EFFECT OF CHILD PARENT RELATIONSHIP THERAPY (CPRT) WITH ADOPTIVE PARENTS OF PREADOLESCENTS: A PILOT STUDY

Alyssa M. Swan, M.S.

Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

December 2017

APPROVED:

Sue C. Bratton, Major Professor
Peggy Ceballos, Committee Member
Leslie Jones, Committee Member
Jan Holden, Chair of the Department of Counseling and Higher Education
Randy Bomer, Dean of the College of Education
Victor Prybutok, Dean of the Toulouse Graduate School

Swan, Alyssa M. *Effect of Child Parent Relationship Therapy (CPRT) with Adoptive Parents of Preadolescents: A Pilot Study.* Doctor of Philosophy (Counseling), December 2017, 179 pp., 28 tables, 41 figures, references, 66 titles.

Older adopted children and their families often express high need for support for attachment and trauma related concerns. Post-adoption mental health intervention focused on enhancing the parent-child relationship among adoptive parents and adoptees is essential for fostering placement permanency among these families. This single group pilot study explored the effect of Child-Parent Relationship Therapy (CPRT) for adoptive parents of preadolescents who reported attachment related concerns, stress in the parent-child relationship, and child behavior problems. Participants were 11 adoptive parents ages 25 to 64 (55% male; 91% couples; 100% married; 56% European American, 27% Asian, 9% Hispanic, and 9% Black American) with adoptees between the ages of 8 to 14 (56% male; 56% Hispanic, 33% European American, and 11% Black American). All child participants were adopted out of foster care. Data was collected at baseline, pretest, midtest, and posttest. Results from non-parametric Friedman test of differences across 4 points of measure indicated that CPRT demonstrated statistically significant improvement for the 3 outcome variables: parental empathy, child behavior, and parent child relationship stress. Specifically, results indicated that prior to receiving CPRT (baseline to pretest), parents demonstrated no change or worsening in functioning across all variables, whereas during the intervention phase findings showed a large treatment effect for parental empathy, a medium effect for parenting stress, and a small effect for child behavior problems. Findings from this pilot study support CPRT as a promising mental health intervention for adoptive parents and preadolescent children. Clinical implications and

recommendations for working with adoptive parents of preadolescents are explored within the context of these findings.

Copyright 2017

By

Alyssa M. Swan

ACKNOWLEDGEMENTS

This journey will always be most precious and special to me because of all the incredible individuals I had the honor of working, learning, and walking beside along the way.

To my parents, family, and friends, thank you for your constant, unconditional love and support, for being my role models and encouragers, and for always being home to me no matter what. To Leeanna and Lyvani, thank you for being my best teachers about children's worlds. I'm so blessed to be your aunt and watch you grow.

To my chair, mentor, and friend, Sue, you always have believed in me more than I do and continue to offer me your love, support, and wisdom. You influence and inspire me as a play therapist and educator, and help me grow as a person. To my committee, Peggy and Leslie, thank you for so willingly being involved in this project, and for always offering me your trust, encouragement, and feedback. To my CPT family and my cohort family, you are irreplaceable in my life, and some of the most passionate, driven, and good-hearted people in the world. I cherish our conversations, hugs, and time.

A huge thank you to Lindsey, Amber L., Amber B., and Kim, our research team, MEACI raters, and all the volunteers who contributed to this project for sharing your heart with our children and families each week. A special thank you to all the adoptive families who were involved in this study, for allowing me into your homes and lives this year. Your love and commitment to your families is extraordinary and inspiring.

Thank you to the Hackett Foundation, Texas Association for Play Therapy's Dan E. Homeyer Research Grant, ACA Growing Healthy and Confident Kids Grant, Texas Counseling Association Educational Endowment, and the University of North Texas Center for Play Therapy for supporting this research.

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS iii

LIST OF TABLES vi

LIST OF FIGURES vii

EFFECT OF CHILD PARENT RELATIONSHIP THERAPY (CPRT) WITH ADOPTIVE PARENTS OF PREADOLESCENTS: A PILOT STUDY 1

Experiences of Adoptive Parents and Preadolescent Adoptees 2

Rationale for Parent-Child Intervention 4

Child-Parent Relationship Therapy (CPRT) 5

Purpose of the Study 8

Methods 8

Participants 9

Instrumentation 10

Procedure 13

Results 16

Research Question 1 18

Research Question 2 19

Research Question 3 20

Discussion 21

Parental Empathy 22

Child Behavior 24

Parenting Stress 27

Limitations and Opportunities for Future Research....30
Conclusion....32
References....33
A. EXTENDED LITERATURE REVIEW....43
B. DETAILED METHODOLOGY....78
C. COMPLETE/UNABRIDGED RESULTS....95
D. EXTENDED DISCUSSION....135
E. RECRUITMENT FLYER....148
F. PARTICIPANT CONSENT FORM....150
G. FAMILY BACKGROUND FORM....154
H. PREADOLESCENT ADAPTED CPRT/FILIAL KIT....160
I. PREADOLESCENT ADAPTED MEACI SCORING DIRECTIONS....162
COMPREHENSIVE REFERENCE LIST....164

LIST OF TABLES

Table 1. Mean Scores of Each Dependent Variable across Time 17

Table 2. Change in Group Mean Scores for Each Dependent Variable across Time 18

Table B.1. Demographic Information for Parent Participants 83

Table B.2. Demographic Information for Preadolescent Children of Focus 84

Table C.1. Mean Scores of Each Dependent Variable across Time 97

Table C.2. Change in Group Mean Scores for Each Dependent Variable across Time 98

Table C.3. Karen's Mean Scores for Each Dependent Variable across Time 102

Table C.4. Karen's Change in Mean Scores for Each Dependent Variable across Time 103

Table C.5. Jacob's Mean Scores for Each Dependent Variable across Time 105

Table C.6. Jacob's Change in Mean Scores for Each Dependent Variable across Time 105

Table C.7. Craig's Mean Scores for Each Dependent Variable across Time 108

Table C.8. Craig's Change in Mean Scores for Each Dependent Variable across Time 108

Table C.9. Henry's Mean Scores for Each Dependent Variable across Time 111

Table C.10. Henry's Change in Mean Scores for Each Dependent Variable across Time 111

Table C.11. Pamela's Mean Scores for Each Dependent Variable across Time 114

Table C.12. Pamela's Change in Mean Scores for Each Dependent Variable across Time 114

Table C.13. Joyce's Mean Scores for Each Dependent Variable across Time 117

Table C.14. Joyce's Change in Mean Scores for Each Dependent Variable across Time 117

Table C.15. William's Mean Scores for Each Dependent Variable across Time 120

Table C.16. William's Change in Mean Scores for Each Dependent Variable across Time ... 120

Table C.17. Lena's Mean Scores for Each Dependent Variable across Time 123

Table C.18. Lena's Change in Mean Scores for Each Dependent Variable across Time 123

Table C.19. Aaron's Mean Scores for Each Dependent Variable across Time 126

Table C.20. Aaron's Change in Mean Scores for Each Dependent Variable across Time 126

Table C.21. Christine's Mean Scores for Each Dependent Variable across Time 129

Table C.22. Christine's Change in Mean Scores for Each Dependent Variable across Time .. 129

Table C.23. Ronald's Mean Scores for Each Dependent Variable across Time 132

Table C.24. Ronald's Change in Mean Scores for Each Dependent Variable across Time 132

LIST OF FIGURES

Figure 1. Overview of study procedures 14

Figure 2. MEACI Total Empathy group mean scores across time 19

Figure 3. CBCL Total Behavior group mean scores across time 20

Figure 4. PSI Total Stress Group Mean scores across time 21

Figure B.1. Overview of study procedures 91

Figure C.1. MEACI Total Empathy group mean scores across time 99

Figure C.2. CBCL Total Behavior group mean scores across time 100

Figure C.3. PSI Total Stress Group Mean scores across time 101

Figure C.4. Karen's MEACI Total Empathy scores over time 103

Figure C.5. Karen's CBCL Total Behavior scores over time 103

Figure C.6. Karen's PSI Total Stress scores over time 104

Figure C.7. Jacob's MEACI Total Empathy scores over time 106

Figure C.8. Jacob's CBCL Total Behavior scores over time 106

Figure C.9. Jacob's PSI Total Stress scores over time 107

Figure C.10. Craig's MEACI Total Empathy scores over time 109

Figure C.11. Craig's CBCL Total Behavior scores over time 109

Figure C.12. Craig's PSI Total Stress scores over time 110

Figure C.13. Henry's MEACI Total Empathy scores over time 112

Figure C.14. Henry's CBCL Total Behavior scores over time 112

Figure C.15. Henry's PSI Total Stress scores over time 113

Figure C.16. Pamela's MEACI Total Empathy scores over time 115

Figure C.17. Pamela's CBCL Total Behavior scores over time 115

Figure C.18. Pamela's PSI Total Stress scores over time 116
Figure C.19. Joyce's MEACI Total Empathy scores over time 118
Figure C.20. Joyce's CBCL Total Behavior scores over time 118
Figure C.21. Joyce's PSI Total Stress scores over time 119
Figure C.22. William's MEACI Total Empathy scores over time 121
Figure C.23. William's CBCL Total Behavior scores over time 121
Figure C.24. William's PSI Total Stress scores over time 122
Figure C.25. Lena's MEACI Total Empathy scores over time 124
Figure C.26. Lena's CBCL Total Behavior scores over time 124
Figure C.27. Lena's PSI Total Stress scores over time 125
Figure C.28. Aaron's MEACI Total Empathy scores over time 127
Figure C.29. Aaron's CBCL Total Behavior scores over time 127
Figure C.30. Aaron's PSI Total Stress scores over time 128
Figure C.31. Christine's MEACI Total Empathy scores over time 130
Figure C.32. Christine's CBCL Total Behavior scores over time 130
Figure C.33. Christine's PSI Total Stress scores over time 131
Figure C.34. Ronald's MEACI Total Empathy scores over time 133
Figure C.35. Ronald's CBCL Total Behavior scores over time 133
Figure C.36. Ronald's PSI Total Stress scores over time 134

EFFECT OF CHILD PARENT RELATIONSHIP THERAPY (CPRT) WITH ADOPTIVE PARENTS OF PREADOLESCENTS: A PILOT STUDY

Approximately 125,000 adoptions occur in the United States each year (Adoption History Project, 2012; U.S. Census Bureau, 2010), with the total number of adopted children totaling over 2 million in 2010 (Kreider & Lofquist, 2014). The majority of these children are adopted within the first three years of life; however, 12.4% of children are adopted at ages 5 years or older (Brodzinsky, 2015). Of the 1,731 adoptive families Brodzinsky surveyed in 2015, 40% of oldest adopted children had received mental health services; 74% of oldest adopted children had experienced at least one significant pre-placement relationship disruption; and over half of oldest adopted children presented with at least one developmental, behavioral, or emotional special need. For many adopted children, their early life experiences and initial attachment relationships lacked emotional attunement and safety, provoking children to avoid closeness and vulnerability within new relationships in the future (Gil, 1996; McGee & Anderson, 2008; Seigal & Hartzell, 2004). The impact of insecure attachment and relational deprivation can manifest in even more pronounced and severe ways during preadolescence (Hawk & McCall, 2010), compounding the impact of hormonal, physical, identity, and social fluctuations during this stage of development (Riley, 2006).

Ignoring the unique mental health needs of adoptive families and preadolescents can have long-term consequences. Interventions that encourage full parental involvement and target the parent-child relationship are critical to supporting adoptive families and adopted children's overall well-being (Hughes, 2006; Landreth & Bratton, 2006; Perry, 2008; Purvis, Cross, & Sunshine, 2007; Seigel & Hartzell, 2004). Child-Parent Relationship Therapy (CPRT; Landreth & Bratton, 2006) is an evidence-based parent-child mental health intervention with over 20 years

of clinical and research application (Lin & Bratton, 2015; Bratton et al., 2017). Based on the promising results of a pilot study (Carnes-Holt & Bratton, 2014) and a replication study (Opiola & Bratton, in-press) of CPRT with adopted children, CPRT is effective in improving parental empathy, child behaviors, and parenting stress among adoptive families. CPRT has been adapted and utilized with preadolescents in clinical practice, yet no published research exists to demonstrate the effects of CPRT with preadolescents.

Experiences of Adoptive Parents and Preadolescent Adoptees

Developmentally, preadolescents experience unique interpersonal and intrapersonal experiences as well as distinct, inherent fluctuations in emotional, physical, cognitive, and social abilities and goals (Adams, 2000; Erikson, 1950; Hall, 1904; Ray, 2016; Seifert & Hoffnung, 2000). Experiencing a sense of relational security within the parent-child relationship offers preadolescents a safe platform to navigate social interactions, experience repairing of relationship, express their emotions, and develop relational and emotional competence (Engels, Finkeauer, Meeus, & Dekovic, 2001; Herschenberg et al., 2011; Kocayoruk, Altintas, & Icbay, 2012; Laible, 2007). Early attachment disruption, due to change in caregiver, trauma, or neglect, violates children's felt sense of safety and adaptive expectation for protection through interpersonal connection (Forbes & Post, 2006; Gil, 1996; Hopkins, 2000; Purvis et al., 2007; Staff, 2016).

Adoptive parents of preadolescents may experience ample parenting stress (Sanchez-Sandoval & Palacios, 2012), differing perceptions of family functioning (McGue, Sharma, & Benson, 1996), lacking parenting skills specific to attachment (Dhami, Mandel, & Sothmann, 2007), child idolizing biological family members, and ongoing, complex child behavioral problems (Koh & Rueter, 2011; Wright & Flynn, 2006). Adoptive parents can feel inadequate or

unwanted in relationship with their adopted preadolescent child (McCreight, 2012; Sullivan, 2012). While parenting a preadolescent is already challenging in many ways due to increased child autonomy and developmental changes, parenting an adopted preadolescent child can have its unique set of additional challenges.

Further, Keyes, Sharma, Elkins, Iacono, and McGue (2008) investigated mental health experiences of adopted and non-adopted adolescents in the US and concluded that being adopted approximately doubled children's odds of experiencing disruptive behaviors and receiving mental health services. Adopted preadolescents are at increased risk for experiencing an emotional or behavioral disorder; in fact, 57% of teens adopted from foster care receive mental health services (Vandivere & McKlindon, 2009). Specifically, experiencing attachment disruption in a caregiver-child relationship, such as adoption, is correlated with preadolescent externalizing problems and disruptive behaviors (de Vries et al., 2016; Phaik Ooi et al., 2006; Roisman et al., 2010); internalizing problems and anxiety (Al-Yagon et al., 2016; Korhonen, Luoma, Salmelin, & Tammien, 2012; Mothander & Wang, 2014; Tambelli et al., 2012), and decreased academic performance (Duchesne & Larose, 2007).

Perhaps not surprising then, but indeed discouraging, the majority of youth who re-enter foster care post-adoption do so as pre-teens or teens with these placement disruptions often occurring several years post-adoption (Livingston Smith, 2014). In 2014, only thirteen states classified as providing substantial post-adoption programming and another thirteen states did not offer any post-adoption services beyond financial subsidy (Livingston Smith). Although foster care services have become a national priority, far less efforts support how these children and their adoptive families function post-adoption. Older adopted children and their families often express high needs for support related to trauma and attachment- related concerns (Brodzinsky,

2013; Sullivan, 2012); however, their unique needs are too often unrecognized and unmet by general mental health services (Barth, Crea, John, Thoborn, & Quinton, 2005; Staff, 2016).

Rationale for Parent-Child Interventions

Efforts to increase placement permanency should not cease during preadolescence. Outcomes of an 8-year study demonstrated that 40% of 203 twelve and thirteen year olds in foster care were placed in permanent homes, supporting the hypothesis that strong relationships with and integration into adoptive families significantly influences the success of placements (Leathers, Falconnier, & Spielfogel, 2010). Adoptive parents have significant influence on their children's functioning during preadolescence (Klahr, McGue, Iacono, & Burt, 2010; Koh & Rueter, 2011; Nilsson et al., 2011; Sharma, McGue, & Benson, 1996) and 34% percent of adoptive parents seek adoption-related services when their children become teenagers (Dhami et al., 2007). Specific attention to increasing emotional connection between preadolescents and caregivers is essential to increasing permanency of placements for older adopted children (Gorbet, 2004). Therefore, interventions that target the parent-child relationship during preadolescence can have a profound impact on children's experiences post-adoption. Given the context that the parent-child relationship is often a conscious or unconscious representation of preadolescents' deepest hurts and fears due to adverse pre-adoptive experiences, the parent-child relationship can also serve as a foundation for preadolescents' relational healing (Riley, 2006; Ruskai Melina, 1986).

Not only does the parent-child relationship serve as a relational model for preadolescents' perceptions of self- and other- relationships (Bowlby, 1980; Badenoch, 2008; Siegel, 1999), the strength and quality of parent-child relationships has considerable influence on how preadolescents regulate their emotions (Colman, Hardy, Albert, Raffaelli, & Crockett, 2006;

Whittle et al., 2008) and cope with stress (Howard & Medway, 2004). Parental sensitivity throughout early and late childhood is influential to children's felt sense of attachment (Keck, 2009). Based on findings of a longitudinal adoption study of 125 early-adopted adolescents and their parents, it can be more difficult for parents to respond empathically toward adolescent children with insecure attachment experiences, compared to adoptive parents of adolescents with whom they feel securely attached (Beijersbergen, Juffer, Bakermans-Kranenburg, & van Ijzendoorn, 2012). Further, Eley et al. (1998) illustrated the family environment, to a greater extent than genetics, contributed to depressive symptoms during middle childhood. High levels of family conflict can lead to lower parent-child involvement (Ary, Duncan, Duncan, & Hops, 1999).

These findings are encouraging, emphasizing the extent to which ongoing, supportive relationships with caring attachment figures, such as adoptive parents, can reestablish or develop attachment security among adopted children who lack secure primary attachment relationships (Badenoch, 2008; Bowlby, 1982; Child Welfare Information Gateway, 2015; Pace et al., 2015; Siegel & Hartzell, 2004). In conclusion, it is critical that adoptive families of preadolescents have access to developmentally appropriate and attachment-sensitive mental health services.

