surrogates, such as foster parents or extended family members caring for the child (Achenbach & Rescorla, 2000). The CBCL is a paper-based questionnaire comprised of 99-113 Likert-scaled items and is based on parents’ perceptions of their children’s behaviors from the
previous two months. Parents rate the descriptive sentences on a scale of not true, somewhat true, or very true or often true. Higher scores typically indicate the child is exhibiting the identified behavior more frequently. The assessment includes several open-ended questions to allow parents to express their view of their child’s behaviors from their own frame of reference. The CBCL takes approximately 15 minutes to complete.

Once parents complete the form, the researcher scores their responses using computer software that classifies their results into three main groupings: Internalizing Problems, Externalizing Problems, and Total Problems (Achenbach & Rescorla, 2000, 2001). The CBCL is composed of eight syndrome scales that categorize clinical behaviors on three domains – Internalizing, Externalizing, and Total Problems – and yield T scores in the normative, borderline, and clinical ranges. Achenbach and Rescorla ensured the T scores on both versions of the CBCL are comparable for Internalizing, Externalizing, and Total Problems scales. T Scores above 65 indicate borderline and clinical scores and specify higher levels of problematic behaviors. A decrease in scores indicates improvement in the targeted behavior.

The normative sample for the CBCL included 738 preschool aged children and 1,753 school aged children from diverse backgrounds and populations (Achenbach & Rescorla, 2000, 2001). The preschool normative sample included children from preschools, pre-kindergarten, and childcare environments seeking consultation for clinical and special needs services. The preschool children were from the United States, Jamaica, Australia, and Canada, and they were ethnically diverse, with 58% White, 17% African American, 9% Latino, and 15% mixed decent or other. The school-age normative sample included children from 40 states and the District of Columbia who were ethnically diverse, with 60% White, 20% African American, 9% Latino, and 12% mixed decent or other (Achenbach & Rescorla, 2001).
Researchers indicated the CBCL has acceptable psychometrics (Achenbach & Rescorla, 2000, 2001; Njoroge & Bernhart, 2011). Achenbach and Rescorla (2000) noted that the CBCL has been continually revised and researched to ensure items related to the problem and total groups are consistent with the intentions of the statements. Evidence of the CBCL’s criterion-related validity included specific items that differentiated children who had and had not been referred for specific concerns. The CBCL has strong test-retest reliability based on a longitudinal study where researchers evaluated the consistency of scores over several days to months (Achenbach & Rescorla, 2000, 2001). The mean score for both the CBCL 1½ -5 and CBCL 6-18 across all tests was $r = 0.90$. Specifically, internalizing problems was $r = 0.90$; externalizing problems was $r = 0.87$; and total problems was $r = 0.90$. Achenbach and Rescorla suggested reassessing parents one or more months apart in order to minimize the test-retest attenuation effect and to allow for change to occur in the child. Due to nature of this study, both the CBCL 1½ -5 amd CBCL 6-18 were utilized by the researcher. Achenbach and Rescorla (2001) emphasized the continuity amongst the ASEBA forms, specifically the preschool and school-age CBCL forms as well as items between the preschool and school-age forms correspond. Continuity and consistency between forms allows researchers to explore similarities and test problems among children at different ages and developmental milestones.

Parenting Stress Index-4

The Parenting Stress Index, 4th edition (PSI-4; Abidin, 2012), measures parents’ perceptions of their stress related to the parent-child relationship, as well as the characteristics of the parent and child that contribute to stress within the parent-child relationship. The PSI-4 is commonly used as a screening tool to help mental health clinicians identify concerns that cause problems in the parent-child relationship and target areas to strengthen the relationship between
parent and child. The PSI contains two domains – child domain and parent domain – and a Total Stress score.

The child domain assesses characteristics in the child that contribute to distress in the parent-child relationship and provides information regarding the degree to which a child’s characteristics are contributing to the parent’s overall stress (Abidin, 2012). The child domain consists of six subscales, including child characteristics of distractibility/hyperactivity, adaptability, reinforces parent, demandingness, mood, and acceptability. High scores on the child domain indicate that the child’s characteristics contribute to the parent’s difficulty in parenting the child and relating to the child. The parent domain is a combination of seven subscales that measure parental stress, which contributes to overall stress: competence, isolation, attachment, health, role restrictions, depression, and spouse/parenting partner relationship. High scores on the parent domain indicate feelings of inadequacy as a parent and experiences of stress caused by the parent’s behaviors. The Total Stress score assesses parents’ overall levels of stress and the impact of stress on their children’s behavior problems and overall dysfunction. High overall stress scores indicate the parent is not parenting effectively. Eight additional items on the PSI-4 focus on life stressors that may be out of the parent’s control. For instance, parental separation, loss of income, or problems at work may impact the parent’s ability to parent well.

The PSI-4 is a self-administered, paper-based instrument that takes approximately 20 minutes to complete (Abidin, 2012). The instrument consists of an item booklet and answer sheet. The item booklet has 109 Likert-scaled items for which a parent chooses strongly agree, agree, not sure, disagree, or strongly disagree. Scores are computer generated. Scores from the 85th-95th percentile are in the borderline range; scores greater than the 90th percentile are clinically significant.
The PSI-4 was normed on a stratified sample of 534 mothers and 522 fathers who were selected to represent the 2007 U.S. population in terms of education, ethnicity, child gender, and child age (Abidin, 2012). According to Abidin, parent stress appeared to be a universal construct with varying populations, as indicated by strong factor structure, validity, reliability, and 40 translated versions of the PSI-4. The PSI-4 maintains its validity across cultures and has been investigated in a number of studies with varying populations, such as children at risk, children with attachment disruptions, and children who have experienced child abuse.

Several research studies indicated that test-retest reliability coefficients for the PSI are stable for the child domain, parent domain, and Total Stress score, with \( r = .55-.82 \) for the child domain, \( r = .96 \) for the parent domain, and \( r = .65-.96 \) for the Total Stress Score (Abidin, 2012). The PSI has a high degree of internal consistency, with coefficient alpha scores ranging from .75 to .98 for both domains and a total stress score coefficient alpha reported at .96 (Abidin, 2012).

The Measurement of Empathy in Adult-Child Interaction

The Measure of Empathy in Adult-Child Interaction (MEACI; Guerney, Stover, & DeMeritt, 1968; Stover, Guerney, & O’Connell, 1971) is a direct observation instrument that measures a parent’s observable empathic behaviors and responses during unstructured play sessions with his or her child. Bratton (1993) refined Stover, Guerney, and O’Connell’s work to improve the coding protocol and enhance rater training. Bratton et al. (2006) included a slightly revised scoring protocol in the CPRT treatment manual to increase its usability and availability to researchers. The MEACI has been frequently used in filial therapy and CPRT research to identify parents’ ability to demonstrate empathic skills and attitudes that align with filial therapy goals. When used in outcome research, the MEACI is designed for use by independent raters blinded to the study.
The MEACI consists of a Total Empathy score, which is comprised of three subscales that represent key attributes of empathic behavior in parent-child interactions: Communication of Acceptance, Allowing the Child Self-Direction, and Involvement (Stover et al., 1971). Blinded to group assignment and timing of the measurement, trained observers evaluate empathic behaviors on a five-point scale. Ratings of one indicate higher levels of empathy, and ratings of five indicate the least empathic responses and behaviors, therefore lower scores indicate higher levels of empathic responses and behaviors.

The MEACI requires raters to achieve acceptable inter-rater reliability ($r = .70$) prior to coding video recorded play sessions (Stemler, 2004). Raters code the parents’ behaviors and responses for six cycles of 3-minute intervals on the three subscales. The MEACI scoring system produces a score for each of the subscales and a Total Empathy score. Originally, Stover et al. (1971) determined a high inter-rater reliability for the three subscales that comprised the total empathy score. In order to determine inter-rater reliability, the raters attended four collaborative trainings and collectively rated 30-minute play sessions. They independently rated seven to ten 20-minute play sessions, and the average reliability correlation coefficients were .88 for Communication of Acceptance, .80 for Allowing the Child Self-Direction, and .88 for Involvement. Bratton and Lin (2015) examined inter-rater reliability correlation coefficients across seven CPRT studies representing over 600 coded play sessions and reported coefficients ranging from .82 to .99 across pre-, mid-, and post-tests for inter-rater reliability, indicating a high level of consistency among raters.

According to Stover et al. (1971), researchers of a large filial therapy project verified and found support for construct validity for the MEACI. Fifty-one mothers and their children participated in the study, with researchers assessing the parents’ levels of empathy utilizing the
MEACI at pretest and posttest play sessions. Parents showed statistically significant increases in their display of empathic behaviors between pre and post play sessions. Positive changes in the parents’ scores indicated the three scales of the MEACI are “extremely sensitive measures of the behaviors in question” (Stover et al., 1971, p. 267). Construct validity is further supported by the MEACI’s consistent outcomes in CPRT research conducted over the past two decades. Bratton and Lin (2015) analyzed MEACI scores from seven studies and, similar to Stover et al., concluded that statistically significant increases on all domains indicated the MEACI was sensitive to measuring communication of acceptance, allowing the child self-direction, and involvement.

Procedures

I met with front line workers, mental health providers, caseworkers, and church officials, to discuss project, role of agencies and clinics for recruitment purposes, criteria, and details of study. Upon receiving approval from participating recruitment sites, I obtained human subject approval from the Institutional Review Board (IRB) at the University of North Texas. I recruited adoptive parents from two local university counseling clinics, area churches that provide programming and ministries for adoptive families, local adoption agencies, and mental health providers who specialize in attachment and adoption clinical work. All agencies and clinicians were located in the Southwestern region of the United States. They distributed flyers advertising the study to adoptive and foster-to-adopt families to assist in identifying appropriate parents and help interested parents understand the purpose of the group. I spoke with interested parents to share additional information about the study interventions and requirements for participation as well as answer parents’ questions. I encouraged interested parents to pass out flyers and share information about the group with other adoptive families.
Parents who reported attachment-related concerns such as difficulties establishing a mutually satisfying parent-child relationship as well as concerns about the adoptive child’s behavior and parental stress were screened for inclusion criteria. Following informed consent, parents with multiple adopted children determined their “child of focus” for study purposes (Bratton et al., 2006) and completed pretest data collection: family background form, CBCL and PSI-4. To ensure integrity of the data collection process, parents completed written assessments without their children present. I provided parents a space free from distractions to assure their answers were thoughtful and aligned with their individual views of their children and the parent-child relationship. Childcare was provided while parents completed assessments. To collect data for the MEACI, parents participated in video recorded 20-minute play session with their child of focus in a quiet room set in a traditional CPRT play session format.