Child-Parent Relationship Therapy (CPRT)

Grounded in child-centered play therapy (CCPT) theory and informed by principles of child development and attachment, CPRT (Landreth & Bratton, 2006) is a developmentally responsive and evidence-based mental health intervention. CPRT is based on Bernard and Louise Guerney's group filial therapy model in which parents are taught CCPT (Landreth, 2012) attitudes and skills to apply therapeutically in relationship with their children (Guerney & Ryan, 2013). Building on the Guerneys' work, Garry Landreth (1991) developed a more structured,

condensed 10-session group filial therapy training format. Landreth and Bratton (2006) formalized the 10-session format and named it CPRT to distinguish it from other filial therapy models. In 2006, Bratton, Landreth, Kellam, and Blackard 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 to apply with their child during weekly parent-child play sessions under a CPRT-trained counselor's supervision. During CPRT, parents learn skills to attune to their children's underlying emotional needs and to communicate empathy, acceptance, and understanding. A unique feature of CPRT is the supervised practice component during which parents practice their new relational skills during at home, video-recorded one-on-one special times with their children. The parent-child relationship becomes the catalyst for healing and parents become therapeutic agents in their children's lives through facilitating one-on-one special times. Parents bring their recorded sessions to group each week for feedback and supervision to support parents' understanding and sensitivity to their children's emotions and experiences. These special times also intentionally provide a context for parents and children to relate in a new, non-threatening environment, cultivated through parents allowing their children to lead their activities and conversation during special times. In fact, McCreight (2002) advocated for adoptive parents of older children facilitating and encouraging opportunities for their children to play, as an avenue to better understand their children's feelings and experiences.

CPRT is a well-researched mental health intervention for young children and their parents/caregivers (Lin & Bratton, 2015) across a variety of presenting concerns and clinical populations. Research on the CPRT model includes over 40 studies examining process and outcomes with parents, teachers, and mentors (Landreth & Bratton, in-press). Of the body of research published since 1995, 19 studies employed controlled group designs, of which 15 used randomized group assignment. The vast majority of studies show statistically significant findings and moderate to large treatment effects on increasing caregiver empathy, decreasing stress in the caregiver-child relationship, and reducing children's behavior problems. Comprehensive systematic reviews (Bratton, Landreth, & Lin, 2010; Lindo, Bratton, & Landreth, 2015) and meta-analyses (Bratton, Ray, Rhine, & Jones, 2005; Lin & Bratton, 2015) conducted in this millennium add further credibility to the findings from individual CPRT studies.

Acknowledging the extensive evidence-base for CPRT, the Substance Abuse and Mental Health Services Administration recognized CPRT as Evidenced-Based intervention, rated effective for improving family functioning and reducing disruptive behaviors, and promising for reducing internalizing problems (NREPP, 2017). Specifically, Carnes-Holt & Bratton (2014) and Opiola & Bratton (in-press) conducted large randomized controlled studies and established CPRT as an effective intervention for adoptive families presenting with attachment related concerns, child behavior problems, and stress in the parent child relationship. Donaldson Adoption Institute (DAI, 2014), based on outcomes of Carnes-Holt & Bratton (2014), designated CPRT as the most promising intervention for this clinical population.

Although originally developed as an early mental health intervention for young children, CPRT has been adapted and utilized with preadolescents in clinical practice (Brown, 2005; Capps, 2012; Carnes-Holt, Meany-Walen, & Ceballos, 2015; Meany-Walen et al., 2014;

Packman & Solt, 2004). Ceballos, Carnes-Holt, and Meany-Walen (in-press) developed the preadolescent-adapted CPRT protocol, utilized in the present study, including adapted language, activities, examples, and parenting strategies for preadolescents.

Purpose of the Study

The current study aims to expand CPRT research to examine the effect of CPRT with adopted preadolescents and explore CPRT as a supportive therapeutic intervention for adoptive families of preadolescents post-adoption. Specifically, the purpose of the current study was to investigate the effect of CPRT for adoptive parents of preadolescents in improving parental empathy, parenting stress, and child behavior over four points of measure (baseline, pretest, midtest, and posttest). The following three research questions were addressed in this study: 1) do participants demonstrate improvement in parental empathy throughout participation in CPRT; 2) do participants report improvement in child behavior throughout participation in CPRT; 3) do participants report improvement in parenting stress throughout participation in CPRT?

Methods

I used a single group repeated measures research design in this pilot study to explore to the effect of CPRT for adoptive parents of preadolescents over four points of measure on parental empathy, child behavior, and parenting stress. I conducted an apriori power analysis using G*Power Statistical Software. I determined that a minimum sample size of 10 participants was necessary to conduct an analysis of differences between related samples across 4 points of measurement. I based G*Power calculation on an alpha level of .05, a power of .80, and a large treatment effect ($f = .40$).

Participants

Participants were 11 adoptive parents of preadolescents who were recruited from a large metropolitan area in the southwest United States. In order to participate in the present study, adoptive parents met the following inclusion criteria: parent was at least 18 years of age; parent identified as being an adoptive or foster-to-adopt parent/caregiver of a preadolescent child between the ages of 8 to 14; parent was able to speak and read English; parent reported clinical or borderline child behavior problems on the CBCL; parent consented to participate in the study; parent completed CPRT intervention; and parent participated in all data collection.

Nineteen parents began the study. All parents were designated to a CPRT group based on geographic location. I facilitated three CPRT groups in three areas across a metropolitan area. Four parents who began the CPRT intervention dropped out prior to mid test data collection due to scheduling conflicts. Of the remaining 15 parents who completed treatment, four were removed from the study: 3 due to incomplete data and one due to disrupted placement of child of focus. Examinations of demographics and baseline data revealed little differences between completers and non-completers, with the exception of ethnicity. Of the 5 parents who did not complete this study, their reported ethnicity was 100% European American whereas completers were more ethnically diverse as a group. A total of 11 parent-child dyads completed CPRT and all data collection and were included in data analysis for the present study.

Parents' ages ranged from 25 to 64, with a mean age of 50.1. Preadolescent children of focus ages ranged from 8 to 14, with a mean age of 10.3. Parents reported their ethnicity as 56% European American, 27% Asian, 9% Hispanic, 9% Black American. Parents reported their preadolescent children's ethnicity as 56% Hispanic, 33% European American, and 11% Black American. Adoptive parents focused on one adopted preadolescent child throughout the study.

Of the 11 parent-child dyads in this study, 7 parent-child dyads were comprised of adoptive parents and children of different ethnic backgrounds.

Fifty-five percent of parents identified as male and 45% as female; preadolescents were 56% male, 44% female. All parents in this study were married. The majority of participants (91%) attended CPRT with their spouse/partner. Regarding sexual orientation, 82% of parents identified as straight and 19% parents identified as gay. All preadolescent children of focus were adopted out of foster care (27% less than 1 year ago, 27% three years ago, 45% more than six years ago). All preadolescent children of focus were adopted after 1 year of age; 56% were adopted over the age of 7 years.

In regard to family composition, parents had a range of 1 to 8 children total (18% one child, 27% three children, 36% four children, 18% seven children, 18% eight children). Of their total number of children, parents had either no biological children (55%) or two biological children (45%). Of the biological children reported, all were adult children living outside the home. No parents reported having biological children living in the home at the time of study. Overall, in regard to children living in the home at the time of the study, five parents had 1 adopted child, two parents had 4 adopted children, two parents had 6 adopted children, and two parents had 7 adopted children. No parents or children of focus were receiving additional counseling services during the study.

Instrumentation

The Child Behavior Checklist for ages 6-18 (CBCL/6-18; Achenbach & Rescorla, 2001) provides a measure of caregivers' views of children and adolescents' school and social competencies, behavior functioning, and problems. The CBCL is comprised of 120 items. For each item, respondents select one response from three possible response options that describe

various problem behaviors exhibited by children and adolescents. Respondents indicate whether or not their child demonstrates each item's specifically stated problem behavior as follows: 0 for not true, 1 for somewhat or sometimes true, or 2 for very true or often true. The CBCL requires approximately 20 minutes to complete and can be scored by hand or computer. The CBCL also includes several open-ended questions to allow respondents to report any behavioral observations. A decrease in syndrome scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2001). The normative sample for the CBCL is comprised of diverse populations, including children attending various school and clinical settings, as well as residents of the United States, Canada, Australia, and Jamaica. The overall test-retest reliability of the CBCL is strong (r = .85).

The Parenting Stress Index (PSI; Abidin, 1995) assesses characteristics of the child and parent that may contribute to stress in the parent-child relationship. Stressful parent-child systems may be at risk for developing problematic parent or child behaviors. The PSI contains 120 items, including 19 optional Life Stress items. The PSI requires approximately 20 minutes to complete and can be scored by hand or computer. Respondents will complete the PSI by responding to each item in the PSI item booklet and circling their best answer on the PSI answer sheet using the following response options: SA (Strongly Agree), A (Agree), NS (Not Sure), D (Disagree), or SD (Strongly Disagree). Total Stress is a composite score measuring the amount of stress experienced in the parent-child relationship and is comprised of two domains: Child Domain and Parent Domain. The norm sample for the PSI included 2,633 mothers, ranging in age from 16 to 61 and average age of 30.9 years. Test-retest reliability coefficients were obtained from four different studies. For Parent Domain, test-retest reliability ranged from .69 to.91. For

Child Domain, test-retest reliability ranged from .55 to .82. For Total Stress, test-retest reliability ranged from .65 to .96.

The MEACI (Stover, Guerney, & O'Connell, 1971) is a direct observation measure designed to operationally define empathy in parent-child interactions during spontaneous play sessions. The MEACI is comprised of 5-point bipolar scale ranging from high rating of 1 to a low rating of 5, thus lower scores indicate higher levels of parental empathy. The MEACI yields a total Empathy score including three subscales identified as core aspects of empathy in adult-child interactions: Communication of Acceptance, Allowing the Child Self-Direction, and Involvement. Trained observers rate across the three dimensions during 3-minute intervals of six consecutive rating intervals of adult-child interactions. The MEACI was refined by Bratton (1993) to enhance usability by establishing a coding protocol that included procedures for training raters. Stover et al. (1971) established inter-rater reliability coefficients for the three subscales. The average reliability correlation coefficients across the 6 coding pairs on Communication of Acceptance, Allowing the Child Self-Direction, and Involvement subscales were .88, .80, and .88 respectively. Seven contemporary studies used the MEACI to examine the impact of CPRT methodology on parental empathy and followed stringent training and coding procedures to establish inter-rater reliability for the MEACI total Empathy score. Across the 7 studies, the inter-rater reliability correlation coefficients at post-coding ranged from .82 to .99. For the purpose of this study, the MEACI was adapted to be sensitive to parent-child interactions that are developmentally appropriate for preadolescents. See Appendix I for preadolescent-adapted MEACI scoring directions.

Procedure

I obtained human subjects approval from the University of North Texas Institutional Review Board prior to contacting potential participants. In order to recruit participants, I contacted directors of adoption agencies, adoption support organizations, school districts, churches, private practitioners and community counseling agencies in a large metropolitan area in the southwest region of the United States via telephone and email to discuss the project and provide them with flyers containing a brief description of CPRT and the investigator's contact information to distribute to the families these sites serve. Individual parents contacted me directly to schedule an intake appointment to determine if parents met inclusion criteria to participate in the study. Prior to the pre-session, parents completed baseline CBCL and PSI assessments and conducted video-recorded 20-minute special one-on-one times with their preadolescent children of focus to be used for baseline MEACI ratings. Baseline data collection took place in a confidential setting and parents completed assessments in a private room free from distraction. I was present to answer any questions and childcare was provided. Special one-on-one times were recorded in a private room with activity kits which were set up prior to participant arrival. 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. Data was collected again at pretest, midtest, and posttest following the same procedures. See Figure 1 for overview of study procedures.

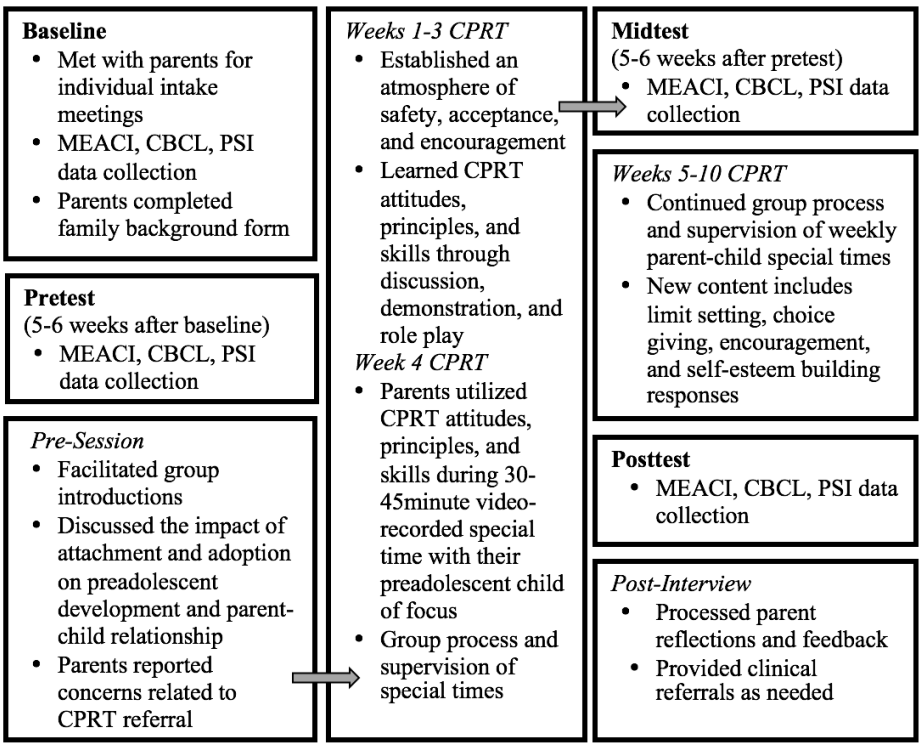

Figure 1. Overview of study procedures.

According to recommendations made by Carnes-Holt and Bratton (2014) and Opiola and Bratton (in-press) who conducted CPRT with adoptive parents, I facilitated an additional session, referred to as pre-session, prior to beginning the 10 weeks of CPRT. During the pre-session, adoptive parents shared their adoption stories and struggles with the group and I provided information about the impact of attachment and adoption on preadolescent development and the parent-child relationship. Following 10 weeks of CPRT intervention and posttest data collection, I facilitated post-interviews with all participants to gain feedback about their participation in CPRT and make follow-up and referral plans as clinically warranted.

CPRT groups met for 2-hour weekly sessions for 10 weeks. CPRT facilitators followed the 10-week CPRT protocol (Landreth & Bratton, 2006), adapted for preadolescents by Ceballos et al. (in press), and included a pre-session. During the first three sessions of CPRT, we aimed to help the group establish an atmosphere of safety and acceptance to encourage parents to openly

share and to normalize parenting experiences (Bratton et al., 2006). Parents learned CCPT attitudes, principles, and skills, through discussion, demonstration, and role play, including being fully present with their child, empathic listening and reflective responding, following the child's lead, understanding verbal and non-verbal content of child's activity or interaction, and the importance of consistency of special times to offer a sense of safety and predictability in the parent-child relationship (Landreth & Bratton, 2006). Prior to session 4, parents facilitated their first video-recorded special times with their preadolescent child of focus. Sessions 4-10 focused on continued support, process, and supervision of parents' video-recorded special times. New didactic content during sessions 4-10 included limit setting, choice giving, encouragement, and self-esteem building responses.

In regard to CPRT facilitators, I led the CPRT groups along with one co-leader; we both identified as European American, straight, and female. Both CPRT facilitators were doctoral level counselors who had completed at least two graduate level courses in play therapy and one graduate level course in CPRT and who received direct supervision from a licensed professional counselor-supervisor and registered play therapist-supervisor with extensive training in play therapy and the CPRT protocol. Free childcare with developmentally appropriate activities and snacks was available each week for all parents. All childcare facilitators were undergraduate and master level research assistants who successfully completed background checks, interviews with lead researcher and attended training, specific to working with adoptees and managing behavior, prior to the start of CPRT. I debriefed with childcare facilitators weekly and provided ongoing training and discussion on choice giving and limit setting. Additionally, video cameras and preadolescent-adapted CPRT/filial kits described in the treatment protocol (Bratton et al.,2006; Ceballos et al., in-press) were made available for loan to parents to ensure all parents recorded

their sessions and had the appropriate play/activity materials. All CPRT sessions were video-recorded for the purpose of weekly supervision and to ensure treatment integrity.

To obtain MEACI data, a team of independent raters, blinded to participant information and time of measurement, rated participants' 20- minute videos of parent-child special times. Four doctoral level counseling students, independent of the present study and with advanced training in play therapy and CPRT, scored the videos. All raters identified as European American, straight, and female. 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 inter-rater 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 inter-rater reliability, checks were performed again at mid and end points of the coding period. Raters demonstrated inter-rater reliability at all three inter-rater reliability training checks.

Results

I conducted a non-parametric Friedman test of differences for each independent variable to evaluate the effect of CPRT for 11 adoptive families who participated in CPRT across 4 points of measure. Dependent variables included MEACI Total Empathy, CBCL Total Behavior, and PSI Total Stress scores. A reduction in scores on the MEACI, CBCL, and PSI indicates improvement. Time served as the independent variable, including baseline, pretest, midtest, and posttest points of measure. Data met all assumptions for running individual Friedman tests for each variable.

I established an alpha level of .05 to test for significant differences across time. To test for practical significance of the CPRT intervention, I calculated Cohen's d effect sizes for each dependent variable to determine the magnitude of the differences between baseline and pretest (no intervention) and pretest to posttest (intervention). I interpreted effect sizes using guidelines reported by Cohen (1988), .2 equals a small effect, .5 equals a medium effect, .8 equals a large effect.

Table 1 presents the mean scores and standard deviations for MEACI Total Empathy, CBCL Total Behavior, and PSI Parenting Stress scores across time. Table 2 presents changes in mean scores on each variable between points of measure.

Table 1

Mean Scores of Each Dependent Variable across Time (N = 11)

		M	*SD*
MEACI Total Empathy	Baseline	44.91	10.97
	Pretest	44.82	7.16
	Midtest	33.36	6.78
	Posttest	36.98	8.91
CBCL Total Problems	Baseline	62.82	8.49
	Pretest	64.55	8.55
	Midtest	60.36	9.89
	Posttest	61.36	10.49
PSI Total Stress	Baseline	246.18	40.16
	Pretest	257.45	43.15
	Midtest	235.36	43.58
	Posttest	228.91	48.00

Table 2

Change in Mean Scores for Each Dependent Variable across Time (N =11)

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	-.09	-11.46	+3.62	-7.84
CBCL Total Problems	+1.73	-4.19	+1.00	-3.19
PSI Total Stress	+11.27	-22.09	-6.45	-28.54

Note. A decrease in mean scores means an improvement in CPRT participants.

Research Question 1: MEACI Total Empathy

A non-parametric Friedman test of differences among repeated measures was conducted to compare participants' MAECI Total Empathy scores across four points of measure: baseline (mean = 44.91), pretest (mean = 44.82), midtest (mean = 33.36), and posttest (mean = 36.98). Results demonstrated a statistically significant difference across time, $X^2(3) = 15.44$, $p = .001$.

With no intervention (baseline to pretest), participants demonstrated no change in parental empathy scores according to raters blinded to measurement time, with a mean change score of -.09 and a negligible effect size of $d = .009$. During intervention (pretest to posttest), participants demonstrated substantial improvement in parental empathy with a 7.84 mean score decrease and a large treatment effect of $d = .970$.

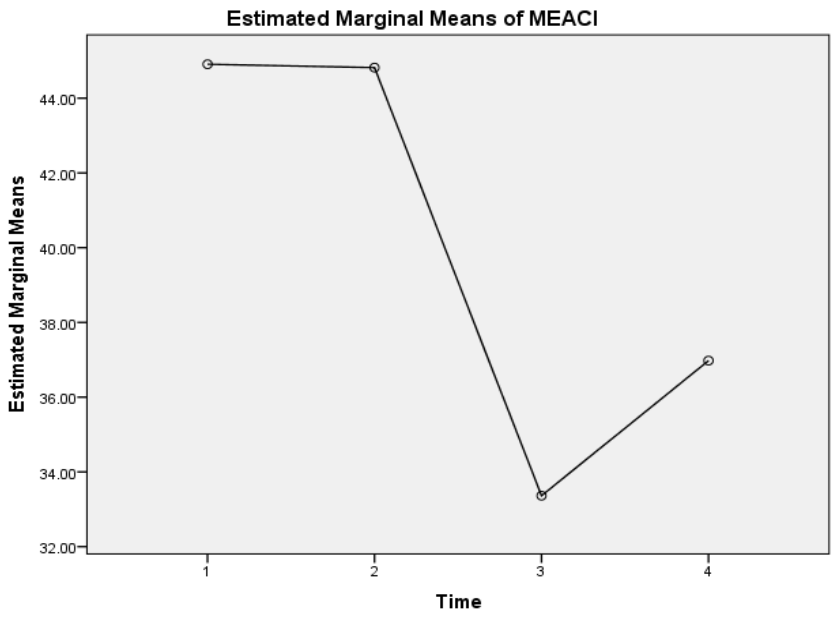

Figure 2. MEACI Total Empathy group mean scores across time.

Research Question 2: CBCL Total Behavior

A non-parametric Friedman test of differences among repeated measures was conducted to compare participants' CBCL Total Behavior scores across four points of measure: baseline (mean = 62.82), pretest (mean = 64.55), midtest (mean = 60.36), and posttest (mean = 61.36). Results demonstrated a statistically significant difference across time, $X^2(3) = 14.62$, $p = .002$.

With no intervention (baseline to pretest), participant reports demonstrated worsening in child behavior, with a mean change score of 1.73 and a small negative effect size of $d = -.203$. During intervention (pretest to posttest), participants demonstrated improvement in child behavior with a 3.19 mean score decrease and a small positive treatment effect of $d = .333$.

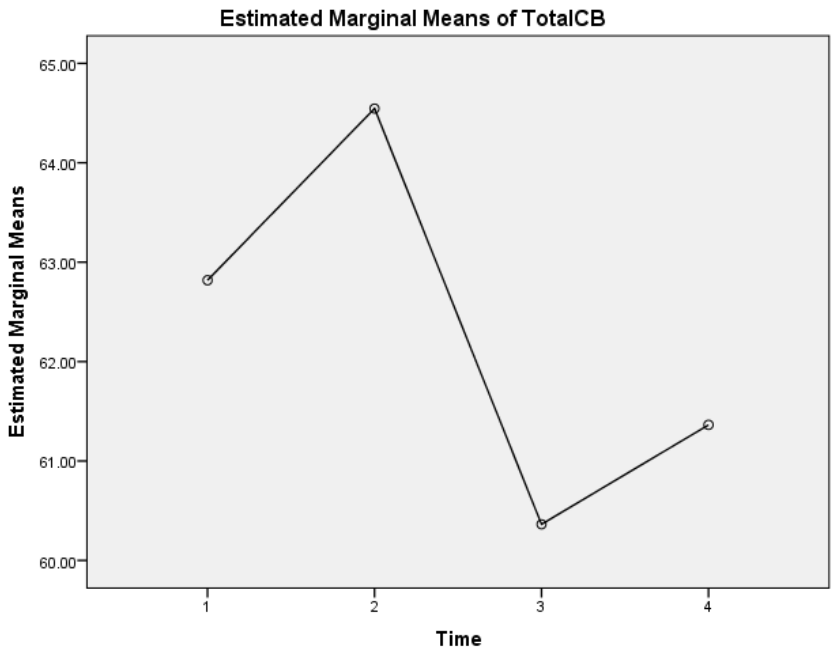

Figure 3. CBCL Total Behavior group mean scores across time.

Research Question 3: PSI Total Stress

A non-parametric Friedman test of differences among repeated measures was conducted to compare participants' PSI Total Stress scores across four points of measure: baseline (mean = 246.18), pretest (mean = 257.45), midtest (mean = 235.36), and posttest (mean = 228.91). Results demonstrated a statistically significant difference across time, $X^2(3) = 10.75$, $p = .013$.

With no intervention (baseline to pretest), participant reports demonstrated increased parenting stress, with a mean change score of 11.27 and a small negative effect size of $d = -.270$. During intervention (pretest to posttest), participants demonstrated substantial reduction in parenting stress with a 28.54 mean score decrease and a medium treatment effect of $d = .626$.

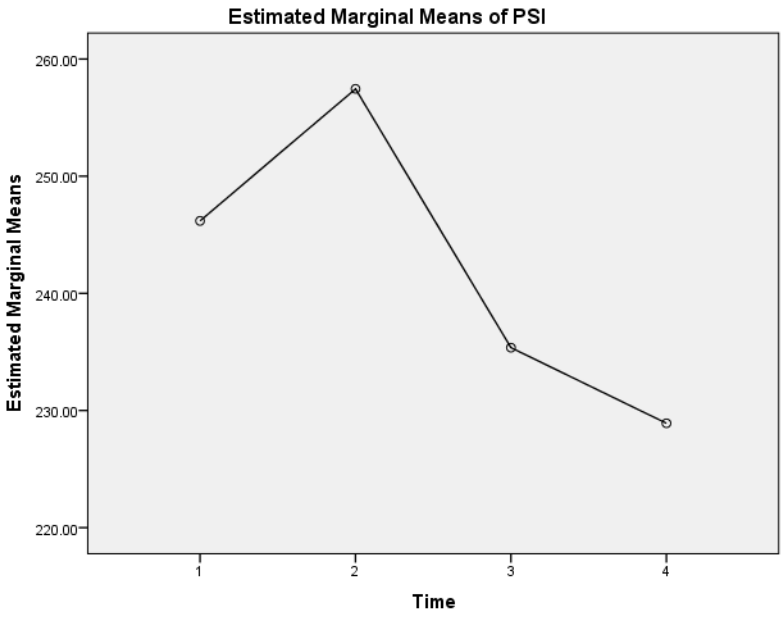

Figure 4. PSI Total Stress group mean scores across time.

Discussion

By conducting this study, I sought to explore the effect of CPRT as a group parenting intervention for adoptive parents of preadolescents. Additionally, I sought to pilot the preadolescent-adapted CPRT protocol (Ceballos et al., in-press) and explore specific research and clinical implications specific to utilizing CPRT as an intervention with adoptive parents of preadolescents. CPRT is an evidence-based mental health intervention shown particularly effective to reduce child disruptive behavior and to improve family cohesion, including stress in the parent-child relationship (Bratton et al., 2017; CEBC, 2017; SAMHSA, 2017), and for adoptive families of young children (Brodzinsky, 2014; Carnes-Holt & Bratton, 2014; Opiola & Bratton, in-press). To date, no published CPRT studies investigated the effect of CPRT on preadolescent-parent relationships.

Overall, results from this present study were positive in demonstrating CPRT as a mental health intervention for adoptive parents of preadolescents. Results demonstrated statistically

significant differences across time for improving parental empathy, child behavior, and stress in the parent-child relationship. During the baseline phase prior to receiving CPRT, parents reported no change or worsening in functioning across all variables. During intervention, as measured by pretest to posttest scores, a large treatment effect for parental empathy, a medium treatment effect for parenting stress, and a small effect for child behavior were observed.

Parental Empathy

Adoptive parents who participated in CPRT reported a statistically significant improvement in parental empathy over time. Results showed that during the baseline phase parents' levels of empathy remained unchanged, whereas during the intervention phase CPRT demonstrated a large treatment effect on parents' empathic behavior and interactions with their children of focus, as reported by independent observers. These findings reinforce a goal of CPRT to increase parents' abilities to respond empathically to the emotional worlds of their children. Results of the current study relate to the findings of previous randomized, controlled CPRT studies with adoptive families that also reported increases in parental empathy as a result of participation in CPRT (Carnes-Holt & Bratton, 2014; Opiola & Bratton, in-press). CPRT identifies the relationship between parent and child as essential to the healing process. Older adopted children may not have experienced a responsive, empathic attachment relationship with a caregiver or parent prior to adoption. CPRT offers parents a new way of attuning to their children's experiences by teaching parents to reflect their children's feelings, allow their child to lead discussion when sharing with their parents, therapeutically communicate limits to behavior, and enjoy mutually satisfying connection and activity during special times. These new parenting skills helped parents to cultivate deeper connection and empathy in relationship with their adopted preadolescent child, fostering relational healing for both parents and preadolescents.

The improvement in MEACI Total Empathy scores are also noteworthy because the MEACI was not a self-report instrument. The MEACI was scored by raters, independent from the research study and blinded to time of measure (baseline, pretest, midtest, or posttest). The results of the MEACI Total Empathy scores, provided by raters' scores after viewing segments of video-taped one-on-one times between parents and their preadolescent children of focus, offer a non-biased observation of parents' increased empathy toward their children throughout CPRT. Further, results of the MEACI provide increased credibility in assessing the impact of CPRT as an intervention to support adoptive parents in connecting with their preadolescent children.

The largest improvements in parental empathy, according to group analysis, were reported between pretest and midtest. During the first half of CPRT, parents learn a new way of being with their children, relationally attuning to their children's emotional needs, and practice new skills in responding to and communicating with their preadolescents. Parents verbally reported intentionality in how they responded to their children during one-on-one times. CPRT facilitators observed parents' commitment to strict adherence to utilizing the skills they were learning. Special one-on-one times provided a new and safe platform for parents and preadolescents to connect. Fostering a greater sense of security in the parent-child relationship allows parents and children to mutually enjoy each other's company during preadolescent years (Seifert & Hoffnung, 2000), compared to higher conflict relationships. Learning new relational skills and processing parenting challenges during group allowed parents to more intentionally respond to their children's needs.

Although visual analysis of Figure 3 from pre to midtest indicates improvement in parental empathy, mid to posttest scores shows a slight reduction in parental empathy, according to raters blinded to time of measurement. During the last half of intervention, between midtest

and posttest, parents reported and demonstrated increased desire and comfort to more authentically integrate their new CPRT attitudes and skills into their natural way of being with their children. Developmentally, it was important for parents to be able to offer genuineness and flexibility in relationship with their preadolescent children. Although clinically beneficial and developmentally appropriate, parents' adjustments and process of embodying the CPRT attitudes and skills may have influenced the slight decrease in the rating of observable parental empathic behaviors as rated by blinded raters on MEACI scores from midtest to posttest.

It is likely that the timing of post data collection, occurring at the end of spring semester with naturally higher stress family schedules and academic stress for children, influenced posttest parental empathy scores as well. Additionally, examination of the raw MEACI scores showed that the trend of one parents' MEACI scores impacted the group totals. Removing this one participant's scores and reanalyzing data confirmed that this one participant caused worsening of group MEACI scores that is evident in current results. If this one participant was removed, parental empathy scores continued to decrease from mid to posttest. Although this indicates that one participant's scores impacted the group posttest mean, this participant met all inclusion criteria and remained in group data analysis.

Child Behavior

Adoptive parents who participated in CPRT also reported a statistically significant improvement in child behavior over time. Results showed that during the baseline phase parents observed child behavioral concerns worsened, whereas during the intervention phase CPRT demonstrated a small treatment effect on child behavior. The preadolescents in this study continued to demonstrate high emotional needs throughout development and over the course of the study. Despite statistically significant reductions as a group across time, average CBCL Total

Behavior scores remained at borderline level at the end of the study phase. Additional exploration of the changes in mean scores of individual participants across time revealed that 8 parents reported decreases in CBCL Total Behavior scores pretest to posttest, indicating perceived reduction of preadolescent problematic behaviors as a result of participation in CPRT. These results are especially meaningful given that parents reported high levels of distress and worry specifically related to their preadolescents' continued behavioral concerns.

This overall promising finding parallels the hopes of training parents in CPRT as a means of facilitating their children's improved holistic functioning including behavioral functioning. Consistent with CCPT theory, a fundamental belief in CPRT is that the parent-child relationship is the mechanism of change, in which children can feel safe to fully express and explore their feelings, thoughts, and experiences. Furthermore, through an attuned and secure relationship parents help co-regulate children's emotions and behaviors. Of particular note for this population of adoptive families, all the children in the current study experienced relational trauma and attachment disruptions in their early relationships. The majority of the preadolescents in this study were adopted over the age of 7 out of foster care and as part of a sibling group. Compared to prior research of CPRT with adoptive parents of young children, the preadolescent children of focus in this study experienced a greater number of years of relational disruptions and inconsistent care, and their prior experiences provoked expectations of mistrust and inconsistency in relationship. Many of the parent-child dyads in the current study were just beginning to build relational foundations of safety, permanency, and trust. I recommend CPRT as an early intervention and preventative model, offering families, such as the parents and preadolescents in this study, attachment-related support to begin building relational security as early as possible in these children's lives.

Based on the premise of CPRT, as the children in this study experienced their parents offering unconditional positive regard, empathy, and genuineness in their parent-child relationship, the children were able to internalize a sense of worth, relational safety and trust in the permanency of their parents' love, all prerequisites to the development of emotional and behavioral regulation. Through this process, children can begin to develop an internal valuing system with which they can utilize to engage in more prosocial behaviors. In CPRT, adoptive parents can become the agents of change in helping their preadolescents develop an increased capacity for emotional regulation and communication of their internal feelings. Relational healing allows children a new outlet for processing their experiences in relationship with their parents, which, therefore, reduces their need to externalize their feelings through maladaptive behavior. Specific to this population of preadolescents with histories of attachment disruption and adverse pre-adoptive experiences, behavioral change may take longer to externally observe due to the need for children to first establish a foundation for relational safety and trust in parent.

Experiencing parental warmth and low levels of physically punitive discipline during childhood is associated with a greater capacity to self-regulate during middle childhood (Colman, Hardy, Albert, Raffaelli, & Crockett, 2006). Anecdotally, one parent described herself as "losing it" during a special time with her child, in which she become frustrated with her son's lack of communication with her. She reported to group that week that she was able to recognize her own emotional dysregulation in the moment, pausing before utilizing her new CPRT responses of recognizing her child's emotions, for example "you're mad at me." Due to the extremes of their preadolescent children's behavior at times, even small moments of connection impacted their overall relationship.

Another parent described her preadolescent, prior to beginning special times, as "not wanting to have anything to do with me." After their second special time, this parent proudly announced to the group that her daughter had initiated a hug with her mom for the first time ever. Several other parents reported similar observations of their preadolescents more freely engaging in or initiating physical affection with their parents following individualized one-on-one special times. Relatedly, despite parents' initial concerns that their preadolescents would not engage in activity during special times, all preadolescents in this study demonstrated a level of anticipation for the special times and were active in directing activity and discussion with their parents.

Although visual analysis of Figure 3 from pre to midtest indicates improvement in child behavior problems, mid to posttest scores show a slight increase in parent observed child behavioral concerns. The timing of this study, rather than clinical effect, may have contributed to this observed fluctuation in scores at the end of CPRT. During this phase of the study, end of the school year contributed to increased stress and pressure for preadolescent children and family schedules. Parents anecdotally described end of the school year (at posttest) as contributing to increased child behavior problems.

Additionally, given the demographic information for the preadolescents included in this study, all experienced pre-placement adverse childhood experiences and the majority of preadolescent children of focus were adopted during late childhood. To provide optimal, holistic post-adoption services, I recommend that some preadolescent adoptees can benefit from receiving individual counseling services while their parents receive CPRT.

Parenting Stress

Adoptive parents who participated in CPRT reported statistically significant reduction in parenting stress over time. Results show that during the baseline phase parents reported increased

stress in the parent-child relationship, whereas during the intervention phase CPRT demonstrated a medium treatment effect on parenting stress. Visual analysis of Figure 3 from pre to midtest indicates marked improvement in parenting stress and mid to posttest scores show that parents continued to report reduction of stress in the parent child relationship at the end of intervention. Reduction in parenting stress throughout CPRT may be impacted by parents' increased confidence in responding to and setting limits in relationship with their children. While their parent-child connections became more stable and parents had a structured, planned time and place in which to focus relational attention to their children during special times, parents may have felt less pressure to maintain constant emotional regulation. Parents' new skills provided them with alternative methods for discipline to decrease power struggles and increase confidence; this may also contribute to reduction in parenting stress over time.

Parents described being an adoptive parent as stressful and isolating at times. Decreases in parenting stress over time may illustrate the benefits of the group process component of CPRT (Landreth & Bratton, 2006). A large portion of group time each week was devoted to providing a space for parents to engage in self-reflection and processing of common experiences in being an adoptive parent of a preadolescent. The majority of parents seemed to experience group as a place to support other adoptive parents, reminisce about important family occasions, including regularly sharing photos and laughing as a way to connect, and increase personal wellness and emotional well-being. The group became a special place of support to parents, paralleling the importance of the special times to their children.

Relatedly, supervision of parents' video-taped one-on-one times with their children is a critical component of the CPRT process (Landreth & Bratton, 2006) and may have contributed to reducing parent-child relationship stress in this study. During the weekly supervision component

of CPRT, parents were able to offer support and validation to one another related to observing peers' attunement and connectedness with their children. In one example, demonstrating the benefits of gaining feedback from other group members, I observed one group member become emotionally touched by a new softness he witnessed in another parent's video-taped special time with his son. Seeing the other parent grow in relationship with his son impacted this parent and he connected with his peers' initial fears of vulnerability and difficulty relating to his preadolescent child and validated his peer's growth in empathy and attunement. The parent receiving supervision and group feedback appeared to gain confidence in his ability to relate to his son and feel emotionally understood by the group. During CPRT, supervision also provided an important opportunity for parents to observe their own interactions with their children from a neutral stance, providing them a format to notice their children's experience, most notably their children's enjoyment, of their special times together, engage in self-reflection, and practice new ways of responding without the pressure of immediate feedback from their preadolescent children.