Due to the nature of this study, I expected that recruitment of a sufficient sample would require a lengthy recruitment period. Thus, I decided to use block randomization technique to account for differences in time for when parents provided consent. To ensure equal numbers in the experimental and control group and to achieve a minimum of 4 and maximum of 6 parents per CPRT group, I required a minimum of 8 consenting parents to begin random assignment to groups and begin intervention. Contrary to my expectation, within a two-week period of beginning the recruitment process, I received informed consent from 42 parents. I used an online random assignment generator to assign parents to either the experimental or TAU group. Due to the large number of couples participating in the study, couples (n= 16 pairs) were randomly assigned as a unit, while single parents or parents participating without their spouse/partner (n = 10) were individually randomly assigned. Although, according to a priori analysis, 42 participants were sufficient to find a statistical difference, it did not allow for attrition. Therefore
I continued to recruit parents. When I received eight additional informed consents I randomly assigned parents to the experimental and control groups. Thus a total of 26 participants (10 couples, 6 individuals) were assigned to the experimental group and 24 participants (9 couples, 6 individuals) were assigned to the TAU. As discussed previously, one parent from the experimental group withdrew from the study due to his inability to complete the training protocol.

Intervention sites for CPRT varied throughout the metropolitan area to lessen parents need to travel and meet family schedules. During the intervention phase, a team of research assistants provided free childcare that included age-appropriate activities and snacks for CPRT sessions. Prior to beginning the groups, the childcare providers received training on the needs of adoptive children and ways to manage challenging behaviors. Informal discussions occurred throughout the 11 weeks and guidance was provided to the childcare providers when needed.

At the completion of the study phase, participants in CPRT and TAU completed post-test data (CBCL, PSI-4, and 20-minute video recorded parent-child play session) using the same procedures as pretesting. Parents received a small stipend for their participation in the study. The TAU participants were offered the opportunity to participate in the CPRT intervention immediately following the study phase. To maintain confidentiality, all assessments, treatment notes, and identifying information were coded numerically and stored in a double locked filing cabinet in the faculty supervisor’s office area. Study procedures are outlined in Figure B.2.
Figure B.2. Study procedures

Treatment Groups

Experimental treatment: CPRT. Parents assigned to the experimental group were divided into small groups of 4 to 6 parents (2 groups of 6; 2 groups of 5; 1 group of 4). Days and times were created based on parent feedback. Parents assigned to the CPRT groups selected from four locations; groups were held at convenient sites throughout a large metropolitan area. Consistent with the protocol (Bratton et al., 2006), parents participated in CPRT once per week for 2-hours for 10 weeks. Prior to beginning CPRT, parents attended a 2-hour pre-treatment session based on Carnes-Holt’s (2012) recommendation with a focus on the specific needs and experiences of adoptive parents including time to share their adoption experiences and to provide information related to attachment dynamics and interpersonal trauma. Material covered in the pre-treatment meeting included information about attachment dynamics and interpersonal trauma, such as characteristics of secure attachment and insure attachment in children and parents, attunement, resonance system, and anticipatory arousal. Free childcare, snacks, and age-appropriate
activities were provided. Childcare providers participated in training and ongoing supervision on the needs of adoptive children and ways to manage challenging behaviors.

The 2-hour group structure allowed time for didactic experiences, emotional support of parents, and supervision of parent-child play sessions. In addition to attending the weekly sessions, parents conducted seven weekly, 30-minute special play times with their “child of focus,” after completing the third CPRT training session (Landreth & Bratton, 2006). Parents recorded their special play times with their children. Consistent with the CPRT protocol (Bratton et al., 2006), two parents shared their videos with group members each week and received feedback and support. Video cameras and toy kits were made available for loan to parents to ensure all parents recorded their sessions and had the appropriate play materials. Materials in toy kits followed the suggested materials by Bratton et al (2006). Lotion, hairbrush, and a real baby bottle were added to facilitate connection between the parent and child. In addition, a doll family that represented the adoptive family’s gender and ethnic make-up was added to honor and communicate acceptance of each family member and the adopted child’s cultural heritage.

All groups were facilitated by two advanced level doctoral counselors. The CPRT facilitators followed the CPRT protocol (Bratton et al., 2006) throughout the study with two overarching objectives in mind: (1) teach and supervise parents in CCPT attitudes and skills, and (2) support and encourage parents as they shared their parenting struggles and integrated the CCPT philosophy into their way of being with their child. Parents learned and practiced foundational CCPT principles including being with and fully attuning to their child’s needs, empathic listening, following the child’s lead, reflecting the child’s feelings and desires, understanding verbal and nonverbal content of the child’s play, encouragement, and limit setting.
Parents were taught the importance of consistency and structuring of playtimes for the adopted child so that their child could build a sense of safety and predictability in the parent-child relationship. Co-facilitators intentionally balanced teaching and emotional support to provide parents with ample opportunities to explore their feelings and perceptions about themselves, their child, and their parenting styles while also ensuring that parents learned the CCPT attitudes and skills necessary to conduct special play times with their children.

The first three sessions focused on foundational CCPT attitudes and skills; ways to establish an environment of safety and acceptance and encourage parents openly share and normalize their experiences (Bratton et al., 2006). Parents learned ways to attune to their child including: conveying the be with attitudes: I am here. I hear you. I understand. I care; following their child’s lead; and understanding and reflecting their child’s feelings and desires. Facilitators focused on cultivating an emotionally safe and nurturing environment and helped parents understand the importance of safety and security for their children. They balanced didactic teaching, new skill demonstration and role-play with providing parents emotional support and acceptance. Parents were prepared for their first special play time with their children. Parents identified a time and place to hold the special playtime, reviewed the special playtime procedural checklist, and gathered play materials for their special play time (see appendix J).

Sessions 4 to 6 focused on identifying and encouraging parental strengths and concentrated on skill refinement (Bratton & Landreth, 2006). Session 4 represented a major shift in training as this was the first week parents shared their experiences from their first play sessions with their adopted children. Thus, the facilitators supervised and processed play session happenings and parents’ observations, experiences, and feelings. The facilitators directed the groups’ attention to providing emotional feedback, and normalization of parenting struggles.
Parents watched their play sessions so they could view their interactions with their child and identify the impact the one-on-one play sessions had on their child. By session 4, facilitators and parents identified and reinforced skill development, and discussed alternative responses and actions when needed. Facilitators continued to teach foundational skills taught in sessions 1-3 and emphasized additional skills of limit setting, choice giving, encouragement, decision-making, and self-esteem building responses.

In sessions 7 to 9 facilitators continued to build on the parents’ skill development by introducing self-esteem building and encouragement versus praise responses (Bratton et al., 2006). The inclusion of these new skills aided parents’ abilities to respond and play with their children in ways that facilitated children’s development of an internal locus of evaluation and self-motivation. Supervision and processing of play sessions continued to be a primary focus in sessions seven and eight, along with an increased emphasis on encouraging group members to offer feedback and support each other (Landreth & Bratton, 2006). In session 9 the group discussed ways to generalize and apply their new skills to their daily interactions with their children. In the final session, parents processed their learning experiences, changes in their relationships with their children, and any observed changes in their children and themselves. Parents were encouraged to continue their play sessions with their children.

Video cameras and special toy kits described in the treatment protocol (Bratton et al., 2006) were made available for loan to parents to ensure all parents recorded their sessions and had the appropriate play materials. CPRT facilitators were five advanced level doctoral counseling students and one counseling faculty member with advanced training and clinical experience in CCPT, CPRT, and adoption and attachment issues. Five counselors identified as Caucasian and one identified as biracial. Prior to the study counselors participated in a two-hour
training to review the CPRT protocol, emphasize the importance of using clinical judgment in applying the protocol, and discuss issues related to parenting an adopted child. All CPRT sessions were recorded for the purpose of weekly supervision and to ensure treatment integrity. A supervisor with advanced training in CPRT provided weekly supervision to participating counselors and viewed a random selection of 20% of CPRT sessions using the CPRT Therapist Skill Checklist (Appendix J) to verify protocol adherence. Sessions were equally drawn from each of the CPRT groups and at least one video was selected from each of the ten sessions. Sessions were viewed in their entirety. Counselors adhered to the CPRT protocol over 95% of the time, with an average adherence of 94.8% per viewed sessions.

Treatment as usual (TAU). Because 96% of parents were recruited from local adoption agencies and ministries, TAU was based on the typical responsive services offered by the adoption agencies and ministries. Services were described as individual parent consultation regarding child behavior management and crises intervention conducted by phone or in person (R. North, personal communication, April 2, 2015; D. Wynne, personal communication, April 29, 2015). Thus, for the purpose of this study, TAU was defined as individual parent consultation and designed for parents to participate in face-to-face or phone consultation, based on parents’ preference, once per week for 30 minutes. In practice, 100% of the parents chose phone consults. Although the individual parent consultation guidelines established for this study (Appendix I) offered parents face to face or phone consultation once per week for 30 minutes per week, 100% of the parents chose phone consults. Although the counselors called parents as scheduled, the majority of parents preferred bi-weekly contact and conversations varied from 15-30 minutes per call. Phone consultations typically consisted of parents seeking advice on how to manage difficult behaviors.
TAU counselors were five first year doctoral counseling interns specializing in child counseling and who had completed one graduate course in child development and one to two courses in play therapy, which included training in parent consultation but no training in CPRT or filial therapy. Four counselors identified as Caucasian and one identified as Black American. Prior to the study, TAU counselors attended a two-hour training on the common concerns of adoptive parents and helpful strategies for working with adoptive families. Throughout the study, counselors participated in weekly supervision.