In this current study, parent and child schedules contributed to fluctuating consistency in special times each week. Several parents opted to conduct their special times at our clinic with the researcher's activity kits in order to ensure consistency and predictability of their special times. Because the families in this study demonstrated high emotional needs, my offering to set up and record parent-child special times each week at the clinic or group site contributed to these parents reported reduced stress in planning their special times. Another consideration when constructing a group for adoptive parents is homogeneity of group (i.e., all adoptive parents). The families in this study presented to CPRT with high interpersonal needs and attending to parents' concerns sometimes took priority during CPRT over learning new parenting skills or

focusing on their children's needs. I recommend that adoptive parents and preadolescent children may benefit from receiving individual counseling services prior to or while attending CPRT.

Limitations and Opportunities for Future Research

As a pilot study to investigate the impact of CPRT for adoptive parents of preadolescents, numerous limitations and confounding variables presented which can be considered to improve future research. No published research studies of adapting CPRT for preadolescents exist to which I can compare the results and conclusions of the current study. When initially designing this study, I anticipated low attrition rates and high treatment adherence by parents, based on previous CPRT research with adoptive parents (Carnes-Holt & Bratton, 2014; Opiola & Bratton, in-press). Attrition was higher than expected in the current study. I recommend that future researchers consider beginning intervention phase in the fall semester or beginning of January to avoid the end of the school year and sports season that can impact intervention completion and data collection.

Family schedules during preadolescence are often busy with academic and social events. In order to support parent's ability to fully invest in the CPRT process, I recommend providing childcare with developmentally-appropriate activities and snacks while parents are attending groups and creating preadolescent-adapted filial kits available for parents to rent for use during their special times. Due to the high emotional and behavioral needs demonstrated by preadolescents in this study and the wide age range of siblings in the families, I recommend that childcare workers receive initial training and ongoing support from counselors with childcare-relevant topics for this population of children including, activities, impact of adoption and development, choice giving, and limit setting.

Due to recruitment and sample size, this pilot study utilized a single group repeated measures research design in effort to explore the effect of CPRT for adoptive parents of preadolescents. Although randomized controlled trials (RCT) are the gold standard for research, the use of a baseline phase in this study allowed participants to serve as their own control group and provided greater rigor over a pre-post single group design. The use of RCTs in future research is needed to investigate the effectiveness of CPRT with this population. Another important limitation to the current study was the lack of preadolescent-report measures included in data analysis. The current study did not include a measure of preadolescents' perceptions of their behaviors and parent-child relationship dynamics. CBCL and PSI data were parent-report data. Parent report data in this study were supported by findings demonstrated from MEACI data which is not a self-report measure, using observers blinded to time of measurement to rate parental empathic behavior.

Additional qualitative explorations of both parent and preadolescent experiences during CPRT would contribute to a greater depth of understanding of the current study's initial results. A larger sample size with randomization is needed to isolate the tested variables. Timing of posttesting and assessment fatigue are possible confounding variables in this study. This study was conducted during the child's academic spring semester when parents and children's schedules were hectic with end of school year activities and final exams which are especially stressful for the children in this study, the majority of whom struggled academically. Parents reported reluctance to complete the fourth point of measurement. I recommend that future researchers utilize a design that requires fewer data collection points. The external stressors impacting these families likely impacted their scores later in the semester (midtest and posttest). Additionally, this study was conducted in one geographic location in the United States which

limits the generalizability of the results. I served as the lead researcher in this study and also as the lead counselor who facilitated the CPRT groups with participants. My significant time and relational involvement with participants as their counselor poses valid threat of researcher bias.

Conclusion

Examining these findings holistically, parents demonstrated greater parental empathy and decreased parenting stress with medium to large effect sizes despite the continuation of their preadolescents' emotional and behavioral concerns. Parents were able to feel more confident and attuned with their preadolescent children who are continuing to need their parents as relational supports as they navigate preadolescence and attachment-related concerns. CPRT helped to equip parents with new ways to respond to and interact with their preadolescent children in a way that supports their continually growing relationship. As anticipated, these findings also support the recommendations made by Carnes-Holt and Bratton (2014) and Opiola and Bratton (in-press) to extend the CPRT model to include a greater number of sessions for families with higher needs, such as many adoptive families who report attachment and behavioral concerns.

Based on the results of this single group repeated measures study, CPRT is a promising intervention for adoptive parents and preadolescent children. The adoptive parents in this study reported statistically significant improvements in parental empathy, child behavior, and parenting stress over four points of measure. Adoptive parents and/or adopted preadolescents may benefit from receiving individual counseling prior to or during participation in CPRT to maximize clinical impact and increase their ability to fully engage in learning CPRT attitudes and skills. Further research is needed to examine effectiveness of CPRT with adoptive parents of preadolescents and to provide additional support for clinical and research use of preadolescent-adapted CPRT protocol (Ceballos et al., in-press).

Acknowledgements

This study was funded by the Hackett Foundation, Texas Association for Play Therapy's Dan E. Homeyer Research Grant, ACA Growing Healthy and Confident Kids Grant, Texas Counseling Association Educational Endowment Award, and the University of North Texas Center for Play Therapy.

References

Abidin, R. R. (1995). *Parenting Stress Index: Professional manual.* Lutz, FL: Psychological Assessment Resources.

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA preschool forms & profiles.* Burlington: University of Vermont, Research Center, Youth & Families.

Adams, G. (2000). *Adolescent development: The essential readings.* Malden, MA: Blackwell publishers.

Adoption History Project. (2012). *Topics in Adoption History.* Retrieved from http://darkwing.uoregon.edu/~adoption/

Al-Yagon, M. (2016). Perceived close relationships, teachers, and peers predictors of social, emotional, and behavioral features in adolescents with LD or comorbid LD and ADHD. *Journal of Learning Disabilities*, 1-19.

Ary, D., Duncan, T., Duncan, S., & Hops, H. (1999). Adolescent problem behavior: The influence of parents and peers. *Behavior, Research, and Therapy, 37(3),* 217-230.

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology.* New York, NY: W & W Norton & Company, Inc.

Barth, R., Crea, T., John, K., Thoburn, J., Quinton, D., & Daniels, F. (2005). Beyond attachment theory and therapy: Towards sensitive and evidenced-based interventions with foster and adoptive families in distress. *Child and Family Social Work, 10*, 257-258.

Beijersbergen M., Juffer F., Bakermans-Kranenburg M., & van IJzendoorn M. (2012). Remaining or becoming secure: parental sensitive support predicts attachment continuity from infancy to adolescence in a longitudinal adoption study. *Developmental Psychology, 48,* 1277–1282.

Bowlby, J. (1980). *Attachment and loss* (Vol. 3). *Loss*. New York, NY: Basic Books.

Bratton, S., Dafoe, E., Swan, A., Opiola, K., McClintock, D., & Barcenas, G. (2017). *Play Therapy Outcome Research Database.* Evidence-based Child Therapy. Retrieved from: http://evidencebasedchildtherapy.com/research/

Bratton, S., Landreth, G., Kellam, T., & Blackard, S. (2006). *Child parent relationship therapy (CPRT) treatment manual: A 10 session filial therapy model for training parents.* New York, NY: Routledge.

Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of the outcome research. *Professional Psychology: Research and Practice, 36*(4), 376-390. doi:10.1037/0735-7028.36.4.376

Brodzinsky, D. (2013). *A need to know: Enhancing adoption competence among mental health professionals*. New York: Donaldson Institute. Retrieved from http://adoptioninstitute.org/old/publications/2013_08_ANeedToKnow.pdf

Brodzinsky, D. (2015). *The modern adoptive families study: An introduction.* The Donaldson Adoption Institute. Retrieved from: http://adoptioninstitute.org/publications/the-modern-adoptive-families-study-an-introduction/

Brown, C. J. (2005). Activity filial therapy with adolescents. *Play therapy with adolescents*, 48.

Capps, J. E. (2012). Strengthening Foster Parent–Adolescent Relationships through Filial Therapy. *The Family Journal*, *20*(4), 427-432.

Carnes-Holt, K. L., Meany-Walen, K., & Ceballos, P. (2015). Child-parent relationship therapy with pre-adolescents. In C. Schaefer & A. Drewes. (Eds.). *Play Therapy in Middle Childhood*. Washington, DC: American Psychological Association.

Carnes-Holt, K., & Bratton, S. C. (2014). The efficacy of child parent relationship therapy for adopted children with attachment disruptions. *Journal of Counseling & Development*, *92*(3), 328-337. doi: 10.1002/j.1556-6676.2014.00160.x

Ceballos, P., Carnes-Holt, K., & Meany-Walen, K. (in-press). CPRT Preadolescent Model. In Landreth, G. & Bratton, S. C. (Eds.). *Child Parent Relationship Therapy* (2nd ed.). New York, NY: Routledge.

Child Welfare Information Gateway. (2015). *Adoption Statistics.* Retrieved from https://www.childwelfare.gov/topics/systemwide/statistics/adoption/

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Colman, R. A., Hardy, S. A., Albert, M., Raffaelli, M., & Crockett, L. (2006). Early predictors of self-regulation in middle childhood. *Infant and Child Development*, *15(4),* 421-437.

Dhami, M., Mandel, D., & Sothmann, K. (2007). An evaluation of post-adoption services. *Child and Youth Services Review, 29(2),* 162-179.

Donaldson Adoption Institute. (2007). *Research: Adoption facts*. Retrieved from http://www.adoptioninstitute.org/research/adoptionfacts.php

Duchesne, S., & Larose, S. (2007). Adolescent parental attachment and academic motivation and performance in early adolescence. *Journal of Applied Social Psychology, 37*, 1501–1521.

Eley, T., Deater-Deckard, K., Fombonne, E., Fulker, D., & Plomin, R. (1998). An adoption study of depressive symptoms in middle childhood. *Journal of Child Psychology and Psychiatry, 39(3),* 337-345.

Engels, R. C., Finkenauer, C., Meeus, W., & Deković, M. (2001). Parental attachment and adolescents' emotional adjustment: The associations with social skills and relational competence. *Journal of Counseling Psychology, 48(4),* 428-439.

Erikson, E. H. (1950). *Childhood and society*. New York, NY: Norton.

Forbes, H., & Post, B. (2006). *Beyond consequences logic, and control: A love based approach to helping attachment-challenged children with severe behaviors.* Orlando, FL: Beyond Consequences Institute, LLC.

Freeman, H., & Brown, B. (2001). Primary attachment to parents and peers during adolescence: Differences by attachment style. *Journal of Youth and Adolescence, 30(6),* 653-674.

Gil, E. (1996). *Treating Abused Adolescents.* New York, NY: Guilford Press.

Gorbet, D. (2004). *Adopted Teens Only: A Survival Guide to Adolescence.* Lincoln, NE: iUniverse.

Guerney, B. (1969). Filial therapy: Description and rationale. *Journal of Consulting Psychology, 28* (4), 304-310. doi: 10.1037/h0041340

Hall, G. S. (1904). *Adolescence: Its psychology and its relations to physiology, anthropology, sociology, sex, crime, religion, and education*. New York, NY: Appleton & Co.

Hawk, B., & McCall, R. (2010). CBCL behavior problems of post-institutionalized international adoptees. *Clinical Child and Family Psychology Review, 13(2),* 199-211.

Hershenberg, R., Davila, J., Yoneda, A., Starr, L. R., Miller, M. R., Stroud, C. B., & Feinstein, B. A. (2011). What I like about you: The association between adolescent attachment security and emotional behavior in a relationship promoting context. *Journal of adolescence*, *34(5),* 1017-1024.

Hopkins, J. (2000). Overcoming a child's resistance to late adoption: How one new attachment can facilitate another. *Journal of Child Psychotherapy, 26(3),* 335-347. doi: 10.1080/00754170003633

Howard, M. S. & Medway, F. J. (2004), Adolescents' attachment and coping with stress. Psychol. Schs., 41: 391–402. doi: 10.1002/pits.10167

Hughes, D. A. (2006). *Building the bonds of attachment: Awakening love in deeply troubled children* (2nd ed). Lanham, MD: Rowman & Littlefield.

Keck, G. (2009). *Parenting Adopted Adolescents: Understanding and Appreciating their Journeys.* Colorado Springs, CO: NavPress.

Keyes, M., Sharma, A., Elkins, I., Iacono, W., & McGue, M. (2008). The mental health of US adolescents adopted in infancy. *Pediatrics and Adolescent Medicine, 162(5),* 419-425.

Klahr, A., Rueter, M., McGue, M., Iacono, W., & Burt, A. (2011). The relationship between parent-child conflict and adolescent antisocial behavior: Confirming shared environmental mediation. *Journal of Abnormal Child Psychology, 39,* 683-694.

Koh, B., & Rueter, M. (2011). Contributions of Parent–Adolescent Negative Emotionality, Adolescent Conflict, and Adoption Status to Adolescent Externalizing Behaviors. *Journal of Clinical Child & Adolescent Psychology, 40(6),* 825-836.

Kornhonen, M., Luoma, I., Salmelin, R., & Tammien, T. (2012). A longitudinal study of maternal prenatal, postnatal, and concurrent depressive symptoms and adolescent well-being. *Journal of Affective Disorders, 136(3),* 680-692.

Kreider & Lofquist, D. (2014). Adopted children and stepchildren: 2010 Population Characteristics. Retrieved from: https://www.census.gov/prod/2014pubs/p20-572.pdf

Laible, D. (2007). Attachment with parents and peers in late adolescence: Links with emotional competence and social behavior. *Personality and Individual Differences, 43(5),* 1185-1197.

Landreth, G (2012). *Play therapy: The art of the relationship* (3rd ed.). New York, NY: Routledge.

Landreth, G. L., & Bratton, S. C. (2006). *Child parent relationship therapy (CPRTt): A ten session filial therapy model.* New York, NY: Routledge.

Leathers, S., Falconnier, L., & Spielfogel, J. (2010). Predicting family reunification, adoption, and subsidized guardianship among adolescents in foster care. *American Journal of Orthopsychiatry, 80(3)*, 422-431.

Lin, Y., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling and Development, 93(1),* 45-58.

Livingston Smith, S. (2014). *Keeping the Promise: The Case for Adoption Support and Preservation.* The Donaldson Adoption Institute. Retrieved from: http://adoptioninstitute.org/wordpress/wp-content/uploads/2014/04/Keeping-the-Promise-Case-for-ASAP-Brief.pdf

McCreight, B. (2012). *Parenting Your Adopted Older Child.* Oakland, CA: New Harbinger Publication, Inc.

McGee, T., & Anderson, D. (2008). Early childhood trauma. In Sanford, D., & Sanford, R. (Eds.), *Thriving as an Adoptive Family* (p. 167-182). Carol Stream, IL: Tyndale House Publishers, Inc.

McGue, M., Sharma, A., & Benson, P. (1996). The effect of common rearing on adolescent adjustment: Evidence from a U.S. adoption cohort. *Developmental Psychology, 32(4),* 604-613. doi:10.1037/0012-1649.32.4.604

Meany-Walen, K., Carnes Holt, K., Ceballos, P., & Michero, E. (2014). Child Parent Relationship Therapy: A model for preadolescents. *British Journal of Play Therapy, 10*, 6-19.

Mothander, P., & Wang, M. (2011). Parental rearing, attachment, and social anxiety in Chinese adolescents. *Youth and Society, 46(2),* 155-175.

Nilsson, R., Rhee, S. H., Corley, R. P., Rhea, S., Wadsworth, S. J., & DeFries, J. C. (2011). Conduct Problems in Adopted and Non-Adopted Adolescents and Adoption Satisfaction as a Protective Factor. *Adoption Quarterly, 14(3),* 181-198. doi:10.1080/10926755.2011.608030

NREPP. (2017). SAMHSA's National Registry of Evidence-Based Programs and Practices. Retrieved from: http://nrepp.samhsa.gov/landing.aspx

Opiola, K., & Bratton, S. (in-press). The effects of Child Parent Relationship Therapy (CPRT) for adoptive families. *International Journal of Play Therapy.*

Pace, C., Di Folco, S., Guerriero, V., Santona, A., & Terrone, G. (2015). Adoptive parenting and attachment: Association of the internal working models between adoptive mothers and their late-adopted children during adolescence. *Frontiers in Psychology, 6,* 1433.

Packman, J., & Solt, M. D. (2004). Filial Therapy for Preadolescents. *International Journal of Play Therapy, 13 (1),* 57-78.

Perry, B. D. (2008). *The neurosequential model of therapeutics. Retrieved from www.childtrauma.org*

Phaik Ooi, Y., Ang, R., Fung, D., Wong, G., & Cai, Y. 92006). The impact of parent-child attachment on aggression, social stress, and self-esteem. *School Psychology International, 27(5),* 552-566.

Purvis, K., Cross, D., & Sunshine, L. (2007). *The connected child: For parents who have welcomed children from other countries and cultures, from troubled backgrounds, with special behavioral or emotional needs*. New York, NY: McGraw-Hill.

Ray, D. (2016). *A Therapist's Guide to Child Development: The Extraordinarily Normal Years*. New York, NY: Routledge.

Riley, D. (2006). *Beneath the Mask: Understanding Adopted Teens.* Burtonsville, MD: C.A.S.E. Publications.

Roisman, G., Monahan, K., Campbell, S., Steinberg, L., & Cauffman, E. (2010). Is adolescence-onset antisocial behavior developmentally normative. *Development and Psychopathology, 22,* 295-311.

Ruskai Melina, L. (1986). *Raising Adopted Children: A Manual for Adoptive Parents.* New York, NY: Harper & Row Publishers, Inc.

Sanchez-Sandoval, Y., & Palacios, J. (2012). Stress in adoptive parents of adolescents. *Children and Youth Services Review, 34*. doi: 10.1016/j.childyouth.2012.03.002

Seifert, M., & Hoffnung, R. (2000). *Child and Adolescent Development* (5th ed.). Houghton Mifflin Harcourt.

Sharma, A.R., McGue, M.K. and Benson, P.L. (1996). The emotional and behavioral adjustment of United States adopted adolescents: An overview. *Children and Youth Services Review*, 18, 83-100.

Siegel, D. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* Guilford Press.

Siegel, D., & Hartzell, M. (2004). *Parenting from the inside-out: How a deeper self-understanding can help you raise children who thrive.* New York, NY: Jeremy P. Tarcher/ Putnam.

Staff, R. (2016). *Parenting Adopted Teenagers: Advice for the Adolescent Years*. London, NI: Jessica Kingsley Publishers.

Stover, L., Guerney, B., & O'Connell, M. (1971). Measurements of acceptance, allowing self-direction, involvement, and empathy in adult-child interaction. *Journal of Psychology, 77*, 261-269.

Sullivan, A. (2012). *From Hopeless to Hopeful: Raising an Older Adopted Child.* Ann Sullivan, Ed.M.

Tambelli, R., Laghi, F., Odorisio, F., & Notari, V. (2012). Attachment relationships and internalizing and externalizing problems among Italian adolescents. *Children and Youth Services Review, 34(8),* 1465-1471.