Data Collection

Prior to the study, parent participants completed a background form, CBCL, and PSI-4. In addition, parents participated in a 20-minute video-recorded play session with their child of focus for the purpose of obtaining MEACI pretest data. Play sessions were offered in a private space set with toys typically used during special play times. To ensure integrity of data collection, parents completed the background form, CBCL, and PSI-4 in an environment free from distractions. Research assistants were available in case parents had questions. Childcare was provided during data collection at no cost to allow parents to focus and not be influenced by their child’s current behaviors. At the conclusion of the study, participants in the experimental and active control groups completed the CBCL, and PSI-4 and participated in a 20-minute video-recorded play session for MEACI posttest data, following the same data collection procedures as pretesting. To maintain confidentiality, all assessments, treatment notes, and identifying information were coded numerically and stored in a locked filing cabinet in the faculty supervisor’s office.

Data Analysis
I collected data from pretest and posttest scores on the CBCL, PSI-4, and MEACI. I used computer software to score the CBCL and PSI-4, and the researcher scored data twice to confirm accuracy. I used the Statistical Package for the Social Sciences (SPSS) to analyze each dependent variable (CBCL Total Problems, PSI-4 Total Stress, and MEACI Total Empathy) using a two (group) by two (repeated measures) split-plot ANOVA to analyze group differences, changes across time, and the interaction effect, which is of particular interest in this study. The treatment groups served as the between-subjects variable and time (pretest/posttest) served as the within-subjects variable.

To obtain MEACI data from the pre and post video recorded parent-child play sessions, a team of independent raters blinded to participants’ assignment to the experimental or TAU control and to whether the video recorded play session was a pretest or posttest session rated participants’ 20-minute play session videos. Eight doctoral level counseling students, independent of the present study and with advanced training in play therapy and CPRT, scored the videos. Raters were required to review the MEACI scoring instructions and participate in intensive training following the coding protocol outlined by Bratton (1993) and Bratton et al. (2006) to ensure an acceptable level of interrater reliability prior to coding the video data. Interrater reliability was initially established using recorded parent-child play sessions independent of the present study. Raters viewed and independently scored nine segments of parent-child play sessions. Following the scoring of each segment ratings were discussed to facilitate clarity of scoring criteria. To ensure maintenance of acceptable interrater reliability, checks were performed again at mid and end points of the coding period using video segments that the raters determined “difficult to score.” I 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 96% agreement. For the mid and end point rating sessions, raters achieved 86% and 94% agreement, respectively.

A reduction in scores on the CBCL, PSI-4, and MEACI indicated improvement in parents’ perception of children’s behaviors, decline in parent-child relationship stress as perceived by parents, and improvement in parents’ empathic responses and behaviors, as directly observed by independent raters. To avoid Type I error that can occur from multiple hypotheses testing, I established a .025 alpha level to test for significant mean differences. To test for the practical significance of the CPRT intervention, I calculated partial eta squared effect sizes ($\eta_p^2$) for each dependent variable. I interpreted effect sizes according to guidelines reported by Cohen (1988): .01 equals a small effect, .06 equals a moderate effect, and .14 equals a large effect.
APPENDIX C

UNABRIDGED RESULTS
I conducted 2 (group) by 2 (times) repeated measures ANOVAs for each dependent variable to evaluate the effectiveness of CPRT for adoptive parents. A sample of 49 adoptive parents participated in the study. I specifically looked at three research questions: Based on parent report, 1) do children of adoptive parents who participated in CPRT exhibit a reduction in behavioral problems compared to a TAU control group? 2) do adoptive parents who participated in CPRT exhibit a reduction in stress in the parent-child relationship compared to a TAU control group? and 3) do adoptive parents who participate in CPRT exhibit an increase in parents’ empathic responding compared to a TAU control group?

A variety of dependent variables were explored in the Statistical Package for the Social Sciences (SPSS) including: the Parenting Stress Index-4th edition (PSI-4) Total Stress scale, the Child Behavior Checklist (CBCL) Total Problems scale, and The Measurement of Empathy in Adult-Child Interactions (MEACI) Total Empathy scale. In addition to identifying change across time and difference in the groups, my primary focus was on the interaction effect between the groups across time. The treatment groups served as the between-subjects variable and time (pretest/posttest) served as the within-subjects variable. To minimize the risk of a Type I error that can occur from multiple hypotheses testing, I established a more conservative alpha level of .025 to test for significant mean differences.

The PSI-4, CBCL, and MEACI were administered prior to treatment and at the end of the intervention. A reduction in scores on the CBCL, PSI-4, and MEACI indicates improvement in parents’ perception of children’s behaviors, decline in parent-child relationship stress as perceived by parents, and improvement in parents’ empathic responses and behaviors, as directly observed by independent raters. Partial eta squared effect sizes ($\eta_p^2$) were calculated to determine the strength of the relationship, specifically the magnitude of the differences between the two groups over time. I interpreted effect sizes according to guidelines reported by Cohen.
(1988) guidelines to interpret the practical significance. Cohen’s guidelines are .01 equals a small effect, .06 equals a moderate effect; and .14 equals a large effect.

Data Screening and Assumptions

Prior to conducting the analyses, each dependent variable was examined to ensure the data met assumptions for a factorial ANOVA. The assumptions for level of measurement, independent observations, normal distribution, and homogeneity of variance were reasonably met for each analysis. Sphericity was assumed based on two points of measurement. The descriptive statistics for all dependent variables are presented in Table C.1. The skewness and kurtosis for the continuous variables were within normal limits, positive or negative one and positive or negative three respectively, with the exception of the MEACI (skewness=1.138). The scores were converted to z-scores and did not exceed the 1.96 value, indicating the results were non-significant; therefore I used the original score for the analysis (Fields, 2013). Normality was evaluated and no major deviations from normality were detected, nor did I identify any outliers (Pallant, 2010). Homogeneity of variance was evaluated utilizing Levene’s Test of Equality of Error Variance and Box’s Test of Equality of Covariance Matrices. For Levene’s Test a non-significant result of .05 or higher indicates the variance of the two groups are equal. The results for each of the dependent variables at pre and posttest were non-significant with $p > .05$. I proceeded to examine Box’s Test and the scores were larger than .001 with the exception of the PSI. Box’s test is very sensitive and after checking normality and homogeneity, and identified group sizes were equal, I feel confident the assumption was met and Box’s test can be ignored (Fields, 2013; Tabachnick & Fidell, 2013).
Table C.1.

Descriptive Statistics for Continuous Variables (n=49)

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Skew</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBCL Total Problems pretest</td>
<td>62.551</td>
<td>8.872</td>
<td>-.191</td>
<td>-.307</td>
</tr>
<tr>
<td>PSI Total Stress pretest</td>
<td>56.041</td>
<td>7.708</td>
<td>.372</td>
<td>-.092</td>
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<tr>
<td>MEACI Total Empathy pretest</td>
<td>43.470</td>
<td>6.888</td>
<td>.327</td>
<td>1.138</td>
</tr>
</tbody>
</table>

Research Question 1: Adopted Children’s Problematic Behaviors

The first ANOVA answered the research question, “Based on parent report, do children of adoptive parents who participated in CPRT exhibit a reduction in behavioral problems compared to a TAU control group?” The Child Behavior Checklist (CBCL) measured children’s global problem behaviors. Specifically, Table C.2 presents the mean scores and standard deviations for the pre and post CBCL Total Problem scores for both the experimental and TAU groups.

Table C.2.

Mean Scores on CBCL Total Problem Scale for Each Group

<table>
<thead>
<tr>
<th></th>
<th>Experimental CPRT Group (n=25)</th>
<th>TAU Control Group (n=24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Pre-test</td>
<td>62.960</td>
<td>8.493</td>
</tr>
<tr>
<td>Post Test</td>
<td>55.920</td>
<td>9.110</td>
</tr>
</tbody>
</table>

Results of analysis of the dependent variable, Total Problem, indicated a statistically significant interaction between treatment group (CPRT/ TAU) and time (pretest/ posttest), $F(1,47) = 17.006, p < .001$ and partial $\eta^2 = .266$. The results indicate that according to parents, adoptive children whose parents participated in the CPRT groups (n=25) demonstrated a
statistically significant decrease in global behavior problems as measured on the CBCL Total Problem scale over time compared with children whose parents received TAU (n=24) and that the treatment effect for CRPT was large, indicating the practical significance of the findings. Figure C.2 illustrates the greater improvement of the CPRT group compared to the TAU group over time. A visual inspection of the graph of the mean scores for the CPRT and TAU groups supports the greater improvement of the CPRT group compared to the TAU group over time (see figure 2). Children whose parents participated in CPRT demonstrated a 7.04 decrease in their mean behavior problem scores compared to a .59 decrease for the control group.

Table C.3.

*ANOVA for CBCL Total Problem Score as Dependent Variable*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial $\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>140.279</td>
<td>140.279</td>
<td>.880</td>
<td>.353</td>
<td>.018</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>355.807</td>
<td>355.807</td>
<td>23.707</td>
<td>&lt;.001*</td>
<td>.335</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>255.236</td>
<td>255.236</td>
<td>17.006</td>
<td>&lt;.001*</td>
<td>.266</td>
</tr>
<tr>
<td>Error</td>
<td>47</td>
<td>7491.987</td>
<td>159.404</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>8243.309</td>
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</tbody>
</table>

*Statistically significant at p > .025.
Research Question 2: Stress in the Parent-Child Relationship

The second repeated measures ANOVA addressed the research question, “Based on parent report, do adoptive parents who participated in CPRT exhibit a reduction in stress in the parent-child relationship compared to a TAU control group?” I utilized the Parenting Stress Index, 4th edition (PSI-4) to measure Total Stress in the parent child relationships.

Specifically, Table C.4 presents the mean scores and standard deviations for the pre and post PSI-4 Total Stress scores for both the experimental and TAU groups.

Table C.4.