U.S. Census Bureau. (2010). *Adopted children and stepchildren*. Retrieved from http://www.census.gov/topics/population/children.html

van den Dries, F., Juffer, M., van IJzendoorn, H., & Bakermans-Kranenburg, M. (2009). Fostering security: A meta-analysis of attachment in adopted children. *Children and Youth Services Review, 31,* 410-421.

Vandivere, S., & McKlindon, A. (2010). The well-being of U.S. children adopted from foster care privately from the United States and internationally. *Adoption Quarterly, 13(4),* 157-184. doi:10.1080/10926755.2010.524871

Whittle, S., Yap, M. B. H., Yücel, M., Fornito, A., Simmons, J. G., Barrett, A, Sheeber, L., & Allen, N. B. (2008). Prefrontal and amygdala volumes are related to adolescents' affective behaviors during parent–adolescent interactions. *Proceedings of the National Academy of Sciences of the United States of America*, *105*(9), 3652–3657.

Wright, L., & Flynn, C. (2006). Adolescent adoption: Success despite challenges. Children and Youth Services Review, 28(5), 487-510.

APPENDIX A

EXTENDED LITERATURE REVIEW

This extended review of literature includes: (a) preadolescence and the parent-child relationship, (b) adoptive families with preadolescents, (c) child-parent relationship therapy, and (d) CPRT with preadolescents.

Preadolescence and the Parent-Child Relationship

Preadolescent Development

In attempt to portray the overall sense of the preadolescent experience, in this section I will begin by defining preadolescence, briefly describing how major theories of development depict preadolescent development, and reviewing research studies pertaining to preadolescent socio-emotional functioning. Preadolescence is a transitional period of development between childhood and the onset of puberty, during ages 9 to 13 years (Bratton & Ferebee, 1999; Meany-Walen et al., 2014). Preadolescence is characterized broadly by physical and hormonal changes, frequent fluctuations in mood, desire for autonomy from parents, and focus on social belonging and peer relationships (Ray, 2016; Shokouni, Limberg, & Armstrong, 2014). Preadolescents are engaging in an ongoing self-identification exploration process which includes experiences of desiring independent thinking, developing a sense of mastery and competence, perceiving a sense of belonging, and gaining freedom to explore different ways of being as they navigate their inner worlds (Ray, 2016). Due to the rapid growth and emotional development that occurs during preadolescence, however, each age 9 to 13 years, categorized within the broad term preadolescence experiences unique developmental tasks and behavioral expressions of their internal experiences.

Several foundational theories of human development exist to describe and study the biological, social, cognitive, and relational nature of how children develop to adulthood (Erikson, 1950; Hall, 1904). Granville Stanley Hall is acknowledged as the father of adolescent

psychology (Adams, 2000) for his early theoretical conceptualization of adolescent development during the early twentieth century. Hall (1904) postulated that all generations reenact evolutionary changes the human species has experienced throughout evolution. From this perspective, infants crying and crawling were considered to be reenacting a primitive animal like era of human evolutionary history while the uncontrolled and unruly tendencies of middle school children represented the barbaric or savage survival periods of early mankind. Hall (1904) conceptualized adolescence as a period of rebirth for humans, who were first born as members of the animal kingdom with selfish needs and drives based on survival and later during adolescence "reborn" as members of a civilized species. According to Hall (1904) the transition from childhood to adolescence, which Hall defined as a storm and stress period, requires sacrifice of personal wants and selfish needs towards a focus on social responsibility and altruism. This internal struggle that manifest during adolescence is characterized by emotional swings and internal turbulence (Adams, 2000).

Erik Erikson's psychosocial theory of human development was founded on the belief that humans possess innate needs to satisfy biological needs as well as integrate and make sense of past and present experiences (Erikson, 1950). Erikson emphasized through his psychosocial theory the importance of both internal psychological factors and external social factors throughout development. Erikson proposed a model of human development that incorporated eight life-span stages characterized by a stage-specific conflict to be negotiated as part of normal development. The stages are cumulative, meaning that the successful navigation of intra-psychic conflicts at early stages serves as foundation upon which subsequent conflicts will be navigated towards identity formation and personality differentiation whereas failure to successfully navigate conflicts at previous stages may result in identity diffusion. Progressing in personality

differentiation greatly depends on the quality of the social relationships within which each conflict occurs (Erikson, 1968).

Preadolescents are bridging two critical stages of development, according to Erikson's theory: maneuvering the industry versus inferiority stage (ages 6 to 12) and approaching the identity versus role confusion stage (ages 12 to 19; Seifert & Hoffnung, 2000). The developmental task during the industry and inferiority stage for preadolescents is focused on mastering tasks, fostering an internal sense of competence, and viewing self as valuable to external figures, such as parents and teachers. Preadolescents in this stage are typically in school, acquiring a belief in their ability to learn and be productive, beginning to view themselves as contributing members of society. Failure to feel competent and perceive self as able to complete tasks successfully can lead children in this stage to feel inferior. Feeling inferior places the preadolescent as risk for feeling socially alienated which may lead to conforming in order to gain acceptance from others and experience a sense of social belonging.

Preadolescents approaching puberty move towards the next Eriksonian stage of development, identity versus role confusion. Older preadolescents are beginning to reevaluate their sense of self and actively working to integrate their experiences in attempt to construct a unified, stable sense of identity. Seeing themselves as products of previous experiences, adolescents during this stage are striving to achieve self-continuity with the goal of this psychosocial stage being fidelity, the ability to maintain loyalty to values and sense of identity despite inconsistencies or conflicts (Adams, 2000; Seifert & Hoffnung, 2000).

Gemelli (1996) described the emergence of increased social focus during late childhood and early adolescent as a major developmental task of "constructing a beginning social identity" (p. 375). Experiences during infancy and toddler years, including levels of emotional attunement

and learning which behaviors pleased or displeased parents, according to Gemelli (1996), begin to establish children's sense of their social self as the superego develops during childhood. These early social experiences are consolidated throughout development and eventually develop into one's social identity during late childhood and continues to increase in complexity throughout adolescence (Gemelli, 1996).

Influence of Parental Attachment Relationship during Preadolescence

Secure attachment relationships with both parents and peers are protective factors for emotional and behavioral functioning during preadolescence. One of the primary developmental tasks during preadolescence is navigating peer relationships and fostering a sense of social belonging. As preadolescents experience consistent experiences in secure relationships with significant figures, namely their parents, their sense of self incorporates an internal image of being loved, valued, and supported (Gemelli, 1996). As such, parents become relational representations for preadolescents to generate positive inner expectations when initiating new relationships.

For typically developing preadolescents, much of their social support and relational efforts shift from parents to peers during this period of time. However, if preadolescents embark on the important life task of navigating social relationships without a secure relational model first established through connection and relationship with parents or other primary attachment figures, preadolescents may experience difficulty establishing themselves in context of being in heathy relationships with others. Consistent with attachment theory (Bowlby, 1982; 1988), secure attachment relationships with parents develop an internal working model of relationships which provides continuity for adolescents' adaptive functioning and positive coping in intimate

relationships from childhood to adulthood (Bowlby, 1980; Bretherton & Munolland, 1999; Li et al., 2015).

Many researchers have investigated the impact of parent-child relationships on adolescents' relational functioning. Freeman and Brown (2001) examined primary attachment identification to parents and peers in relation to adolescents' attachment style among 99 high school-age adolescents. They found that parents and peers were equally as likely to be identified as adolescents' primary attachment relationship; however securely attached adolescents were more likely to identify parents as their primary attachment relationship compared to their peers rated as insecurely attached, who were more likely to demonstrate preference for peers as their primary attachment relationships (Freeman & Brown, 2001).

Relatedly, Ma and Huebner (2008) examined the quality of parent and peer attachments related to adolescents' perceived level of life satisfaction among 587 middle school age adolescents. Peer attachment partially mediated the relationship between life satisfaction and parent attachment for female adolescents. They found that although peer attachment positively influenced life satisfaction during adolescence, parent attachment was determined to be a stronger, more unique predictor of overall perceived level of life satisfaction for adolescents.

Seifert and Hoffnung (2000) posited that when children become securely attached to their parents during early childhood, those parents and children often enjoy each others' company during middle school years more than insecurely attached parent-child dyads. In efforts to gain a holistic perception of long term impact of adolescent attachment patterns, Pascuzzo, Cyr, and Moss (2013) offered an eight-year longitudinal investigation of adolescent-parent attachment and emotional and relational strategies in adulthood. Quality of attachment to parents by preadolescent children at age 14 predicted degree of anxious romantic attachment style eight

years later at age 22. Attachment to parents was a stronger predictor than peer attachment for anxious romantic attachment relationships, supporting attachment theory that parents provide internal working models of relationships for their children, influencing both peer and romantic relationship acquisition. Relationships between adolescents and parents influence adolescents' development of romantic attachment relationships in adulthood (Pascuzzo et al., 2013).

Given that parent-child relationships serve as a primary relationship model, adolescents' internal experiences, such as self-esteem, anxiety, and affect regulation, may manifest as a result of insecurity in this relational foundation. In 2001, Engels, Finkensauer, Meeus, and Dekovic utilized structural equation modeling to estimate the relationship between adolescent-parent attachment and emotional adjustment among a sample of 412 12-18 year olds. Relational competence and parental attachment were strong predictors of adolescent emotional adjustment, highlighting that the adolescent-parent relationship can provide a foundation for social and emotional skills that adolescents utilize for the initiation and maintenance of peer relationships. Despite adolescents navigating developmentally-typical, increased autonomy and independence from parents, the adolescent-parent relationship continues to play a critical role in adolescents social and emotional functioning (Engels et al., 2001).

Further, Howard and Medway (2004) investigated 75 adolescent-parent dyads and explored how attachment impacts how adolescents cope with stress. Securely attached adolescents' level of stress was related to increases in family communication and decreased negative or avoidant coping strategies. Insecurely attached adolescents were more likely to avoid positive coping strategies when faced with stress. Increasing the quality of adolescent-parent attachment relationships fostered adolescents' use of effective coping which may suggest enhancement of adolescents' ability to adjust to stress later in life (Howard & Medway, 2004).

Preadolescent Behavioral and Emotional Concerns

Internal emotions resulting from insecurity within parent-child relationship can lead to difficulty regulating emotions and inaccurate representations of self in context of others, which may manifest externally as behavioral problems for preadolescents as they struggle to express their internal emotions and insecurities. Al-Yagon, Kopelman-Rubin, Brunstein Kllomek, and Mikulincer (2016) explored the impact of adolescent-parent attachment relationships on loneliness and school functioning among 356 Israeli junior high students. Findings suggested that secure adolescent-parent attachments, to the parental unit as a whole, yield optimal adolescent social and emotional functioning whereas insecure adolescent-parent attachments yield poorer adolescent outcomes. When relationships are perceived to be unsafe or non-nurturing from previous experiences, initiating and maintaining new relationships may be scary and anxiety-provoking due to this inconsistent representational model of relationships and not knowing what to expect from others. (Purvis et al., 2013).

Further, Tambelli, Laghi, Odorisio, and Notari (2012) explored how attachment relationships impact internalizing and externalizing problems in a sample of 816 adolescents ages 11-19. Secure attachment relationships to both parents and peers were protective factors for adolescent emotional and behavioral functioning. Adolescents who experienced internalizing and externalizing behaviors reported anger toward parents and perceived a strong sense of rejection by their parents. Tambelli et al. (2012) pointed out that parents' influence the kind of peers with whom their children affiliate not only through social class and modeling values, but also by offering their children a relational model for navigating extra-familial interpersonal relationships.

From a sample of 6301 Chinese adolescents, Li et al. (2015) investigated how perspective taking and empathic concern influence the connection between child-parent attachment and

indirect aggression during preadolescence. Results indicated that parental attachment and empathic concern predicted indirect aggression. Additionally, parental attachment was negatively correlated with indirect aggression (Li et al., 20115). de Vries, Hoeve, Stams, and Asscher (2016) examined the associations between adolescent externalizing behavior and child-parent attachment among 102 adolescents at-risk for developing delinquent behaviors. They found that affiliation with deviant peers and low parental monitoring significantly impacted the relationship between adolescent-parent attachment and delinquency. Poor adolescent-parent attachment and aggression was mediated by adolescent cognitive processes (de Vries et al., 2016).

Duchesne and Larose (2007) examined how the quality of adolescents' attachment to their parents influence academic motivation and school functioning. Adolescents' attachment to their parents was positively correlated with academic motivation, suggesting that adolescents who experience secure parental attachment were more likely to feel confident in the school environment and perceive positive support from teachers which further enhanced academic motivation (Duchesne & Larose, 2007). Phaik Ooi, Ang, Fung, Wong, and Cai (2006) also explored how parent-child attachment affects preadolescent behavioral and emotional experiences using multiple regression analysis with a sample of 91 boys, ages 8-12, who exhibited disruptive behaviors. They concluded that higher rated quality of parent-child attachment predicted lower level of children's aggression and social stress and higher self-esteem (Phaik Ooi et al., 2006), indicating that higher quality parent-child attachment impacted the boys' behavioral and emotional experiences.

Roisman et al. (2010) conducted a longitudinal study of 1,364 children from ages 1 month to 15 years across to examine the onset of antisocial behavior during adolescence as

measured the CBCL and Youth Self-Report (YSR). Compared to their peers, children who demonstrated early-onset and persistent antisocial behavior experienced higher contextual adversity, such as poor parenting, poverty, and absence of a primary caregiver, as well as a greater number of intra-individual disadvantages, such as health problems, difficult temperament, and cognitive deficits, from infancy through mid-adolescence (Roisman et al., 2010). Additionally, children who exhibited antisocial behavior problems primarily during adolescence were reportedly also more disadvantaged infancy through mid-adolescence (Roisman et al., 2010).

Parental Stress and Emotional Responsiveness during Preadolescence

Although presenting a thorough and complete review of literature pertaining to the interpersonal neurobiology of relationships is beyond the scope of this literature review, it is critical to acknowledge the scientific evidence supporting the criticalness of parent-child connection. Attachment disruptions occurring even as early as prenatally and during infancy impact the structuring of the brain (Badenoch, 2008). The resonance between primary attachment figures and child is an experience of neurological interpersonal integration whereby the child's brain is stimulated by the parent's emotional attunement and responsiveness and vice versa, creating neural pathways that impact brain development and connection (Siegel, 1999).

Badenoch (2008) pointed out that a child's developing attachment style is often parallel to their parent's attachment style due to this intricate dance of interpersonal resonance, or lack thereof, between caregiver and child throughout development. Tronick (2003) estimated that mothers are misattuned with their infants 66% of the time due to a variety of common human experiences, e.g., paying attention to other responsibilities, being tired, getting sick. However, these findings demonstrated that parent-child dyads are able to repair and reconnect following

periods of misattunement. This process of child communicating needs and parental responsiveness and reconnection supports and reinforces the development of a secure relational model. Badenoch (2008) regarded building this parent-child responsive relational model as one of the most valuable attributes parents can instill in their children (p. 101).

Thus, consistent emotional responsiveness from parents is important because adolescents are continually constructing their emotional identities by distinguishing their own thoughts, feelings, and beliefs from those expressed by others (Seifert & Hoffnung, 2000). For example, when parents of younger children express sadness, a younger child is likely to also feel sad; when parents of adolescent children express sadness, adolescents may express and internalize a complementary emotion to their parents' sadness, like fear or disappointment (Harter & Barnes, 1983). In effort to deepen the understanding of how the adolescent brain responds to emotional regulation in the context of the parent-child relationship and provide neurological support for the impact of parental attunement on adolescents' ability to self-regulate, Whittle et al. (2008) investigated the impact of parent-child interactions on a sample of 137 early adolescents' brain structure and affective behavior. A positive association existed between increased amygdala volume and duration of aggressive behavior exhibited by adolescents during parent-child interactions. As adolescence marks a critical period of both biological and relational maturation, increased volume in the amygdala increases the risk and illuminates the predisposition toward sustained negative affect that can interfere with regulation and manifest externally as aggression even later in life (Whittle et al., 2008).

Colman, Hardy, Albert, Raffaelli, and Crockett (2006) examined the predictors of self-regulation in middle childhood in a longitudinal study of a sample of 549 children at ages 4-5 and 8-9. Experiencing parental warmth and low levels physically punitive discipline during

childhood was associated with a greater capacity to self-regulate during middle childhood. When initial levels of self-regulation were accounted for, associations between caregiver influence and child's increased capacity for self-regulation remained significant (Colman et al., 2006), providing support for how influential parenting practices are on children's ability to self-regulate throughout development.

During preadolescence, children are able to see themselves within social context and begin to develop a sense of oneself as belonging to various subgroups within society as a whole (Gemelli, 1996). Because of this, children strive for the opportunity to take an active role in and desire acceptance and positive regard from their microsystem, including family, school, and peer groups (Bronfenbrenner, 1989). Through studying 117 adolescents' perceptions of parent and peer attachment, social behavior, and emotional competence, Laible (2007) provided further empirical support for how imperative parent-child attachment is for adolescent development. He reported that the relationship between parent and peer attachment and adolescent social behavior was mediated by emotional competence. Laible (2007) argued that secure adolescent-parent and peer attachment relationship are associated with more social and emotional competence among adolescents. Experiencing secure attachment relationships to parents and peers influenced social behavior because adolescents in these relationships are able to empathize with others, express emotions, and regulate their affect more successfully than adolescents in insecure attachment relationships (Laible, 2007). Preadolescents are embarking on a developmental period involving an active and constant process of constructing their sense of self, a process requiring their self-concepts to become increasingly organized and complex (Damon & Hart, 1992). Because preadolescents are constantly re-envisioning and revising their internal sense of self, they thrive in environments which support and encourage this internal exploration and autonomous process

working towards culminating secure and congruent self-identities in adulthood (Rogers, year; Seifert & Hoffnung, 2000).

Using a structural equation modeling approach, Kocayoruk (2012) investigated how competence mediated the connection between adolescent-parent attachment and adolescents' overall wellbeing and adjustment. Findings supported that the adolescent-parent attachment relationship enhances adolescent adjustment and wellbeing by fostering a high level of perceived competence among adolescents (Kocayoruk, 2012), which compliments the preadolescent developmental tasks of gaining a sense of mastery and competence over their worlds. Environments that offer feedback to promote preadolescents' competence, provide enough challenge that preadolescents must rely on internal sources to problem solve, and support and accept preadolescents' curiosities and independent behaviors, rather than environments which demand extrinsic approval and external control, help to foster internal motivation which further bolsters preadolescents' construction of self.