*Mean Scores on PSI-4 Total Stress Scale for Each Group*
Experimental CPRT Group (n= 25) | TAU Control Group (n= 24)
---|---
M | SD | M | SD
Pre-test | 56.320 | 7.862 | 55.750 | 7.702
Post Test | 51.240 | 4.935 | 56.125 | 7.942

Results for the analysis of the dependent variable, *Total Stress*, demonstrated a statistically significant interaction effect between treatment group (CPRT/ TAU) and time (pretest/ posttest), $F(1,47) = 25.204, p < .001$ and partial $\eta^2_p = .349$. Figure C.4 illustrates the greater improvement in mean scores of the CPRT group (n=25) compared to the TAU (n=24) group over time. These results indicate that adoptive parents who participated in CPRT reported a statistically significant decrease in stress in the parent-child relationship over the TAU group parents and the treatment effect was large ($\eta^2_p = .349$), indicating the practical significance of the findings. A visual inspection of the graph of the mean scores for the CPRT and TAU group supports the greater improvement of the CPRT group compared to the TAU group over time (see figure 3). Parents who participated in CPRT reported a 5.08 decrease in their mean parent-child relationship stress scores compared to a .375 increase in stress for the TAU group.

Table C.5.

*ANOVA for PSI Total Stress Score as Dependent Variable.*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial $\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>113.995</td>
<td>113.995</td>
<td>1.179</td>
<td>.283</td>
<td>.024</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>135.533</td>
<td>135.533</td>
<td>18.750</td>
<td>&lt;.001*</td>
<td>.285</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>182.186</td>
<td>182.186</td>
<td>25.204</td>
<td>&lt;.001*</td>
<td>.349</td>
</tr>
<tr>
<td>Error</td>
<td>47</td>
<td>4543.393</td>
<td>96.668</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The last ANOVA assessed the final research question, “Based on parent report, do adoptive parents who participate in CPRT exhibit an increase in parents’ empathic responding compared to a TAU control group?” The Measurement of Empathy in Adult-Child Interaction (MEACI) measured parent’s empathic behaviors and responses. Specifically, Table C.6 presents the mean scores and standard deviations for the pre and post MEACI Total Empathy scores for both the experimental and TAU groups.

*Table C.6*

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Figure C.2. Means between groups over time on PSI-4 Total Stress Score

Research Question 3: Parental Empathy

*Statistically significant at p < .025.*
**Mean Scores on MEACI Total Empathy Scale for Each Group**

<table>
<thead>
<tr>
<th></th>
<th>Experimental CPRT Group (n = 25)</th>
<th>TAU Control Group (n = 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Pre-test</td>
<td>43.612</td>
<td>5.810</td>
</tr>
<tr>
<td>Post Test</td>
<td>27.830</td>
<td>4.533</td>
</tr>
</tbody>
</table>

Results of analysis for the dependent variable, *Total Empathy*, showed a statistically significant interaction between treatment group (CPRT/ TAU) and time (pretest/ posttest), $F(1,47) = 61.554, p < .001$, partial $\eta^2 = .567$ and power of 1.00. Figure C.6 illustrates the mean scores for the CPRT and TAU groups support the greater improvement of the CPRT (n=25) group compared to the TAU (n=24) over time. These results indicated that, according to reviewers blinded to parents group assignment, CPRT parents demonstrated a statistically significant increase in empathic responses and behaviors compared to the control group and the treatment effect was large ($\eta_p^2 = .567$), indicating the practical significance of the findings. A visual inspection of the graph of the mean scores for the CPRT and TAU group supports the greater improvement of the CPRT group compared to the TAU group over time (see figure 4). Parents who participated in CPRT demonstrated a 15.78 decrease (improvement) in their mean empathy score compared to a .469 increase (worsening) for the control group.

Table C.7

**ANOVA for MEACI Total Empathy Score as Dependent Variable**

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>$p^*$</th>
<th>$\eta_p^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>1503.856</td>
<td>1503.856</td>
<td>28.821</td>
<td>&lt; .001*</td>
<td>.380</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>1435.688</td>
<td>1435.688</td>
<td>54.657</td>
<td>&lt; .001*</td>
<td>.538</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>1616.858</td>
<td>1616.858</td>
<td>61.554</td>
<td>&lt; .001*</td>
<td>.567</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
<td>----------</td>
<td>----------</td>
<td>--------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>Error</td>
<td>47</td>
<td>2452.445</td>
<td>52.180</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>7026.814</td>
<td></td>
<td></td>
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</tbody>
</table>

*Statistically significant at p < .025.

Figure C.3. Means between groups over time on MEACI Total Empathy Score
This study sought to determine the effectiveness of a group based parent-child intervention, CPRT, compared to TAU, with adoptive parents and their adopted children. In addition, this study hoped to replicate and confirm the results of Carnes-Holt and Bratton’s (2014) pilot study and address study limitations. Currently, there is a dearth of evidence-based mental health interventions that target adoptive families and the relationship between parents and their adopted children.

Results from this present study indicated a statistically significant improvement in the experimental group compared to the TAU group, for child behavior problems, parent-child relationship stress, and parents’ empathic responses and behaviors. Furthermore, the findings support Carnes-Holt and Bratton’s results, indicating that CPRT appears to be an effective early intervention for adoptive families and offers a promising intervention for adoptive families who reported attachment-related concerns including difficulties establishing a mutually satisfying parent-child relationship as well as concerns about the adoptive child’s behavior and parental stress. Practical significance was explored to determine the magnitude of difference between the two groups on the three dependent variables. Following Cohen’s (1988) guidelines for determining effect sizes the CPRT experimental group demonstrated large treatment effect on children’s global behavior problems, parent-child relationship stress, and parents’ empathic behaviors.

The statistically and practical significant findings in support of CPRT are encouraging in light of significant needs of adoptive families and dearth of evidence-based treatments for this population. As an effective treatment, CPRT has the potential to prevent the onset of future problems and prevent disruptions in placement. Several components of the CPRT model that
could be responsible for the noteworthy beneficial change are discussed in the following sections.

Effectiveness of CPRT on Child Behavior Problems

Parents who participated in the CPRT experimental group reported a statistically significant decrease in children’s global behavior problems from pretest to posttest as measured by the Total Problem scale of the CBCL when compared to the treatment as usual group. Figure C.1 illustrates the difference in mean scores from pretest to posttest with the experimental group parents demonstrating a 7.04 decrease in their mean scores compared to a .59 decrease for the control group. These results are consistent with findings from Carnes-Holt and Bratton’s (2014) study and other controlled studies that showed statistically significant decreases in child behavior problems as a result of the CPRT intervention (Bratton & Landreth, 1995; Ceballos & Bratton, 2010; Costas & Landreth, 1999; Harris & Landreth, 1997; Jang, 2000; Kale & Landreth, 1999; Ray, 2003; Sheely & Bratton, 2010; Smith & Landreth, 2004; Tew, Landreth, Joiner, Solt, 2002; Yeun & Landreth, 2002).

The statistical and practical significance of the finding for decrease in overall problem behaviors is particularly important for adoptive parents whose children tend to present with co-occurring behavioral problems rather than a single presenting issue (Juffer & IJzendoorn, 2005). As in the Carnes-Holt and Bratton (2014) study, parents in this study reported a combination of internalizing and externalizing child behavior difficulties that were often confusing and overwhelming. Parents’ inability to manage complex behavior problems can potentially lead to disrupted placements for adopted children (Hughes, 2006; Child Welfare Information Gateway, 2012). Thus, mental health approaches that focus on a single diagnosis may not be the most effective treatment for adoptive families. Findings from the present
study give credibility and support to CPRT as an effective intervention for adoptees presenting with broad spectrum behavior problems.

These findings are particularly important for adoptive parents because their children’s behaviors can be confusing and frustrating; and far too often lead to disrupted placements (Hughes, 2006; Child Welfare Information Gateway, 2012). A major focus of CPRT is helping parents understand their child’s underlying needs, often rooted in early experiences. Due to their less than optimal pre-adoption experiences, adoptees may behave in self-defeating ways in order to protect themselves (West, 1992). For adoptees with insecure attachments, finding safety in the parent-child relationship is challenging as they desire closeness with their parent but feel threatened by their parents’ attempts to comfort and soothe them. CPRT helps parents approach the adoptee from a framework of empathic understanding and acceptance through play. Play allows children to communicate their understanding of their world and express their experiences, needs, and feelings through toys, activities, and materials. In CPRT, parents enter into their child’s world through the weekly 30-minute special playtimes where the child is encouraged to lead and can play in the way one needs to, sending a message that the entire child is welcome and accepted in this special space (Ray & Landreth, 2015). During special playtimes, parents focus on the relationship and provide children with empathic and unconditional positive regard (Landreth & Bratton, 2006). This potentially allows adopted children to feel safe, accepted, and understood. According to Axline (1969) this process allows children to lower their defenses and become freer to relate and share their needs and explore their sense of self and open to choosing more congruent and self-enhancing behaviors.

Adoption experts propose that adopted children can catch up emotionally, behaviorally, and developmentally when they are in relationships with emotionally attuned and responsive
adults (Brodzinsky, 2013; Purvis et al., 2007; Siegel & Hartzell, 2003; Zilberstein, 2013). It is plausible that the current study’s findings regarding improved behavioral functioning was due to CPRT’s focus on the primacy of the parent-child relationship as the agent of change. CPRT is designed to help parents learn the basic principles, attitudes, and skills of CCPT, initially during weekly, 30-minute supervised play sessions, in order to foster a more attuned, unconditionally accepting, and consistent relationship with their children (Landreth & Bratton, 2006). According to the principles of CPRT, when children experience this type of safe and secure relationship consistently over time, they begin to feel understood and accepted, experience themselves as lovable and capable, and experience others as safe, dependable, and trustworthy. As a result, children are then free to give up self-defeating behaviors that, for many adopted children, may have been used as a means of self-protection, and choose more self-enhancing and functional behavior (Bratton, Carnes-Holt, & Ceballos, 2011).

Also, another possible contributing factor to the large treatment effects for adopted children’s global behavior problems was parents changed perceptions of their children. During weekly groups, parents were offered alternative perspectives of children’s behaviors that highlighted the child’s best attempts to get his or her needs met. As a result, parents were able to see their children from a new lens, one of possibilities and acceptance instead of as a problem. In addition, parents perception of their parental efficacy could have impacted their children’s behavior (Landreth & Bratton, 2006, p. 23). CPRT focuses on improving parents’ confidence and parental locus of control. When parents feel discouraged and overwhelmed in their attempts to parent their adopted child, they may blame themselves, feel out of control, or doubt their ability to respond and parent effectively. CPRT focuses on encouraging parents and trusting in the parents’ ability to positively impact their child’s development. Teaching parents CCPT skills
may have empowered parents to focus on their child’s capabilities instead of controlling their child’s behavior.

Effectiveness of CPRT on Parent-Child Relationship Stress

Parents who participated in the CPRT experimental group reported a statistically significant decrease in their parent-child relationship stress compared to the TAU group. Figure C.2 illustrates the mean scores from pretest to posttest with the CPRT group demonstrating a 5.08 decrease in their mean scores compared to a .375 increase for the TAU group. These results were consistent with findings from Carnes-Holt and Bratton’s (2014) study and other controlled studies that showed statistically significant decreases in parent-child relationship stress as a result of the CPRT intervention (Bratton & Landreth, 1995; Ceballos & Bratton, 2010; Chau & Landeth, 1997; Ferrell, 2004; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Kale & Landreth, 1999; Kidron & Landreth, 2010; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Ray, 2003; Sheely & Bratton, 2010; Tew, Landreth, Joiner & Solt, 2002; Yeun & Landreth, 2002).

The statistical and practical significance of the finding regarding reduction in parent-child relationship stress is important because stress in the parent-child relationship related to attachment and behavioral issues is the most common reason that adoptive parents seek help from professionals (Barth et al, 2005; Howe & Fearnley, 2003; Hughes, 2006). A high level of familial stress is a major factor in parents placing adopted child in residential care or relinquishing their rights (Brodzinsky, 2013; Child Welfare Information Gateway, 2012). The focus in CPRT is on enhancing the parent child relationship. Because relationships are reciprocal with both parent and child contributing to stress in the relationship, CPRT focuses on the needs of both the parent and child. Based on the present findings, CPRT’s significant
impact on adoptive families’ stress gives credibility and support for CPRT as an effective intervention for reducing relationship stress in this population of families, one that has the potential to prevent future problems including failed placement by providing parents with the attitudes and skills to respond in more attuned and empathic ways across their child’s lifespan.

The group component of CPRT seemed meaningful to the parents in this study and may have contributed to the significant reduction of perceived familial stress. Parents in both CPRT and TAU groups shared feelings of isolation in their parenting role and feeling misunderstood and discounted by others including family members and parents of biological children. Landreth and Bratton (2006) emphasized the significance of the CPRT group process component in helping parents feel supported, accepted, and understood. Landreth and Bratton described creating a safe, reassuring, and nonthreatening environment in which parents can share their experiences as well as “explore feelings, attitudes, and perceptions of themselves, their adopted children, and their parenting struggles” (p. 47). The group facilitators offered empathy, unconditional positive regard (UPR), and genuineness along with a supportive group atmosphere may have contributed to parents growing in self-acceptance and parental-efficacy, which could result in lower stress levels. In the present study, special attention was paid to group dynamics including linking parents, normalizing and generalizing parental concerns and fears, and building group cohesion in order to foster a community of support. It is plausible that being with other parents with similar experiences may have normalized their parenting struggles and helped them see their children less negatively, thereby positively impacting their perception of stress in the parent-child relationship.

The weekly, parent-child playtimes are a cornerstone of the CPRT filial therapy model. Parents in the present study consistently reported on the importance of this one-on-one time for
themselves and for their children. These special playtimes allowed parents the freedom to simply focus on being with their child, with an emphasis on “more connecting and less correcting” (Bratton et al., 2006). It is reasonable to suggest that this weekly time provided an oasis in the week where parent and child were freed from the constraints and stress of daily interactions, which may, in part, explain parents’ perception of less stress in the parent-child relationship.

Effectiveness of CPRT on Parental Empathy

Parents who participated in CPRT demonstrated a statistically significant increase in their empathic interactions with their children over parents in the TAU control group and the treatment effect was large. This result is consistent with the Carnes-Holt & Bratton’s (2014) study as well as several other controlled studies that found statistically significant increases in parental empathy as a result the CPRT intervention (Bratton & Landreth, 1995; Carnes-Holt & Bratton, 2014; Chau & Landreth, 1997; Costas & Landreth, 1999; Ferrell, 2004; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Kidron, 2004; Kale & Landreth, 1999; Kidron, 2004; Lee & Landreth, 2003; Smith & Landreth, 2003; Yuen & Landreth, 2002). As further evidence of CPRT’s effect on parental empathy, 24 of the 25 parents in the experimental group increased in their empathic interactions with their children as indicated by their mean change score on the MEACI, and one parent stayed the same. The MEACI results are particularly noteworthy because the direct observation raters were independent from the study and blinded to participants group assignment and time of measurement (pre or post). These findings provide credibility and support for CPRT as an effective intervention for increasing adoptive parents’ empathic interactions with their children.

The statistical and practical significance of adoptive parents’ increase in empathic interactions with their children as a result of CPRT is especially noteworthy for this population
of parents. Adopted children with a history of interpersonal trauma are often hypersensitive to parents’ attempts to connect and discipline in traditional ways causing them to feel threatened and fearful (Bowlby, 1980; Cozolino, 2006; Siegel & Hartzel, 2003). According to Zilberstein (2013) and Siegel and Hartzel (2003) adopted children can overcome early attachment hardships when they receive emotionally attuned and responsive caregiving in their new family. Fostering an attuned, responsive and secure relationship is at the heart of CPRT. As discussed in previous sections, a major goal of CPRT is to teach parents CCPT attitudes and skills that can create an atmosphere of safety, consistency, warm acceptance, and empathic understanding (Landreth & Bratton, 2006). The structure of the CPRT group offers parents a balance of didactic, supportive, and supervision experiences designed to enhance learning through opportunities to observe, practice (role play), and directly apply CCPT skills associated with unconditional acceptance and empathy with their children. CPRT is a “do as I do” approach. Facilitators’ role model the relational skills they want parents to learn with the objective that parents feel heard, understood, and accepted.

Two essential components of CPRT are the inclusion of weekly, video recorded parent-child play sessions and supervision. Many of the adoptive parents in the present study reported feeling discouraged and challenged in their attempts to connect with and understand their child. As mentioned previously, the inclusion of one-on-one playtimes allowed parents to create a safe haven in the week where they could enjoy playing with their child without interruptions or undue stress. Moreover, this time was structured to foster parents’ success in applying CCPT attitude and skills. Perhaps most important and consistent with the CPRT protocol, play sessions are limited to 30-minutes once per week to avoid overwhelming parents. Weekly supervision of video recorded play sessions allowed parents to receive
feedback from the CPRT facilitator and other parents in the group with a focus on self-awareness, skill development, increased understanding of their children’s underlying needs, and processing parents’ reactions and feelings. Over the course of the present study, parents remarked on their increased self-awareness and their ability to differentiate their own emotional response from their child’s emotional state, which may have allowed them to respond with greater empathy, understanding, and acceptance. Parents who participate in the CPRT experimental group reported a statistically significant increase in their Total Empathy scores of the MEACI when compared to the treatment as usual group. Figure C.3 illustrates the mean scores from pretest to posttest with the experimental group demonstrating a 15.78 decrease compared to a .469 increase for the control group.

Researcher’s Observation

Throughout the course of this study, I observed what seemed to be important learnings regarding: a) adoptive parents eagerness for support and education; b) children exhibiting fewer behavior struggles; and c) parents reporting adopted child’s increased capacity to play. These observations are supported by verbal feedback that parents shared with the investigator throughout the study.

Adoptive Parents Eager for Training and Education

Many parents who participated in this study were eager to find further parenting training to help alleviate their concerns for their adopted children and decrease stress in their parent-child relationship. Approximately 37 parents reported that they had previously participated in adoption conferences and workshops, weekend family camps, classes on other parenting models, and support groups for adoptive and foster families. They shared they continually sought out trainings and read parenting related books because their children’s behaviors change and they...
didn’t feel prepared or capable of handling the changes. This is consistent with the literature. Brodzinsky (2013) and Barth and colleagues (2005) discussed that adoptive parents are more apt to seek mental health services.

From my conversations and discussions with parents it was evident that the parents were well informed on the impact of relationship breaks for children and the risk factors associated with early interpersonal trauma. They could state contemporary theories and parenting approaches. It appeared parents struggled with applying the information into practice. One parent shared “we have been to many trainings but this is the first time I feel like I know what to do when my kid gets upset. I no longer need to guess. Thank you for helping me and my family.” CPRT’s approach appears to support parents through hands-on learning and supervision. The combination of didactic and experiential learning offered parents the support they needed to integrate the material.

Children Exhibited Fewer Daily Behavior Struggles

Over the 10 weeks parents in the CPRT group communicated subtle but important changes in the day-to-day functioning of their children. Parents were excited about small signs of change in their relationships. Week 5 appeared to be a the magical moment when parents began to see subtle changes in their kids. The impact of these changes had large benefits in the daily function and emotional relief of parents. One parent shared how challenging it was to drop her child off at school because her child would scream and cry for long periods of time. She worried about the impact of the daily separation had on her child’s emotional health. About 5 weeks into the group this mom shared “I began to notice that my 4 year old would give me a hug in the morning, whimper that she would miss me and then walk into her classroom. At first I held my breath because I didn’t think it would last. But we are going into our second week and
she is able to separate easier. This makes a big difference in our morning routine and my day overall. I feel like a big weight has lifted off my shoulders.” Another parent disclosed that her four year old, who was diagnosed with RADS shortly after being adopted, began to give her kisses and show affection for the first time since she brought her home. The parent was ecstatic to share a change in their relationship and how impactful it was to receive love and affection from her daughter.

Parents also discussed how other caregivers, teachers, and family members were commenting on the changes in their adopted child. Other caregivers commented on the children’s willingness to reach out to connect with peers, children verbalizing their feelings instead of withdrawing or externalizing their emotions, children’s ability to regulate and calm, and increased ability to problem solve instead of exploding and destroying the environment. The positive changes and interactions seen in the children appear to be global as immediate and extended caregivers noted positive changes in the adopted child’s ability to relate and engage with others. The global changes are promising and further research is needed to see if there is a longitudinal impact on the children and families.