In discussion of parental impact on preadolescents' process of navigating social relationships throughout development, it is also important to discuss how, just as in any relationship, the parent-child relationship is reciprocal in nature. External factors as well as their children's behaviors and emotionality impact parents' experiences within these relationships which circularly continues to impact both the parent and child's experiences within the parent-child relationship. Hershenberg et al. (2011) examined how adolescent girls' attachment to their parents impacts their emotional response behavior to intimacy in the parent-child relationship. Secure adolescent-parent attachment was associated with adolescents' emotional response behaviors including, overall positivity, increased congruence between verbal content and affect, lower levels of embarrassment, and enhanced emotional regulation. These findings were

maintained even when stress in the adolescent-parent relationship and parents' ability to respond to intimacy were controlled for (Herschenberg et al., 2011). Therefore, Hershenberg et al. (2011) proposed that adolescents who experienced themselves as worthy of their parents' love and trust, characteristics of secure adolescent-parent attachment relationships, were able to display relationship promoting behaviors towards their parent regardless of situational factors present.

Korhonen, Luoma, Salamelin, and Tamminen (2014) explored the association between maternal depression and adolescent psychosocial functioning in a sample of 191 mothers and 192 adolescents, using CBCL and YSR measures longitudinally from mother's pregnancy through child's adolescence. Maternal depression during pregnancy and 2 months postnatal was associated with more externalizing and internalizing problems during adolescence. Maternal depression during early childhood was associated poorer social competence during adolescence. Reccurrent and chronic maternal depression best explained adolescents' overall psychosocial problems (Korhonen et al., 2014). Korhonen (2014) concluded that timing of maternal depression explained the type of psychosocial problems in adolescence, impacted by the children's developmental task at the time of maternal depression. Demidenko, Manionm, and Lee (2015) explored adolescent-parent attachment and communication patterns among adolescents diagnosed with depression. Adolescent girls diagnosed with depression expressed lower perceived paternal warmth and more perceived rejection from parents, lower parental emotional availability, higher paternal negative affect, lower parental attachment, and higher levels of problematic communication. Likewise, the fathers of depressed adolescent girls reported worse communication with their daughters than fathers of non-depressed daughters (Demindenko et al., 2015). These studies highlight the reciprocal nature of parent-child

relationships and essential role parents play in providing experiences of co-regulation for their developing children.

Further examining the impact of parental characteristics and parenting practices, Mothander and Wang (2014) investigated adolescent-parent attachment and social anxiety among a sample of 510 Chinese adolescents. Findings supported that low perceived parental rejection and presence of parental emotional warmth were related to positive adolescent-parent attachment (Mothander & Wang, 2014). Duncombe, Havighurst, Holland, and Frankling (2012) conducted a multiple regression analysis to investigate the impact of parenting practices on disruptive behavior and emotional relegation of 373 Australian children, ages 5 to 9 years old. Parental mental health, inconsistent discipline, negative parental emotional expressiveness revealed the strongest relationships with children's disruptive behavior and ability to emotionally regulate.

Adoptive Families with Preadolescents

The number of adoptions in the United States increased dramatically during the twentieth century; formal court adoption was rare in 1900, and by 1970 the number of annual adoptions finalized peaked at 175,000 (Adoption History Project, 2012). In recent years, approximately 125,000 children are adopted annually in the United States, including domestic and international adoptions (Adoption History Project, 2012) and it is estimated that 1 in 35 children in the United State is adopted (U.S. Census, 2010). International adoption is estimated to impact more than 40,000 children annually from more than 100 countries (Juffer & van Ijzendoorn, 2005). Approximately 40% of all Americans know someone who was adopted and 1 in 4 Americans consider adoption for their families (Evan B. Donaldson Adoption Institute, 2013).

Brodzinsky (2015), supported by the Evan B. Donaldson Adoption Institute, conducted a large scale survey research study of 1,731 adoptive parents to examine the characteristics and needs of modern adoptive families. Over 74% of the adoptive families surveyed were two-parent, married household and 66% of adoptive parents reported that at least one child whom they adopted was ethically different than them. The vast majority of adopted children were adopted within the first three years of life; however, 12.4% of adopted children were five years or older when they were placed in their adoptive family. Forty-three percent of adopted children were in age groups of middle childhood and preadolescence at the time of data collection (Brodzinsky, 2015).

Seventy-four percent of the respondents' oldest adopted children had experienced one or more pre-placement risks prior to entering their current adoptive family; the top pre-placement risks for older adopted children included prenatal substance exposure, neglect, and orphanage history. Over half of the respondents' oldest adopted children presented with one or more special need, including developmental delays, emotional problems, medical problems, behavioral problems, and learning problems. Over forty percent of the adoptive parents' oldest adopted children had received mental health services with most common presenting concerns of attention, anxiety, attachment problems, and oppositional/defiant behavior (Brodzinsky, 2015).

Importance of Attachment and Early Experiences

Adoptive families face challenges, directly related to the impact of trauma and early adverse experiences on child development and neurobiology, that require adoption competent and trauma-informed professional mental health services to adequately address their needs and qualitatively improve the well-being of children and families post adoption (Livingston Smith, 2014). However, a considerate amount of heterogeneity exists among characteristics of

individuals who have been adopted. For example, the most common form of adoption is stepparent adoption and experiences of these individuals are likely quite distinct from individuals adopted through the child welfare system or internationally (Haugaard, 1998). While the formal process of adoption itself does not directly impact brain development, early experiences and interpersonal relationships do (U.S. Children's Bureau, 2016).

Early life experiences and caregiver-child relationships lay the foundation for attachment experiences throughout the lifespan (Bowlby, 1980; Carnes-Holt, 2012; Siegel & Hartzell, 2004). Attachment patterns in children's early relationships can profoundly shape how children regulate their emotions and development and maintain relationships in the future (Carnes-Holt, 2012; Seigal & Hartzell, 2004). Children who experienced disruptions in their early attachment relationships often have difficulty feelings safe in relationships. For many adopted children, their initial caregiver relationships did not foster secure attunement and responsiveness to their emotional and physical needs. Early attachment disruption, due to change in caregiver, trauma, or neglect, violate these children's felt sense and their attachment system's inherent expectation for safety and protection through interpersonal connection (Forbes & Post, 2006; Hopkins, 2000; Purvis et al., 2007). Lacking an internal felt sense of security and safe base due to relationship disruptions, adopted children have the potential to experience relational difficulties as they navigate preadolescence, including behavioral problems, insecurity, and anxiety (Feeney, Passmore, & Petersn, 2007).

The brains of preadolescents who experienced early attachment disruptions and/or trauma can become sensitive to perceived threats to maintain safety and expect a lack of caregiver support. However, the brain can be rewired to readjust to secure attachment experiences through ongoing, supportive relationships with caring attachment figures, such as adoptive parents

(Badenoch, 2008; Bowlby, 1982; Child Welfare Information Gateway, 2015; Siegel & Hartzell, 2004). Van den Dries, Juffer, van IjZendoorn, and Bakermans-Kranenburg (2009) conducted a meta-analysis of attachment in adopted children. They reported that children who were adopted after the age of one demonstrated less attachment security than non-adopted children. Adopted children presented with more disorganized attachments compared to non-adopted children. When compared to institutionalized children, adopted children exhibited less disorganized attachments (Van den Dries et al., 2009), providing support that secure attachment experiences with adoptive parents have the potential to reestablish attachment security in adopted children.

Further, Pace, Di Folco, Guerriero, Santona, and Terrone (2015) conducted a pilot study investigating the association of internal working models of attachment between 30 adoptive mothers and 46 late-adopted adolescents, mean age of 13.9, who were adopted between the ages of 4 and 9 years. Using the Friend and Family Interview (FFI) and Adult Attachment Interview (AAI), seventy percent of the preadolescent-parent dyads were in accordance in their attachment classifications, as adoptive mothers with high coherence and low unresolved loss tended to have children classified as securely attached, highlighting the influence of adoptive mothers' attachment on the attachment experience of their late-adopted preadolescent (Pace et al., 2015).

Depending on their early attachment experiences, adopted preadolescents may behave in ways that are characteristic of younger developmental periods, including intense feelings of insecurity, fear, anger, and guilt. Contrasted to their adoptive family's functioning, adopted preadolescents may unintentionally send unclear communication cues to their adoptive parents. Adoptive parents who are eager to connect with their adopted child may feel confused and uncertain how to respond (Carnes-Holt, 2012). Adoptive families often embark on journeys of immense emotional experiences, both positive and negative, and an ample amount of transition

and stress (Child Welfare Information Gateway, 2015). Klahr, McGue, Iacono, and Burt (2010) conducted a longitudinal study of adoptive parent-child dyads assessing conduct problems and parent-child conflict at child ages 9 and 16 and found that parent-child conflict predicted the development of externalized behavioral conduct problems as adopted preadolescents developed into late adolescence.

Wright and Flynn (2006) qualitatively examined the successes and challenges of adolescent adoption. In their study, adolescents and parents reported that the experience of connectedness and relatedness characteristic of being a family as well as increased quality of life significantly contributed to success of adoption. However, adoptive parents and adolescents alike described challenges associated with adoption, including ongoing adolescent behavior problems, sense of grief and loss related to absence of birth family, and family conflict related to discipline. According to Wright & Flynn (2006), adoptive parents feel more competent and less successful when they feel fully committed, informed, and supported from training or counseling. The parent-preadolescent relationship in the context of adoptive families is a partnership (Wright & Flynn, 2006) in which true understanding and mutual communication become essential components to foster rich meaningful attachment between parents and preadolescents.

Sanchez and Palacios (2012) sought to evaluate the family-related factors that predict parenting stress among 156 adoptive families with domestically-adopted adolescent children. Statistically significant correlations were found between adoptive mothers and fathers reported levels of stress on the Stress Index for Parents of Adolescents. Compared to non-adoptive parents, adoptive parents reported higher scores in adolescent domain, indicating they perceive that characteristics of their adolescent child significantly impact stress in the parent-child relationship (Sanchez & Palacios, 2012). Multiple regression analyses revealed that 49% of the

variance in the regression model for parenting stress in adoptive families was explained by the following variables: multiple adoptions, low maternal communication of affect, parental insistence that differences between adopted and biological children existed, and seeking professional help related to adoption (Sanchez & Palacios, 2012).

McGue, Sharma, and Benson (1996) examined adoptive family functioning in US and reported that parental ratings of family functioning demonstrated lower correlation with adopted adolescent child ratings of family functioning than biological adolescent child ratings. Nonbiological children may perceive their adoptive family environment differently than their non-adopted siblings and parents. Because early experiences are not the same for biological and adopted children in the same new family unit and members can have different perspectives on the same situations depending on earlier experiences, families may experience misattunement and misunderstanding at some point, externally or internally, due to these different perspectives. A positive factor is that adoptive parents exhibit an increased disposition for seeking psychological assistance (Miller et al., 2000), serving as advocates for their children. Preadolescence is inherently a period of rapid change and development and, when coupled with adoption related factors, providing effective and available counseling and training services for adoptive families with preadolescents is essential.

Intersection of Development and Adoption-Specific Concerns for Preadolescents

Preadolescents who have been adopted are at increased risk for being identified as having an emotional or behavioral disorder and fifty-seven percent of teens who have been adopted from foster care receive mental health services (Vandivere & McKlindon, 2009). Many children who have been adopted continue to experience ongoing adjustment difficulties, some of which likely intensify throughout the lifespan and can pose risk for healthy development and placement

disruptions (Livingston Smith, 2014). Purvis, Cross, Dansereau, and Parris (2013) described that children who experience early out of the home care, such as in orphanages or foster care, often experience "complex developmental trauma" (p.1), induced by a broad range of experiences including abuse and neglect, natural disasters, medical interventions, and interpersonal relationship disruptions. van der Kolk and Courtois (2005) further defined complex developmental trauma as as ''the experience of multiple, chronic, and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature'' (p. 402).

From a sample of 4,682 adolescents who had been adopted, Sharma, McGue, and Benson (1996) investigated the impact of age at adoption, age groups of 0-1, 2-5, 6-10, and 10+ years, on 12 factors of emotional and behavioral adjustment and family functioning post-adoption, including licit and illicit drug use, negative emotionality, antisocial behavior, prosocial behavior, optimism/self-confidence, interests, amphetamine, school adjustment, parental nurturance, parental involvement, and parental control. The overall functioning of adolescents who were adopted in first year of life, 0-1 years age group, was most similar to the control group; adolescents who were adopted at age 10+ exhibited functioning that was most different from the non-adopted control (Sharma et al., 1996). Those adolescents adopted over age 10 demonstrated statistically significant differences from adopted at age 0-1 group and non-adopted control group on all factors except interests and prosocial behavior, respectively.

Relatedly, Gleitman and Savaya (2011) conducted a study of 169 adolescents who were adopted between ages birth to nine years in Israel to examine how age at adoption and pre-adoption experiences impact their post-adoption adjustment. Approximately 50% of the sample reported history of institutional care and multiple placements pre-adoption. Results from the sample's responses on the Youth Self Report indicated that these adopted adolescents indicated

moderate relationship quality and open communication with parents, typical peer orientation, high self-esteem, and low levels of problem behaviors compared to non-adopted peers. However, Gleitman and Savaya (2011) found a statistically significant association between time spent in institutional care and less open communication with parents.

Juffer and van Ijzendoorn (2005) conducted a meta-analysis of behavior problems and mental health referrals among international and domestic adoptees. International adoptees who experienced early experiences of extreme deprivation prior to adoption exhibited more total problems and externalizing problems than international adoptees without pre-adoption adversity. Overall, internationally adoptees were referred to mental health services more often than non-adopted children; however domestic adoptees presented more behavior problems and were referred to mental health services more often than internationally adopted children (Juffer & Ijzendoorn, 2005).

Having been adopted is not an isolated factor contributing to impairment in adopted adolescents' functioning. Warren (1992) examined epidemiological data of a national sample of 3,698 adolescents, 145 identified as adopted, and indicated that adoption status increased a youth's likelihood of being referred for mental health services and that adopted youth were more likely to be referred even when they displayed few behavior problems (Warren, 1992). More recently, Koh and Rueter (2011) reported that adolescent externalizing behaviors were indirectly associated with adoption status through conflictual parent-adolescent relationship, highlighting that family characteristics account for a significant degree of variance in adopted adolescents' demonstration of externalizing behaviors.

Further demonstrating the impact of the adoptive family system on preadolescent functioning post-adoption, Nilsson, Rhee, Corley, Rhea, Wadsworth, and Defries (2011) studied

conduct problems in adopted and non-adopted adolescents and concluded that adolescents who have been adopted exhibit fewer conduct problems in adoptive families who report higher levels of adoption satisfaction. There were no significant differences between adopted and non-adopted adolescents on overall conduct problems (Nilsson et al., 2011).

Hawk and McCall (2010) conducted a literature review of 18 studies which used the Child Behavior Checklist (CBCL) to examine the behavioral and emotional problems experienced by international, institutionalized adoptees at post-adoption. Age at adoption, specifically children in the samples who were adopted after 6-18 months, was noted as a major factor contributing to the manifestation of more internalizing, externalizing, and attention problems. Another conclusion Hawk and McCall (2010) reported is that post-institutional adopted children typically experienced more problems than samples of non-adopted children and adopted children did not experience institutional care, with behavioral and emotional problems being more likely to manifest, or become more severe, during adolescence. Early caregiver-child interactions that are deficient, often characteristic of institutionalized care, impact later difficulties for these children, laying the social-emotional foundation for these children's general disposition that can become more noticeable and severe in adolescence (Hawk & McCall, 2010).

As part of the Florida Adoption Project, Nalavany, Glidden, and Ryan (2009) conducted a survey research study of 1,865 adoptive parents in the United States to explore the extent that behavioral problems, as measured using the CBCL, mediated the relationship between parental adoption satisfaction and presence of children's learning disorder. Adoption satisfaction was positively correlated with family functioning and adoption preparation and negatively correlated with placement age, child age, internalizing problems, and externalizing problems (Nalavany et al., 2009). Additionally, they concluded that the relationship between learning disorder diagnosis

and parental satisfaction was almost exclusively mediated by child's internalizing and externalizing behavior problems (Nalavany et al., 2009), further demonstrating the impact of preadolescent emotional and behavioral functioning on overall family functioning.

Nalavany, Ryan, and Hinterlong (2009) utilized repeated measures cross-sectional multivariate analyses to explore the severity of externalizing behaviors, as measured by scores on the CBCL, over three years among a sample of 1,136 boys, ages 6 to 18, with pre-adoptive histories of childhood sexual abuse. They reported a significant correlation between externalizing behaviors across the three-year period and pre-adoptive history of childhood sexual abuse. Nalavany et al. (2009) reported significant increases in aggressive behavior at wave 2 of data collection and pointed out that approximately 57% of the boys entered adolescence at this time. Given that adoption services were negatively correlated to clinically significant externalizing behaviors and that externalizing behaviors, especially aggressive behaviors, across the three time periods, they suggested that adoption-competent and responsive services and family interventions are salient in helping children and families with pre-adoptive trauma histories adjust to adoption.

Need for Developmentally Appropriate and Attachment Responsive Services

The majority of youth who re-enter foster care post-adoption do so as pre-teens or teens with these placement disruptions often occurring several years post-adoption, underscoring the criticalness of providing early, ongoing services for adoptive families (Livingston Smith, 2014) and the need for post-adoption mental health services to respond to the pervasive, ongoing emotional, behavioral, and attachment needs of adopted preadolescents. In 2014, only thirteen states were classified as providing substantial post-adoption programming and another thirteen states did not offer any post-adoption services beyond financial subsidy (Livingston Smith).

Adopted children and their families often express high needs for support for trauma and attachment- related concerns (Brodzinsky, 2013); however, their unique needs are too often unrecognized and unmet by general mental health services (Barth, Crea, John, Thoborn, & Quinton, 2005). Livingston Smith (2014) published an extensive report on the nature and extent of publically-funded post-adoption services. Although foster care services have become a national priority, Livingston Smith (2014) highlighted that far less attention is being paid to how these children and their adoptive families are served post-adoption.

In a longitudinal study of 560 adoptive children living in the United States, the California Long-Range Adoption Study, Wind, Brooks, and Barth (2007) explored the influences of pre-adoptive risk and preparation on utilization of post-adoption services. Seventeen percent of the sample were adopted at 4 years of age or older. Adoptive families who utilized general post-adoption services, including case management and support groups, increased from 31% of participants at 2 years post-adoption to 81% of participants at 8 years post-adoption. Accessing clinical post-adoption services, including individual and family counseling, increased from 9% at 2 years to 31% at 8 years post-adoption (Wind et al., 2007). Specific to adopted adolescents, Wind et al. (2007) discussed that as children enter adolescence they may experience an emergence of fearing or wishing for contact with and fantasizing about their biological family and fear rejection from their adoptive family. Relatedly, their adoptive parents may feel challenged to accept their child's developmental process of separation-individuation issues while simultaneously supporting child's interest in biological family, maintaining family emotional bonds and boundaries, and navigating their own fears related to parenting and adoption (Wind et al., 2007).