Children’s Increased Capacity to Play

I observed adoptive parents surprise at the developmental impact early interpersonal trauma had on the children’s play development. Parents reported many of their adopted children did not play or use their imaginations. They described their children as concrete and inflexible. The adopted children struggled to play with toys and expressive materials, such as art. Parents who had both biological and adopted children discussed differences in their children’s play and shared their belief that the differences was associated with temperament and their adopted child’s challenging behaviors. Parents were unaware of the impact of early caregiver disruptions or
repeated disruptions can have on their adopted children’s play development. Parents were more familiar with the impact early trauma had on their children’s physical and cognitive development. As a result parents were hesitant to collect or purchase certain toys because they did not believe their child would play with the toys. Literature supports their claim that their children’s play capacity was underdeveloped. Malchiodi (2015) described the impact of early trauma and relationship disruptions as developmental trauma (p. 7, 193). She stated developmental trauma could interrupt a child’s capacity to play and participate in creative expression. Instead children create highly developed coping strategies that protect themselves and limit their ability to be creative and imaginative. It appeared that parents’ understanding of their children’s developmental age increased their ability to respond with empathy, understanding, and acceptance.

Prior to beginning play sessions, the CPRT groups discussed developmental, emotional, and play delays in children. Parents needed additional time to process their play experiences with their adopted children. Many parents discussed the challenges of unpredictable developmental burst, which Bruce Perry (2006) refers to as developmental moving targets. Parents found it challenging to know how to attune and respond effectively when their children were always changing. Over the 10 weeks, parents became more attuned and could accurately reflect their child’s emotional state and underlying need, increasing the parents confidence in their parenting competence.

Parents discussed examples of their children’s developmental growth in imaginative play. One parent shared that during special playtime her 4-year-old daughter did not play or use her creativity, instead she always played with the same play material, playing cards. The parent reported she played by the rules and was very rigid in how they played. The parent struggled to
connect with her child during the card game. Slowly the parent began to notice the child begin to change the rules and create new rules to the game. After their fourth session, the daughter began to play with other toys and explored alternative ways to play with the toys. Two weeks before the groups ended, the parents shared that the child created an imaginative scene that shocked them. They were excited and confused by the shift in play but were excited to see the child grow.

One mother discussed how her child rarely played like her other children, instead the child directed and managed her siblings. This mother shared that her child had to be in complete control of the playtimes. The mother had two epiphanies during group. First she realized that her 8-year-old child’s need for control was a coping strategy/protective factor. Second she recognized her child’s need for control was an emotional trigger for her and caused her to seek control. The mom began to honor her child’s desire for control during special playtimes and took breaks to keep herself engaged and emotionally responsive. The mother was surprised to see her daughter’s behaviors change and she began to play instead of control others.

Limitations of the Study and Recommendations for Future Research

The present findings are promising and add further information for mental health providers working with adoptive families. I have noted several limitations that need to be taken into account. First, the generalizability of my results is limited by sample size, isolated geographic location, and voluntary nature of participants. Although the study had adequate sample size, a larger study would advance the findings of this study. A multi-site study could address both the sample size and geographic limitations and expand the evidentiary support and generalizability of CPRT; as well as advance CPRT being recognized as an evidenced based treatment for young adoptive children. In addition there are no follow-up studies for
CPRT. Carnes-Holt and Bratton (2014) and this study looked at the immediate results. A longitudinal study could help researchers and clinicians recognize the long-term impact of CPRT with adoptive families.

The use of parent report assessment instruments was a limitation of this study. Both the CBCL and PSI-4 utilized parents’ self-report and may have evaluated parent perception instead of actual changes in stress levels and child behavioral problems. The PSI is a single-focused perspective of a dual relationship and, therefore, may not holistically identify total stress in the parent-child relationship. Assessing children’s perspectives of stress in the parent-child relationship would address this issue; however, I have been unable to locate such an instrument for young children. Although both the CBCL and PSI-4 provide a limitation as parent-report instruments, they are the most frequently-used screening and assessment tools in play therapy research and have strong psychometric properties (Njoroge & Bernhart, 2011; Achenbach & Rescorla, 2000; Abidin, 2012; Lin & Bratton, 2015). The inclusion of another source of measurement per dependent variable, such as a teacher report or a direct observation tool, would address this concern.

Another limitation to the study was the lead researcher (LR) heavy involvement in the recruitment and intervention process. I was the lead facilitator for all the CPRT groups, which has the potential to impact treatment decisions. I met weekly with an expert in CPRT and co-facilitators for weekly supervision to ensure adherence to CPRT protocol, explore biases and how personal biases may interfere with treatment delivery and outcomes, and help minimize the chance for prejudicing the findings.

To address the limitations from Carnes-Holt and Bratton’s (2014) study the addition of TAU was added to resemble services typically offered by adoption agencies and
ministries. TAU was not manualized, thus treatment integrity could not be ensured. To address the lack of a manualized treatment, individual parent consultation guidelines were created and provided to counselors (see appendix I). Although weekly face-to-face or phone consultations were preferred, parents chose bi-weekly conversations. This changed the intended dose of intervention, possibly weakening the comparability of the two groups. A study comparing group CPRT to individual CPRT may help confirm the benefits of the group component. Similarly, a study comparing group CPRT and another group parenting model, preferably an evidenced-based model, would add to the confidence of the findings and firmly establish CPRT as an evidence-based treatment.

Implications and Recommendations for Practice

The results of this replication study present important implications for practice and research in the area of family and parenting interventions for adoptive families. The effectiveness of CPRT as an intervention with adoptive families who are struggling to connect could present another treatment modality that focuses on strengthening the parent-child relationship. Additionally, new avenues of research can be explored as a result of this study.

Implications for Practice

CPRT is an empirically supported therapeutic parenting intervention that has been shown effective with a range of social, emotional, and behavioral concerns (Bratton & Lin, 2015; Landreth & Bratton, 2006). Specific to this study, CPRT shows promise as an early mental health intervention for adoptive families who present with attachment related concerns. The results of this replication study have several implications for practice with adoptive families who reported child behavior problems and stress in the parent-child relationship.
Adoptive parents in this study presented with a high need for emotional support and required time to process their day-to-day challenges. They reported feeling overwhelmed by their adopted child’s behavior problems and were unclear on how to respond when their child was having both behavioral and emotional difficulties. The findings indicate that the 11 sessions for the intervention group was effective in helping parents learn skills to approach their children’s emotional and behavioral struggles. Although the 11 sessions were enough to find effectiveness, parents’ verbal and behavioral feedback suggested a desire for further support. Additional sessions or follow-up session may be needed to provide adoptive parents support and opportunities share new challenges.

The group CPRT model appeared to have greater appeal for adoptive parents than TAU design. Few parents in the TAU group participated in consultation session on a weekly basis; instead preferring periodical phone calls. The results from this study indicate that individual parent consults via phone did not reduce parent-child relationship stress, reduce child’s behavior problems, or improve parental empathy, possibly suggesting adoptive parents need more support than TAU provided. In addition, the lack of face-to-face contact could have plausibly contributed to parents sporadic involvement with TAU. Parents may need the personal connection and belonging that occurs with face-to-face interventions, such as CPRT. Parents in the CPRT groups were committed to weekly meetings and vast majority rarely missed a meeting. Mental health providers may want to consider face-to-face interventions and group interventions for adoptive parents. Additionally, when delivering direct contact services for adoptive families, providers may need to consider offering childcare. Parents in this study expressed appreciation for childcare because their babysitters and other family members were reluctant to watch their adopted child due to the child’s unpredictable and challenging behaviors.
Conclusion

Adoptive parents can have a major influence on helping adoptees overcome adverse effects of early attachment disruptions and relational trauma (Perry & Szalavitz, 2006; Purvis et al., 2007). Unfortunately not all adoptive parents feel well equipped to manage their child’s socio-emotional and behavioral needs potentially leading to further disrupted placements for adopted children (Hughes, 2006; Child Welfare Information Gateway, 2012). Brodzinsky (2013) emphasized the need for adoption competent interventions that are responsive to the unique challenges and stressors of adoptees and focus on the parent-child relationship. The present study responds to the call for evidenced based interventions that focus on the parent-child relationship. The parent-child relationship is at the heart of the CPRT approach. In CPRT, parents learn to be therapeutic agents of change for their children and how to foster a more attuned, unconditionally accepting, and consistent relationship with their children (Landreth & Bratton, 2006). The present study’s findings are particularly important for adoptive parents who feel ill prepared to respond when their adopted child is exhibiting intense emotions and challenging behaviors.

The statistical and practical significance of the findings regarding improvement in child behavior problems, parent-child relationship stress, and parental empathy provide support for CPRT’s utility with adoptive families. In addition, the findings from this replication study confirm and expand the results of Carnes-Holt and Bratton’s (2014) study. Replication research enhances the credibility of previous results and helps clinicians, researchers, educators and policy makers make informed decisions about effective interventions for those seeking mental health services (American Psychological Association, 2006; Kazdin, 2016). And lastly, the findings from this study, together with the findings from the Carnes-Holt & Bratton study can
serve to advance CPRT towards being recognized as an effective and well-established treatment for adoptive families.

Acknowledgments

This study was funded by the Group Foundation for Advancing Mental Health Research, Chi Sigma Iota Excellence in Counseling Research Grant, Association for Humanistic Counseling’s Make-A-Difference Grant, Texas Association for Play Therapy’s Dan E. Homeyer Research Grant, and the University of North Texas Center for Play Therapy.
APPENDIX E

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

**Title of Study:** A Therapeutic Group Parenting Model for Adoptive Parents: Effects on Children’s Behavior Problems, Stress in the Parent-Child Relationship, and Parents’ Empathic/Attachment Behavior with their Children

**Principal Investigator:** Sue Bratton, Ph.D., Licensed Professional Counselor and Supervisor (LPC-S), Registered Play Therapist and Supervisor (RPT-S), University of North Texas, Department of Counseling & Higher Education.

**Lead Student Research Assistant:** Kristie Opiola, M.Ed., Licensed Professional Counselor and Supervisor (LPC), University of North Texas, Department of Counseling and Higher Education.

**Purpose of the Study:** You are being asked to participate in a research study to explore the effectiveness of a group parenting intervention, Child Parent Relationship Therapy (CPRT), aimed at enhancing the parent-child relationship of adoptive families with children ages 2 to 7 years old, compared to individual parent consultation. The goal of CPRT is to help adoptive parents build a stronger relationship with their children, better understand their children’s needs, and learn developmentally appropriate discipline strategies and responses that foster children’s healthy development. Specifically, the purpose of the study is to explore the effects of CPRT on children’s behavior problems, stress in the parent-child relationship, and parents’ empathic/attachment behavior with their children.