Dhami, Mandel, and Sothmann (2007) conducted a program evaluation of an adoption support program in Canada to examine the post-adoption service experiences of 68 adopted children and their families. Parents of children who were not adopted as infants reported significantly more concerns about their parenting abilities and lack of post-adoption support than parents of children who were adopted as infants. Additionally, parents of children who experienced abuse or neglect prior to adoption reported significantly more concerns related to children's behaviors, emotional wellbeing, and social relationships than parents of children with no history of abuse or neglect. Thirty-eight percent of parents in this study reported needing post-adoption services when their child became a teenager (Dhami et al., 2007).

And further, adoption adds complexity to the developmental transitions marked of preadolescence and parent-preadolescent relationships. Duchesne and Larose (2007) recommend parenting interventions that provide parents with skills in becoming a source of emotional support for their adolescent. Al-Yagon et al. (2016) highlighted the need for practitioners to develop effective interventions that target and promote the quality of adolescent-parent attachment, encourage collaboration between adolescents and parents, and support parents in providing a secure base for their adolescent children. Strengthening adolescent-parent attachment relationships is preventative in mitigating negative social and behavioral adolescent outcomes (Al-Yagon et al., 2016).

Child-Parent Relationship Therapy (CPRT)

Historical Overview and Description of CPRT

Sigmund Freud (1959) contributed the first documented account to facilitate therapy for a young child, 5-year-old Hans, through the use of Hans' father whom he consulted with during the 1950's. Dorothy Baruch (1949), Natalie Fuchs (1957), and Clark Moustakas (1959) also

began advocating for parental involvement with their children at this time. Filial therapy was first formally introduced as a clinical intervention in 1964 by Bernard Guerney as an outgrowth of child-centered play therapy. B. Guerney (1964) defined filial therapy as "the training of parents of young children to conduct play sessions with their own children in a very specific way" (p. 305). Grounded in child-centered philosophy and as a response to close the national gap between supply and demand for mental health services for children in the 1960's, filial therapy was an innovative approach to train parents to be agents of change in their children's lives (L. Guerney, 2000). The filial therapy approach was developed from the perspective that children's parents have greater emotional impact in children's lives than any other adults and that both children and parents can benefit from parents' increased knowledge and skills in relating to their children (L. Guerney & B. Guerney, 1989).

In 1966, B. Guerney in conjuction with his wife Louise Guerney, and two colleagues, Andronico and Stover, secured national funding to conduct a large research study including 71 mothers and their children who participated in filial groups for approximately one year. Seventy-five percent of these families completed treatment. Results demonstrated positive effects on children's behavior problems and mother's satisfaction with their children. During this study, over 600 parent-child play sessions were observed. From these observations, ratings were collected of mother's empathy, acceptance, involvement, affection, ability to let child lead, and leadership (L. Guerney, 2000). Measures for rating parent-child interactions were subsequently developed and demonstrated reliability and validity (Stover, Guerney & O'Connell, 1971). The Measurement of Empathy in Adult Child Interactions (Stover, Guerney & O'Connell, 1971) was adapted by Bratton (1993) and is still being utilized as a direct observation scale in contemporary

filial therapy research to operationalize and study parental empathic behavior during parent-child play sessions.

Child-Parent Relationship Therapy (CPRT) is influenced by the pioneering works of Louise and Bernard Guerney during the mid-1960's and early 1970's who developed filial therapy, promoted training parents in child-centered play therapy principles and supervising parents during individual play sessions with their children, and emphasized parents' capacities to become the therapeutic agents of change in their children's therapeutic process. In the 1980's, Garry Landreth condensed the Guerney's filial therapy model into a 10-session format, later termed Child-Parent Relationship Therapy (CPRT; Landreth, 1991). In effort to increase research rigor and replication fidelity, the CPRT model was later published into a textbook (Landreth & Bratton, 2005) and manualized as a structured 10-week CPRT model (Bratton, Landreth, Kellam, & Blackard, 2006).

Founded on the principles of child-centered play therapy (Landreth, 2012) and grounded in the developmental understanding of children's socio-emotional and behavioral needs, the overarching goal of CPRT is to strengthen child-parent relationships through the use of play, children's most natural medium of communication (Bratton & Landreth, 2005; Landreth, 2012). CPRT was developed with beliefs that secure parent-child attachment is an essential factor for wellbeing and development and parent-child relationships can be strengthened by providing parents with a developmentally responsive format and skills to respond to their children's emotional worlds.

CPRT is typically delivered in a 10-week format in which parents attend a weekly 2-hour parenting group to learn specific skills grounded in child-centered play therapy that focus on helping parents more effectively attune to their children's underlying emotional and relational

needs, demonstrate empathic responding during interactions with their child, and utilize developmentally responsive choice-giving and limit setting in response to problematic child behavior. Parents practice their new child-centered play therapy skills and attitudes during seven video-taped weekly 30-minute at home play times with their children. The play times offer a safe, warm, and consistent space for parents to be an active participant in child-initiated play and an opportunity for parents to demonstrate unconditional positive regard, understanding, and acceptance of their child, serving as active participant in and witness to child's play (Landreth & Bratton, 2005).

Evidence-base for CPRT

CPRT is a manualized, research-supported mental health intervention with a total of 20 controlled outcome studies demonstrating its effectiveness, including 15 randomly controlled trials and five quasi-experimental designs (Bratton et al., 2006; Bratton et al., 2015). CPRT has been effectively adapted for mentors (Jones, Rhine, & Bratton, 2002) and teachers (Helker & Ray, 2009; Morrison & Bratton, 2010; Morrison & Bratton, 2011; Smith & Landreth, 2003). Since the mid 1990's, researchers aimed to produce controlled outcome research to demonstrate the 10 session, manualized CPRT filial therapy model as an effective and responsive intervention for families and children experiencing a variety of presenting concerns, including childhood sexual abuse, parental incarceration, child behavioral problems, and attachment.

In 1995, Bratton and Landreth conducted the first CPRT outcome research study, examining the impact of CPRT with 43 single parents and their children, ages 3 to 7 years. When compared to the waitlist control group over time, parents who received the 10-week CPRT intervention demonstrated statistically significant reductions in children's behavior problems and parent-child relationship stress and statistically significant increases in parental acceptance and

empathic interactions with their children (Bratton & Landreth, 1995). Landreth and Lobaugh (1998) examined the efficacy of CPRT with 32 incarcerated fathers and their children, ages 4 to 9 years. They found that when compared to the waitlist control group over time, parents in the CPRT group reported statistically significant improvements in parental acceptance, parent-child relationship stress, and children's self-concept (Landreth & Lobaugh, 1998).

Costas and Landreth (1999) examined the effects of CPRT with 26 non-offending parents and their children who had experienced sexual abuse, ages 4 to 10 years. When compared to the waitlist control group over time, parents who received CPRT for ten weeks exhibited statistically significant increases in empathic interactions with their children, parental acceptance and demonstration of unconditional love as well as reductions in parent-child relationship stress. Marked improvements were reported by parents in the CPRT group on children's behavior problems, anxiety, emotional adjustment and self-concept, although these improvements were not statistically significant.

Additionally, researchers have demonstrated that CPRT is also a culturally responsive Intervention for families and children. Lee and Landreth (1995) researched the effects of CPRT with 32 immigrant Korean parents living in the United States with their children, ages 2 to 10 years. When compared to the waitlist control group from pre- to post-intervention, parents in the CPRT group demonstrated statistically significant increases in empathic interactions with their children and parental acceptance and statistically significant reductions in parent-child relationship stress (Lee & Landreth, 1995).

Chau and Landreth (1997) investigated the effectiveness of CPRT with 34 Chinese parents living in the United States and their children, ages 2 to 9 years. They found that when compared to the waitlist control group over time parents in the CPRT group showed statistically

significant improvements in parent-child relationship stress, empathic interactions with their children, and parental acceptance (Chau & Landreth, 1997). In 2002, Yuen, Landreth, and Baggerly conducted a study to investigate the efficacy of CPRT with 35 immigrant Chinese parents and their children, ages 3 to 10 years, who were identified as behaviorally at-risk. Following the 10-week CPRT intervention, parents demonstrated statistically significant increases in empathic interactions with their children and parental acceptance and reductions in parent-child relationship stress and child behavior problems.

Aiming to further establish CPRT as a culturally responsive intervention, Ceballos and Bratton (2010) examined the effects of CPRT with 48 Latino parents and their children. Results indicated that, when compared to the waitlist control group over time, parents in the CPRT group reported statistically significant reductions in their children's externalized and internalized problems and parent-child relationship stress. Notably, 85% of children in the CPRT group moved from clinical levels of behavioral concerns to borderline or normal functioning following CPRT (Ceballos & Bratton, 2010). Similarly, Sheely and Bratton (2010) investigated the efficacy of CPRT as a culturally responsive intervention with 23 low-income African American parents and their children who were at-risk for developing socio-emotional and behavioral concerns. When compared to the waitlist control over time, parents in the CPRT group reported statistically significant reductions in children's total behavior problems and parent-child relationship stress (Sheely & Bratton, 2010).

Specific to adoption, Carnes-Holt and Bratton (2014) conducted the first and only published study to date that directly examines the effects of CPRT for adopted children with attachment disruptions. Sixty-one adoptive parents participated in 10 weeks of CPRT intervention, conducted seven at-home play times with their children, and completed pre- and

posttest measures. Results demonstrated statistically significant findings and large treatment effects for the CPRT group compared to the waitlist control over time in reducing adopted children's externalized problems and total problems scores and increasing parents' empathic interactions with their children as observed by raters blinded to group assignment (Carnes-Holt & Bratton, 2014).

Based on the promising results of the pilot study of CPRT with adopted children (Carnes-Holt & Bratton, 2014), the Donaldson Adoption Institute (DAI, 2014) recognized CPRT as an evidence-based approach for working with foster/adoptive families and regarded CPRT as the parent-child intervention with the most promise for this clinical population. Opiola and Bratton (in-press) conducted a follow up study to Carnes-Holt and Bratton (2014) and echoed findings related to effectiveness of CPRT as mental health intervention for adoptive families.

CPRT with Preadolescents

Although originally developed an early mental health intervention for young children, CPRT has been adapted and utilized with preadolescents in clinical practice (Brown, 2005; Capps, 2012; Carnes-Holt, Meany-Walen, & Ceballos, 2015; Meany-Walen et al., 2014; Packman & Solt, 2004), acknowledging the critical role parents play in their children's lives across development as well as the therapeutic use of expressive arts as a developmentally responsive means for communication during preadolescence. Incorporating creative activities into one-on-one times with preadolescents is developmentally responsive and effective for enhancing emotional expression and relational connection during preadolescence (Bratton, Dillman Taylor, & Akay, 2014; Bratton & Ferebee, 1999; Carnes-Holt, Meany-Walen, & Ceballos, 2015; Meany-Walen et al., 2014; Ojiambo & Bratton, 2014). Parents of preadolescents often feel inadequately prepared to respond to their preadolescent child's emotional and

behavioral fluctuations during this period of development (Baril, Crouter, & McHale, 2007). CPRT provides parents with an opportunity to: interact with other parents to normalize their experiences and receive peer support; learn attachment and trauma informed and developmental appropriate ways of responding to their adopted preadolescent child; and increase confidence and enjoyment in spending time with their preadolescent child (Meany-Walen et al., 2014).

Given that CPRT was originally developed as an intervention for young children, the vast majority of research to support the effectiveness of CPRT has focused on young children's emotional, social, and behavioral outcomes. In response to the gap in published literature pertaining to CPRT with preadolescents, authors have published case examples and descriptive articles, encouraging positive outcomes and providing practical recommendations for adapting CPRT for preadolescents (Brown, 2005; Capps, 2012; Carnes-Holt, Meany-Walen, & Ceballos, 2015; Meany-Walen et al., 2014; Packman & Solt, 2004). Brown (2005) detailed modifications for utilizing filial therapy with adolescents in middle school, including developmental considerations, adaptations of parent materials during CPRT groups, and benefits of activity times between parents and adolescents to strengthen the parent-child relationship. Meany-Walen et al. (2014) published a descriptive chapter and case example of adapting CPRT for preadolescents, including suggestions for modifying the CPRT protocol to be responsive to the developmental and attachment needs of preadolescents. Similarly, Carnes-Holt et al. (2015) and Packman and Solt (2004) provide outlines of modifications to CPRT and case illustrations of CPRT for preadolescents. Capps (2012) provided an overview of the rationale and modifications of the CPRT model when utilized to strengthen foster parent- adolescent relationships.

There are no published outcome research studies on the effectiveness of CPRT with preadolescents. To date, there is only one documented study of the effectiveness of CPRT with

preadolescents and is an unpublished dissertation study (Waruszewski, 2012). Waruszewski (2012) conducted a quasi-experimental, repeated measures research study of twenty-six Christian mothers of preadolescents aged 11 to 14. The 10-week CPRT protocol was shortened to a brief format of 6 weeks and biblical teachings were integrated into the weekly CPRT group sessions. Upon completion of the abridged and adapted CPRT intervention, mothers' scores on the Child Behavior Questionnaire- 20 (Robin & Foster, 1989) and Relationship Frustration score on the PRQ—CA (Kamphaus & Raynolds, 2006) revealed trends of decreased frustration, levels of conflict, and negative communication in the family system; although no statistically significant changes over time were found (Waruszewski, 2012). Although Waruszewki (2012) shortened the CPRT protocol and adapted materials focus primarily on mothers and Christian beliefs, this unpublished study offers preliminary research support for the use of CPRT with preadolescents.

CPRT provides parents with opportunity explore the impact of their own experience of being parented and constructed philosophy of discipline within the safety and universality experienced in a group of other parents with similar experiences (Yalom & Leszcz, 2005). The group component of CPRT allows parents to experience themselves as a parent by receiving direct feedback, support, and encouragement from group members and leaders (Bratton et al., 2006). CPRT is based on strengths-based, person-centered philosophy that parents have the capacity to become more self-regulated and authentic in their interactions, inherently paralleling the goal for their children's outcomes. Group leaders model CPRT skills during group interaction that parents will later use with their preadolescent children during at-home one-on-one times, communicating genuineness, empathic responding, and unconditional positive regard. Because preadolescents have a growing capacity to reflect on their complex inner emotional world, their rules for expressing and processing these emotions must also become more sophisticated

(Gemelli, 1996). Creative activities provide preadolescents opportunities to go beyond verbal communication and utilize spontaneous process to discover innovative solutions and deepen self-expression (Degges-White & Davis, 2011).

Through CPRT, parents are taught how to become the therapeutic agents of change for their preadolescent children through creative activities which provides a foundation for parents to begin to understand and respond to their adopted preadolescents' unique needs, ultimately strengthening the parent-child relationship and fostering secure attachment experiences between adopted preadolescents and their parents (Bowlby, 1988; Carnes-Holt & Bratton, 2014; Purvis et al., 2007). In CPRT, the parent-child relationship becomes the catalyst for healing. Ceballos et al., (in-press) developed the preadolescent-adapted CPRT protocol, utilized in the current study, including developmentally appropriate modifications to language, limit setting, examples, and activities for preadolescents.

APPENDIX B

DETAILED METHODOLOGY

I used a single group repeated measures research design in this pilot study to explore to the effect of CPRT for 11 adoptive families who participated in child-parent relationship therapy (CPRT; Landreth & Bratton, 2006) over four points of measure on parental empathy, child behavior, and parenting stress. I conducted an apriori power analysis using G*Power Statistical Software. I determined that a minimum sample size of 10 participants was necessary to conduct an analysis of differences between related samples across 4 points of measurement. I based G*Power calculation on an alpha level of .05, a power of .80, and a large treatment effect (f = .40). Individual means and standard deviations are also presented to explore the impact of CPRT for individual participants.

Research Questions

The following three research questions were addressed in this study:

1) do participants report improvement in parental empathy throughout participation in CPRT;
2) do participants report improvement in child behavior throughout participation in CPRT;
3) do participants report improvement in parent child relationship stress throughout participation in CPRT?

Definitions of Terms

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

Preadolescents. Preadolescence is a developmentally transitional period between childhood and onset of puberty (Meany-Walen et al., 2014). For the purpose of this study, preadolescents are operationally defined as children between the ages of 8-14.

Adoptive Parent. For the purpose of this study, an adoptive parent refers to a caregiver who has adopted a child through a court process and assumed full responsibility and rights as legal guardian of their child.

Foster-to-Adopt. For the purpose of this study, foster-to-adopt describes parents who are fostering while waiting to adopt the child they are caring for (Helping Hand Home, 2016).

Child-Parent Relationship Therapy (CPRT). Landreth and Bratton (2006) defined Child-Parent Relationship Therapy (CPRT) as:

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

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

Child of Focus. Child of focus refers to an adopted child between the ages of 8 and 14 years identified by the parent as exhibiting problematic behaviors. The child of focus received weekly one-on-one special times with an adoptive parent for the study period. For the purpose of this study, the parent focused on one preadolescent child of focus for all special times.

Parental Empathy. For the purpose of this study, parent empathy is operationally defined as the total score on the Measurement of Empathy in Adult Child Interaction (MEACI) which is comprised of three subscales: Communication of Acceptance, Allowing the Child Self-Direction, and Involvement (Bratton, 1993, Guerney & Stover, 1971).

Child Behavior. For the purpose of this study, total child behavior is operationally defined as the overall total score on the Child Behavior Checklist (CBCL) for ages 6-18 which is comprised of the following two subscales: Externalizing Behaviors and Internalizing Behaviors (Achenbach & Rescorla, 2001).

Parenting stress. For the purpose of this study, parenting stress is operationally defined as the total stress score on the Parenting Stress Index (PSI) which is comprised of two domains: Child Domain and Parent Domain (Abidin, 1995).

Participants

Participants were 11 adoptive parents of preadolescents who were recruited from a large metropolitan area in the southwest United States. In order to participate in the present study, adoptive parents met the following inclusion criteria: parent was at least 18 years of age; parent identified as being an adoptive or foster-to-adopt parent/caregiver of a preadolescent child between the ages of 8 to 14; parent was able to speak and read English; parent reported clinical or borderline child behavior problems on the CBCL; parent consented to participate in the study; parent completed CPRT intervention; and parent participated in all data collection.

Nineteen parents began the study. All parents were designated to a CPRT group based on geographic location. I facilitated three CPRT groups in three areas across a metropolitan area. Four parents who initially participated in the CPRT intervention dropped out prior to completion of the CPRT intervention and did not complete mid or post test data collection. Of the remaining

15 parents, four were removed from the study: 3 due to incomplete data and one due to disrupted placement. Examinations of demographics and baseline data revealed little differences between completers and non-completers, with the exception of ethnicity. Of the 5 parents who did not complete this study, their reported ethnicity was 100% European American whereas completers were more ethnically diverse as a group. A total of 11 parent-child dyads completed CPRT and all data collection and were included in data analysis for the present study.