**Study Procedures:** Upon your consent, you will be randomly assigned to participate in either the CPRT intervention or individual parent consultation. You will meet weekly and have the opportunity to learn how to respond to your child’s emotional and behavioral needs. In addition, you will participate in weekly, 30-minute play sessions with your child at home. The amount of time you will spend each week varies according to the intervention group you are assigned. The total amount of time for the interventions and completing assessments are 26 hours for the CPRT training and 13.5 hours for the individual parent consultation.

**Group 1- Child Parent Relationship Training (CPRT):** 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 accepted. Demonstrations, live practice sessions, role-plays and group discussion will be used to help you apply CPRT skills. You will be encouraged to conduct seven 30 minute weekly one-on-one playtimes with your child. The 2 hour weekly group sessions will be video recorded for the purpose of the CPRT facilitator’s supervision. Your identity will not be revealed and all videos will be destroyed at the end of the project. Your participation will take a total of approximately 26 hours which includes the 10 weeks of CPRT as well as the time spent completing assessments before and after the 10 week CPRT.
Group 2: Individual Parent Consultation: You will meet with a counselor to receive support regarding the concerns you have with your adopted child. You will learn skills that are designed to help you address your child’s behavioral difficulties and ways to respond to your child in difficult situations. You will be encouraged to conduct seven 30 minute weekly one-on-one playtimes with your child. The weekly consultation sessions will last 45 minutes and video recorded for the purpose of the CPRT facilitator’s supervision. Your identity will not be revealed and all videos will be destroyed at the end of the project. Your participation will take a total of approximately 13.5 hours which includes the 10 weeks of 45 minute individual parent consultation as well as the time spent completing assessments before and after the 10 week intervention. At the completion of 10 weeks of parent consultation, you may choose to participate in a CPRT group.

Before the ten-week training, you will be asked to answer some basic questions about yourself, your child, and your relationship with your child. This will be done in written form by completing a family background form and two standard assessment forms: the Parent Stress Index (PSI-4) and the Child Behavior Checklist (CBCL). The PSI-4 asks questions about your stress level related to parenting your child, and the CBCL asks questions about your child’s behavior. You will also participate in a 20-minute video recorded play session with your child to help us understand how you and your child typically interact.

After the ten-week training, you will be asked to complete a PSI-4 and CBCL and participate in a final video recorded play session with your child.

Foreseeable Risks:
There are no significant personal risks foreseen as likely from involvement in this study. Your participation is completely voluntary. You may withdraw at any time during the course of the study. The investigator will attempt to minimize discomfort by ensuring that you do not feel pressured to disclose information that would cause discomfort. Possible risks may include one or more of the following:
1. Anything that is said or done during the intervention is considered confidential, meaning that the counselor will not reveal anything that happens in the session. However, if you disclose child abuse, neglect, exploitation or intent to harm another person, the counselor is required by law to report it to the appropriate authority.
2. Because these groups are counseling interventions, you may experience thoughts and emotions that could be strong or difficult for you. The counselors are experienced and trained to help you express and work through these emotions. If any potential harmful effects are noted, the counselor will consult with a supervisor. If it is determined by the counselor and supervisor that remaining in the group would not be beneficial or could be harmful to you, the counselor will meet with you to provide an appropriate referral (for example, a request you may be referred to community-based services).

Benefits to the Participants or Others:
Possible positive outcomes for your participating in the project may include a closer and less stressful parent-child relationship, increased confidence in parenting and reduced problem behaviors of your child. You may also benefit from meeting other parents who are experiencing similar experiences with their child. The results of this study may provide
mental health practitioners and adoption agencies across the nation with knowledge that helps
them enhance parent-child relationships for adoptive families so that adoptive families can heal
and receive the support they may need during challenging times.

**Compensation for Participants:** Upon your completion of your participation in the study, you
will receive a $25 gift card as compensation for your participation in this study.

**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 video recorded play sessions
other than the investigator. Your recordings will be kept for no more than three years beyond
the end of data collection and then the recordings will be destroyed by the investigator. All
recordings and assessments will be securely locked in a secure location in 425 S. Welch St.
Complex 2 at the University of North Texas, Denton, TX.

**Questions about the Study:** If you have any questions about the study, you may contact Dr.
Sue Bratton at (940) 565-3468 or Sue.Bratton@unt.edu.

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

- You understand 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 from the study 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 the research participant and you voluntarily consent to
  your participation in this study.
- You understand you may keep 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
May 28, 2015

Supervising Investigator: Dr. Sue Bratton
Student Investigator: Kristie Opiola
Department of Counseling and Higher Education
University of North Texas

Re: Human Subjects Application No. 15228

Dear Dr. Bratton:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled “Efficacy of a Therapeutic Group Parenting Model on Adopted Children’s Behavior Problems, Stress in the Parent-Child Relationship, and Parents’ Empathic/Attachment Behavior with their Children.” The risks inherent in this research are minimal, and the potential benefits to the subject outweigh those risks. The submitted protocol is hereby approved for the use of human subjects in this study. Federal Policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only, May 28, 2015 to May 27, 2016.

Enclosed is the consent document with stamped IRB approval. Please copy and use this form only for your study subjects.

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. The IRB must also review this project prior to any modifications. If continuing review is not granted before May 27, 2016, IRB approval of this research expires on that date.

Please contact Shelia Bourns, Research Compliance Analyst at extension 4643 if you wish to make changes or need additional information.

Sincerely,

Chad R. Trulson, Ph.D.
Professor
Department of Criminal Justice
Chair, Institutional Review Board

CT/sb
APPENDIX F

FLYER
Parenting Your Adopted Child Can Be Challenging...

Do you feel like your child's behaviors are often out of control?
Do you find yourself feeling out of control and at a loss for how to respond?
Would you like your relationship to be less stressful and closer/more enjoyable?

Learn ways to connect and form a secure attachment with your adopted child!

Child-Parent-Relationship (C-P-R) Training Can Help!
Donaldson Adoption Institute has recognized CPRT as the parenting program with the most robust findings in helping adoptive families

In 10 weeks, you will learn knowledge, skills and strategies to help you:
Understand the impact of distressing pre-adoption experiences on your child's current functioning
Become more attuned to your adopted child's emotional needs
Communicate more effectively with your child
Effectively discipline & limit inappropriate behavior
Help your child develop self-control

In 10 weeks, parents report:
Decrease in child behavior problems
Reduction in stress in the parent-child relationship
Closer relationship with their child and improved communication
Greater confidence in parenting skills

C-P-R Training is a 10-session program for parents/caregivers of adopted/fostered children ages 2–7 years

CHILD CARE and age appropriate activities and snacks will be provided

Parenting Groups begin first week of September
Groups located across the DFW metroplex

Spaces are limited. Call or email us today to learn more!

Call Kristie Opiola, M.Ed., LPC or Dr. Sue Bratton, LPC at UNT's Center for Play Therapy at (940) 565-3864
Email: kristie.opiola@unt.edu or sue.bratton@unt.edu
APPENDIX G

SITE APPROVAL LETTERS
April 29, 2015

Dr. Sue Bratton and Kristie Opiola  
University of North Texas  
Center for Play Therapy  
425 S Welch Street  
Denton, TX 76203-5017

Dear Dr. Sue Bratton and Kristie Opiola:

Buckner is excited to collaborate with UNT Center for Play Therapy regarding offering Child Parent Relationship Therapy (CPRT) with adoptive parents. We are willing to distribute fliers regarding this program to our families. In addition, Buckner will offer the use of meeting space for the parenting groups as needed.

We are looking forward to this opportunity and believe this will be a valuable resource for our families.

Please feel free to contact me should you have any questions: dwynne@buckner.org or 214-319-3458.

Best Regards,

[Signature]

Debbie Wynne, MSED, LPC-S, LCPAA, RPT-S  
Senior Director Global Permanency Services  
Buckner Adoption and Maternity Services, Inc.
April 23, 2015

Dr. Sue Bratton and Kristie Opiola
University of North Texas
Center for Play Therapy
425 S Welch Street
Denton, TX 76203-5017

Dear Dr. Sue Bratton and Kristie Opiola:

Tapestry is excited to collaborate with you regarding offering Child Parent Relationship Therapy (CPRT) with adoptive parents. We are willing to distribute fliers regarding this program to our families. In addition, Tapestry will offer the use of meeting space for these parenting groups if needed. We are looking forward to this opportunity and believe this will be a valuable resource for our families.

Best regards,

Ryan North
Executive Director
Tapestry Adoption & Foster Care Ministry

www.tapestryministry.org
APPENDIX H

FAMILY BACKGROUND FORM
Family Background Information

Name of Parent Completing Form: ______________________________________________________

Home Phone: ____________________________ (May call: Yes No  Message: Yes No )

Work Phone: ____________________________ (May call: Yes No  Message: Yes No )

Home Address: ______________________________________________________________________
____________________________  __________________________
Street    City   State  Zip

Best time/place to contact you: ______________________________________________________________________
____________________________  __________________________
Street    City   State  Zip

Occupation: __________________________

* INFORMATION ON PARENTS *

Mother’s Name: ______________________________________________________________________
____________________________  __________________________
Last    First  M.I
Date of Birth: ____________________________ Occupation: ____________________________

Employer: ____________________________ How long: ____________________________

Mother’s Education Level:
8th grade or below _____  Trade School/Some College ___  Undergraduate Degree ___
High School ___  GED ___  Graduate Degree ___

Marital Status
Never married____  Currently married____  Divorced____  Widowed____  Deceased____

Father’s Name: ______________________________________________________________________
____________________________  __________________________
Last    First  M.I
Date of Birth: ____________________________ Occupation: ____________________________

Employer: ____________________________ How long: ____________________________

Father’s Education Level
8th grade or below _____  Trade School/Some College ___  Undergraduate Degree ___
High School ___  GED ___  Graduate Degree ___

Marital Status
Never married____  Currently married____  Divorced____  Widowed____  Deceased____

* INFORMATION ON CHILD OF FOCUS*

Child’s Name: __________________________
____________________________  __________________________
Last    First  M.I
Date of Birth ___ / ___ / ___

Child’s Gender/Sex: Male____ Female____  Age ____  Adoption Date ___ / ___ / ___

What age was your child when adopted? _____________________

Did your child live with you prior to being adopted?  Yes No  If yes, how long? __________

How long has your child lived in your home? ________________

Was your child adopted through (circle one)
Foster Care  Private Adoption  Kinship  Agency- Domestic  Agency- International  Other ________
**Child's Ethnicity:**  African American___  Bi-racial___  Hispanic/Latin___
Asian ___  Caucasian___  Native American___  Other __________

**Name of Child's School and Location:**

**Grade Level (now):_____**  *Has your child ever been retained?*  Yes   No   *If yes, what grade? _____*

**Is your child receiving special education or other services (physical, speech, occupational therapy, etc)?**
Yes   No   *If yes, list services ________________________________

**School Problems** (check all that apply):
Academic problems___  Discipline problems___  Social Problems___  Other ___

**Early Language/Speech Problems** (explain) _________________________________________

**Has your child ever received mental health services (psychiatrist, psychologist, or a counselor)?**  Yes   No

**Previous Mental Health Professional/Agency:**
Name ___________________________________________  Address ________________________________________
Phone: _______________  Dates of Service: __________________________ (beginning - ending)

**Check the following items for a diagnosis or medication that your child is now receiving or has received:**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Current</th>
<th>Past</th>
<th>Name of medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>______</td>
<td>______</td>
<td>___________________</td>
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<tr>
<td>ADHD</td>
<td>______</td>
<td>______</td>
<td>___________________</td>
<td>______</td>
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<tr>
<td>Conduct Disorder</td>
<td>______</td>
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<tr>
<td>Anxiety/</td>
<td>______</td>
<td>______</td>
<td>___________________</td>
<td>______</td>
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<tr>
<td>Nervousness</td>
<td>______</td>
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<td>___________________</td>
<td>______</td>
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<tr>
<td>Bipolar</td>
<td>______</td>
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<tr>
<td>Oppositional</td>
<td>______</td>
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<td>___________________</td>
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<tr>
<td>Defiant Disorder</td>
<td>______</td>
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<tr>
<td>Mood/Anger</td>
<td>______</td>
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<tr>
<td>Tics</td>
<td>______</td>
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<tr>
<td>Insomnia/</td>
<td>______</td>
<td>______</td>
<td>___________________</td>
<td>______</td>
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<tr>
<td>Sleeplessness</td>
<td>______</td>
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<tr>
<td>Obsessive/</td>
<td>______</td>
<td>______</td>
<td>___________________</td>
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<tr>
<td>Compulsive</td>
<td>______</td>
<td>______</td>
<td>___________________</td>
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<tr>
<td>Seizures</td>
<td>______</td>
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<tr>
<td>Post-Traumatic</td>
<td>______</td>
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<tr>
<td>Stress Disorder</td>
<td>______</td>
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<td>___________________</td>
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<tr>
<td>Other</td>
<td>______</td>
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</table>
What other medication is your child currently taking?

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<thead>
<tr>
<th>Medication</th>
<th>Taken for what reason?</th>
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</table>

Is your child currently receiving counseling elsewhere?  Yes  No

Has your child been hospitalized for mental health concerns?  Yes  No
If yes: When  Where

History of health/physical problems includes: (check all that apply):
- Asthma
- Disability
- Nervous stomach
- Bedwetting
- Dizziness
- Neurological problems/exam
- Bone/joint/muscle
- Severe Headaches
- Surgeries
- Chest pain
- Heart Palpitations
- Serious overeating/under-eating
- Chronic illness
- Hospitalization
- Shortness of breath without exertion
- Developmental delay(s)
- Major accident
- Sleep problems
- Chronic Diarrhea
- Major illness
- Other

Physical Disability: Yes  No  (If yes, explain)

Illness: Yes  No  (If yes, explain)

* FAMILY INFORMATION *

Child’s current household:
- Adoptive mother only
- Adoptive Father only
- Adoptive Parents
- Foster- to- Adopt Parents
- Other

Blended Family (both spouses/partners with children from a previous relationship)

Including yourself and your child, how many people live in your home?

List members of your household, including self and child of focus

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Relationship to child of focus</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Gross Household Annual Income (including Child Support Payments)
Less than $25,000  25,000 – 40,000  40,001 +

*CHILD’S PREADOPTION HISTORY*

Has your child been abused (check all that apply): Physically  Emotionally  Sexually

Has your child been neglected (check all that apply): Physically  Emotionally

Number of caregivers/ homes your child has lived with/in prior to living in your home:

_____ years with biological parents  _____ years in institutional care  _____ years in foster care,  ____ # foster homes

Child’s first language: English  Other
**CURRENT CONCERNS**

(30) *Circle the item that you see as the most significant issue for your child. Underline any additional concerns.*

<table>
<thead>
<tr>
<th>Problems Related to Abuse</th>
<th>Academic/School Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current or past physical abuse</td>
<td>Learning difficulties</td>
</tr>
<tr>
<td>Current or past sexual abuse</td>
<td>Problems with peers</td>
</tr>
<tr>
<td>Current or past emotional abuse</td>
<td>Problems with teachers</td>
</tr>
<tr>
<td>Current or past neglect</td>
<td>Speech Problem</td>
</tr>
<tr>
<td>History of abandonment</td>
<td></td>
</tr>
<tr>
<td>Suspected sexual abuse</td>
<td></td>
</tr>
<tr>
<td>History of family domestic violence</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mood-related Concerns</th>
<th>Family Relationship Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disturbing memories</td>
<td>Difficulty adjusting to family changes</td>
</tr>
<tr>
<td>Difficulty going to sleep/staying asleep</td>
<td>Discipline concerns</td>
</tr>
<tr>
<td>Nightmares/night terrors</td>
<td>Parent-child relationship problems</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>Sibling concerns</td>
</tr>
<tr>
<td>Sadness</td>
<td>Divorce/Separation</td>
</tr>
<tr>
<td>Depression</td>
<td>Religious/Spiritual Concerns</td>
</tr>
<tr>
<td>Feelings of guilt and shame</td>
<td></td>
</tr>
<tr>
<td>Excessive worrying</td>
<td></td>
</tr>
<tr>
<td>Anger/Irritable</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rule-Breaking/Behavior Problems</th>
<th>Other Behavioral Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression toward others</td>
<td>Sexual identity concerns</td>
</tr>
<tr>
<td>Drug/alcohol use</td>
<td>Inappropriate sexual behavior</td>
</tr>
<tr>
<td>Fire-setting</td>
<td>Overeating/refusal to eat</td>
</tr>
<tr>
<td>Intentionally hurting animals</td>
<td>Bedwetting or soiling</td>
</tr>
<tr>
<td>Running away</td>
<td>Hyperactive/inattentive</td>
</tr>
<tr>
<td>Stealing</td>
<td></td>
</tr>
</tbody>
</table>

*Remember to circle the most significant issue.*

When did you first become concerned about the main/most significant issue? ______________________

How have you attempted before now to deal with this issue? ___________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Are you currently taking a parenting class? Yes  No

What do you enjoy most about this child? ______________________

What do you find most difficult about this child? _________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Anything else you would like to share about your child? ___________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
APPENDIX I

INDIVIDUAL PARENT CONSULTATION PROTOCOL
Individual Parent Consultation Protocol

Week 1

• Call parents and introduce yourself and share contact information
• Briefly discuss parents parenting concerns/ concerns for child
• Ask parents their goal for participating in study (ind. parent consultation and CPRT group)
• Review plan for parent consultation
  o Parent consultations are set by the parent- this can be weekly, biweekly, monthly or as needed.
  o Parent consultations may last for 15-45 minutes based on need
• Parent will contact you by calling the Center for Play Therapy or emailing you. If you get an email from the parent, please print the email and place a copy of the email in the client file
• Identify days and times that are bet for both you and the parent
• Identify preferred method for meetings (in person, Skype, or phone consultations) - if in person, please schedule first in-person contact
  o In-person Schedule:
    ▪ FW- Friday afternoon/evenings or Saturdays (8-2) or Tuesday evenings in Ft Worth location
    ▪ Dallas- Sundays from (1-3) in Dallas location
    ▪ Irving- any time before 9 pm (except Tuesday evenings) in Irving location
    ▪ Denton- during clinic hours in Denton location
• Please write a brief note of what was discussed with the client. We will give you a chart format in our training

Weeks 2-10

• For each consultations- please use your counseling skills to listen to the parent and respond in a supportive way. Parenting an adoptive child can be challenging and confusing for many parents. Offer behavior modification techniques if and when needed. Please do not offer additional services unless you speak with Kristie or Sue first.
  o At the end of the consultation, remind the parent how they can reach you if they have an additional need. If the parent recognizes a need to meet weekly, feel free to set up a weekly time together otherwise remind them of how to get a hold of you.
  o If you have not heard from your parent for a month, please check in monthly.
• Please note what was discussed each session. The clients file is located in designated filing cabinet

Training for CPRT Individual Parent Consultations

1. Foundations of attachment (holistic development, basis for viewing the world, overview of secure attachment patterns and insecure attachment patterns, impact of trauma and adoption on attachment styles)
2. Pre-adoption Experiences for children (this is potential experiences- institutional care, foster care, early trauma, placement experiences, dissolutions and re-homing, prenatal drug and alcohol exposure)
3. Common struggles of adopted children (inconsistent development, survival, fight, flight, and freeze responses, common dx, internal states, hyperarousal)
4. Experiences of adopted parents (own personal past experiences, confusion of adopted child's behaviors, disruption in the family system, increased mental health needs and dis/satisfaction with mental health services)

5. Common/trends in post-adoption services (TBRI, Theraplay, Empower to Connect; inadequate training for mental health providers, mixed support, etc)

6. Brain research (IPNB, implicit memories, anticipatory arousal, hand model of the brain, mirror neurons, etc.)
APPENDIX J

CPRT THERAPIST SKILLS CHECKLIST
Child Parent Relationship Therapy (CPRT)

Therapist Skills Checklist—Session #

Form B - Treatment Integrity (Supervision and Research)

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


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