Parents' ages ranged from 25 to 64, with a mean age of 50.1. Preadolescent children of focus ages ranged from 8 to 14, with a mean age of 10.3. Parents reported their ethnicity as 56% European American, 27% Asian, 9% Hispanic, 9% Black American. Parents reported their preadolescent children's ethnicity as 56% Hispanic, 33% European American, and 11% Black American. Fifty-five percent of parents identified as male and 45% as female; preadolescents were 56% male, 44% female. All parents in this study were married. The majority of participants (91%) attended CPRT with their spouse/partner. Regarding sexual orientation, 82% of parents identified as straight and 19% parents identified as gay. All preadolescent children of focus were adopted out of foster care (27% less than 1 year ago, 27% three years ago, 45% more than six years ago). In regard to family composition, parents had a range of 1 to 8 children total (18% one child, 27% three children, 36% four children, 18% seven children, 18% eight children). Of their total number of children, parents had either no biological children (55%) or two biological children (45%). Of the biological children reported, all were adult children living outside the home. No parents reported having biological children living in the home at the time of study. Overall, in regard to children living in the home at the time of the study, five parents had 1 adopted child, two parents had 4 adopted children, two parents had 6 adopted children, and two parents had 7 adopted children. No parents or children were receiving additional counseling

services during the study. The distribution of gender, age, ethnicity, and marital status across parent participants is displayed in Table B.1.

Table B.1

Demographic Information for Parent Participants (N = 11)

Demographic Variables		Number of Parents
Sex	Male	6
	Female	5
Age	20-29	2
	30-39	0
	40-49	2
	50-59	5
	60-69	2
Sexual Orientation	Straight	9
	Gay	2
Ethnicity	European American	6
	Black American	1
	Hispanic	1
	Asian	3
Marital Status	Married	11

Adoptive parents focused on one adopted preadolescent child throughout the study. Because 2 families had only 1 adopted child and 2 parents participating in CPRT, both parents in these two families focused on the same preadolescent child during CPRT and special one-on-one times. Thus, the 11 adoptive parents focused on a total of 9 preadolescent children in this study.

Preadolescent children's ages ranged from 8 to 14, with a mean age of 10.33. Fifty-six percent of preadolescents in this study were male and 44% female. Parents reported their preadolescent children's ethnicity as 56% Hispanic, 33% European American, and 11% Black American. In conjunction with parent ethnicity reports, of the 11 parent-child dyads in this study, 7 parent-child dyads were comprised of adoptive parents and children of different ethnic backgrounds.

Parents reported that preadolescent children of focus (n = 9) were adopted at the following ages: < 1 year = 0; 1-2 years old = 4; 3-7 years old = 0; 7-8 years old = 2; 9-10 years old = 1; 11 years old = 2. Overall, all preadolescent children of focus were adopted after 1 year of age and 55.5% were adopted over the age of 7 years old. All preadolescent children of focus were adopted out of foster care. Parents reported their adopted children's length of placement with them as < 1 year = 3; 3 years = 2; 6 years = 1; 7 years = 1; 8 years = 1; 10 years = 1. Overall, five children had been adopted in current placement for 3 years or less and four children had been adopted in current placement for six years or more. No children were receiving additional counseling services during the study. The distribution of age, gender, ethnicity, and adoption related demographics across preadolescent children of focus is displayed in Table B.2.

Table B.2

Demographic Information for Preadolescent Children of Focus (N = 9)

Demographic Variables		Number of Children
Current Age of Child	8 years	2
	9 years	3
	10 years	0
	11 years	0
	12 years	3

	13 years	0
	14 years	1
Sex	Male	5
	Female	4
Ethnicity	European American	3
	Black American	1
	Hispanic	5
	Asian	0
Age of Child When Adopted	< 1 year	0
	1-2 years old	4
	3-7 years old	0
	7-8 years old	2
	9-10 years old	1
	11 years old	2
Length of Placement with Parents	< 1 year	3
	3 years	2
	6+ years	4
Adoption Source	Foster Care	9

Instrumentation

Child Behavior Checklist for ages 6-18—Parent Version

The Child Behavior Checklist for ages 6-18 (CBCL/6-18; Achenbach & Rescorla, 2001) provides a measure of caregivers' views of children and adolescents' school and social competencies, behavior functioning, and problems. The CBCL is comprised of 120 items. For each item, respondents select one response from three possible response options that describe

various problem behaviors exhibited by children and adolescents. Respondents indicate whether or not their child demonstrates each item's specifically stated problem behavior as follows: 0 for not true, 1 for somewhat or sometimes true, or 2 for very true or often true. The CBCL requires approximately 20 minutes to complete and can be scored by hand or computer. The CBCL also includes several open-ended questions to allow respondents to report any behavioral observations. A decrease in syndrome scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2001). The CBCL consists of three scales measuring, Total Problems, Internalizing Problems, and Externalizing Problems, comprised of the following eight syndrome subscales: (a) Anxious/Depressed, (b) Withdrawn, (c) Somatic Complaints, (d) Social Problems, (e) Thought Problems, (f) Attention Problems, (g) Rule Breaking Behavior, and (h) Aggressive Behavior (Achenbach & Rescorla, 2001).

The syndrome subscales are categorized as one of two classifications: Externalizing Problems and Internalizing Problems. Internalizing Problems refer to problems experienced within the self and is measured by the following three syndrome subscales: Anxious/Depressed, Withdrawn, Somatic Complaints (Achenbach & Rescorla, 2001). Externalizing Problems refer to children's outwardly expressed behavior and problems that involve conflicts with other people and is measured by the following two syndrome subscales for the 6 to 18 year old version of the CBCL: Rule Breaking Behavior and Aggressive Behavior (Achenbach & Rescorla, 2001).

The normative sample for the CBCL is comprised of diverse populations, including children attending various school and clinical settings, as well as residents of the United States, Canada, Australia, and Jamaica. The overall test-retest reliability of the CBCL is strong ($r = .85$). Coefficients of test-retest reliability for the syndrome subscales of the CBCL are as follows: (a) Anxious/Depressed, $r = .68$; (b) Withdrawn, $r = .80$; (c) Somatic Complaints, $r = .84$; (d)

Attention Problems, r = .78; (e) Rule Breaking Behavior, r = .85; (f) Aggressive Behavior, r = .87; (g) Internalizing Problems, r = .90; (h) Externalizing Problems, r = .87; and (i) Total Problems, r = .85 (Achenbach & Rescorla, 2001).

Parenting Stress Index

The Parenting Stress Index (PSI; Abidin, 1995) assesses characteristics of the child and parent that may contribute to stress in the parent-child relationship. Stressful parent-child systems may be at risk for developing problematic parent or child behaviors. The PSI contains 120 items, including 19 optional Life Stress items. The PSI requires approximately 20 minutes to complete and can be scored by hand or computer. Respondents will complete the PSI by responding to each item in the PSI item booklet and circling their best answer on the PSI answer sheet using the following response options: SA (Strongly Agree), A (Agree), NS (Not Sure), D (Disagree), or SD (Strongly Disagree).

Total Stress is a composite score measuring the amount of stress experienced in the parent-child relationship and is comprised of two domains: Child Domain and Parent Domain. The Child Domain consists of six subscales: 1) Distractibility/Hyperactivity, 2) Adaptability, 3) Reinforces Parent, 4) Demandingness, 5) Mood, and 6) Acceptability. Elevated scores in the Child Domain suggest that child characteristics are significant factors contributing to overall stress in the parent-child relationship. The Parent Domain consists of seven subscales: 1) Competence, 2) Isolation, 3) Attachment, 4) Health, 5) Role Restriction, 6) Depression, and 7) Relationship with Spouse. Elevated scores in the Parent Domain suggest that parent characteristics are significant factors contributing to overall stress in the parent-child relationship. The PSI also measures Life Stress in order to account for stressful life events and circumstances beyond one's control (Abidin, 1995).

The norm sample for the PSI included 2,633 mothers, ranging in age from 16 to 61 and average age of 30.9 years. Ethnic composition of the mother sample was: 76% White, 11% Black American, 10% Hispanic, and 2% Asian. The children who were the focus of the sample's PSI responses ranged in age from 1 month to 12 years of age, with an average age of 4.9 years. Test-retest reliability coefficients were obtained from four different studies. For Parent Domain, test-retest reliability ranged from .69 to.91. For Child Domain, test-retest reliability ranged from .55 to .82. For Total Stress, test-retest reliability ranged from .65 to .96. Normative data for the PSI has also been collected on small samples of 200 fathers and 223 Hispanic parents. The PSI has been validated with diverse populations in the United States and in other countries as well as with various at-risk populations including battered women, negligent mothers, parental drug exposure, teenage parents, and families at risk for parenting problems (Abidin, 1995).

Measurement of Empathy in Adult-Child Interaction

The MEACI (Stover, Guerney, & O'Connell, 1971) is a direct observation measure designed to operationally define empathy in parent-child interactions during spontaneous play sessions. The MEACI is comprised of 5-point bipolar scale ranging from high rating of 1 to a low rating of 5, thus lower scores indicate higher levels of parental empathy. The MEACI yields a total Empathy score including three subscales identified as core aspects of empathy in adult-child interactions: Communication of Acceptance, Allowing the Child Self-Direction, and Involvement. Trained observers rate across the three dimensions during 3-minute intervals of six consecutive rating intervals of adult-child interactions. The MEACI was refined by Bratton (1993) to enhance usability by establishing a coding protocol that included procedures for training raters.

Stover et al. (1971) established inter-rater reliability coefficients for the three subscales. After attending 4 training sessions for collaborative rating, 6 pairs of coders independently rated 7 to 10 twenty-minute live parent-child play sessions. The average reliability correlation coefficients across the 6 coding pairs on Communication of Acceptance, Allowing the Child Self-Direction, and Involvement subscales were .88, .80, and .88 respectively. Seven contemporary studies used the MEACI to examine the impact of CPRT methodology on parental empathy and followed stringent training and coding procedures to establish inter-rater reliability for the MEACI total Empathy score (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Elling, 2003; Glover & Landreth, 2000; Harris & Landreth, 1997). These seven studies adhered to the coding procedures outlined in Bratton's (1993) MEACI training protocol which was adapted from the original scoring criteria and procedures provided by Stover et al., 1971. The MEACI training protocol is provided in the CPRT treatment manual (Bratton et al., 2006). Across the 7 studies, the inter-rater reliability correlation coefficients at post-coding ranged from .82 to .99. Construct validity for the MEACI was demonstrated in a study with 51 mothers who participated in filial therapy training (Guerney & Stover, 1971). Parents' levels of empathic interactions with their children showed statistically significant increases (.005) between the first and third post training play sessions, demonstrating that the scales are extremely sensitive measures of empathic behaviors. For the purpose of this study, the MEACI was adapted to be sensitive to parent-child interactions that are developmentally appropriate for preadolescents. See Appendix I for preadolescent-adapted MEACI scoring directions.

Weekly Ratings of Self-Identified Goals

In effort to collect more individualized data that was personally relevant to each individual participant's presenting concerns in the parent-child relationship, each participant

created a self-identified goal to measure on a weekly basis, from pretest to posttest, throughout their participation in CPRT. At pre-session, I helped parents identify goals to narrow in on one aspect of the parent-child relationship individual parents wanted to see improve by the end of their participation in CPRT. I provided parents with a form and invited each parent to complete this sentence, filling in the blank with their self-identified goal, "This past week, I experienced *(self-identified goal)* in relationship with my child…"

Using a 10-point Likert scale operationalizing the options of none of the time, some of the time, most of the time, and all of the time, provided directly underneath the prompt on individual rating forms each week, parents circled the response that most characterized their experience of their self-identified goal in relationship with their child each week. Once created, self-identified goals remained constant for each parent throughout CPRT, in order to compare change over time. Of important note, these ratings were not standardized and were informal ratings uniquely relevant to each participant. Results of weekly ratings of self-identified goals are not used for comparisons between participants in this study, rather served as an informal assessment of participants' experiences in the parent-child relationship on a weekly basis.

Procedure

I obtained human subjects approval from the University of North Texas Institutional Review Board prior to contacting potential participants. In order to recruit participants, I contacted directors of adoption agencies, adoption support organizations, school districts, churches, private practitioners and community counseling agencies in a large metropolitan area in the southwest region of the United States via telephone and email to discuss the project and provide them with flyers containing a brief description of CPRT and the investigator's contact information to distribute to the families these sites serve. Individual parents contacted me

directly to schedule an intake appointment to determine if parents met inclusion criteria to participate in the study.

Prior to the pre-session, parents completed baseline CBCL and PSI assessments and conducted video-recorded 20-minute special one-on-one times with their preadolescent children of focus to be used for baseline MEACI ratings. Baseline data collection took place in a confidential setting and parents completed assessments in a private room free from distraction. I was present to answer any questions and childcare was provided. Special one-on-one times were recorded in a private room with activity kits which were set up prior to participant arrival. Data was collected again at pretest, midtest, and posttest following the same procedures. 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. See Figure B.1 for overview of study procedures.

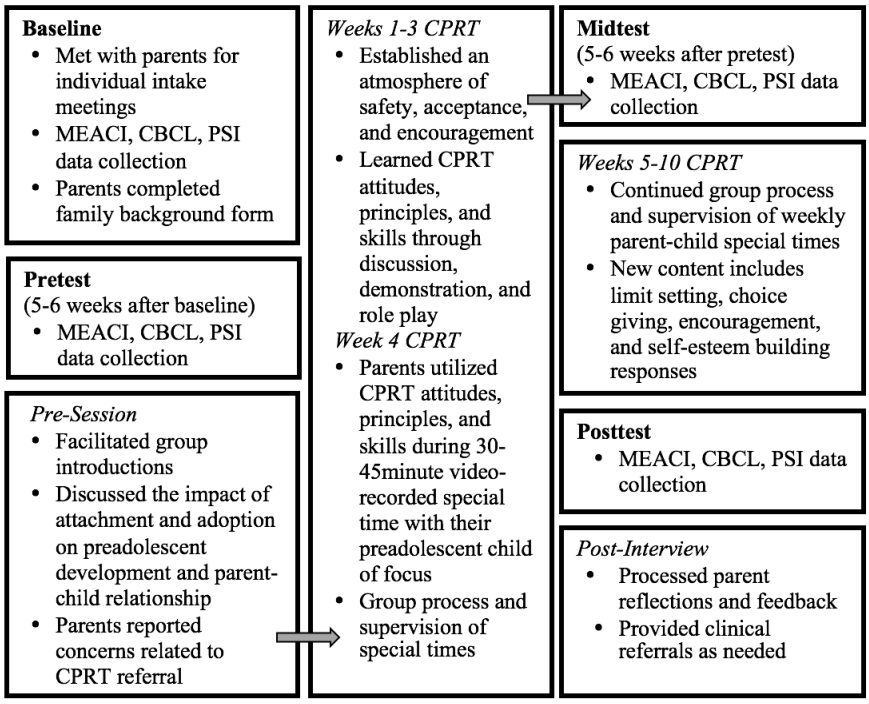

Figure B1. Overview of study procedures.

According to recommendations made by Carnes-Holt and Bratton (2014) and Opiola and Bratton (in-press) who conducted CPRT with adoptive parents, I facilitated an additional session, referred to as pre-session, prior to beginning the 10 weeks of CPRT. During the pre-session, I facilitated group discussions and provided information about the impact of attachment and adoption on preadolescent development and the parent-child relationship. Following 10 weeks of CPRT intervention and posttest data collection, I facilitated post-interviews with all participants to gain feedback about their participation in CPRT and make follow-up and referral plans as clinically warranted.

CPRT facilitators followed the 10-week CPRT protocol (Landreth & Bratton, 2006), adapted for preadolescents by Ceballos et al. (in press), The overarching objectives for CPRT facilitators were: 1) teach and supervise parents in CCPT attitudes and skills, 3) facilitate opportunities through special times for adoptive parents and their preadolescent children to connect in a new, developmentally appropriate way, and 3) support and encourage parents in processing parenting struggles and integrate CCPT skills and attitudes into their way of being with their preadolescent child. During the 2-hour weekly groups, CPRT facilitators offered emotional support and encouraged emotional connection between parents, provided didactic experiences, including treatment manuals, demonstrations, and role-play, and processed and supervised parents' video-recorded special times with their preadolescent children. The balance of teaching, supervising, and facilitating group connection provided parents with ample opportunities to explore their perceptions and feelings about themselves, their preadolescent child, and their parenting experiences while also ensuring that parents learned the CCPT attitudes and skills necessary to facilitate their special times with their preadolescent child of focus.

During the first three sessions of CPRT, we aimed to help the group establish an atmosphere of safety and acceptance to encourage parents to openly share and to normalize parenting experiences (Bratton et al., 2006). Parents learned CCPT attitudes, principles, and skills, through discussion, demonstration, and role play, including being fully present with their child, empathic listening and reflective responding, following the child's lead, understanding verbal and non-verbal content of child's activity or interaction, and the importance of consistency of special times to offer a sense of safety and predictability in the parent-child relationship (Landreth & Bratton, 2006). Prior to session 4, parents facilitated their first video-recorded special times with their preadolescent child of focus. Sessions 4-10 focused on continued support, process, and supervision of parents' video-recorded special times. New didactic content during sessions 4-10 included limit setting, choice giving, encouragement, and self-esteem building responses.

In regard to CPRT facilitators, I led the CPRT groups along with one co-leader; we both identified as European American, straight, and female. Both CPRT facilitators were doctoral level counselors who had completed at least two graduate level courses in play therapy and one graduate level course in CPRT and who received direct supervision from a licensed professional counselor-supervisor and registered play therapist-supervisor with extensive training in play therapy and the CPRT protocol. Free childcare with developmentally appropriate activities and snacks was available each week for all parents. All childcare facilitators were undergraduate and master level research assistants who successfully completed background checks, interviews with lead researcher and attended training, specific to working with adoptees and managing behavior, prior to the start of CPRT. I debriefed with childcare facilitators weekly and provided ongoing training and discussion on choice giving and limit setting. Additionally, video cameras and

preadolescent-adapted CPRT/filial kits described in the treatment protocol (Bratton et al.,2006; Ceballos et al., in-press) were made available for loan to parents to ensure all parents recorded their sessions and had the appropriate play/activity materials. All CPRT sessions were video-recorded for the purpose of weekly supervision and to ensure treatment integrity.

To obtain MEACI data, a team of independent raters, blinded to participant information and time of measurement, rated participants' 20- minute videos of parent-child special times. Four 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 inter-rater 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 inter-rater reliability, checks were performed again at mid and end points of the coding period. Raters demonstrated inter-rater reliability at all three inter-rater reliability training checks.

APPENDIX C

COMPLETE/UNABRIDGED RESULTS

I conducted a non-parametric Friedman test of differences for each independent variable to evaluate the effect of CPRT for 11 adoptive families who participated in CPRT across 4 points of measure. Dependent variables included MEACI Total Empathy, CBCL Total Behavior, and PSI Total Stress scores. A reduction in scores on the MEACI, CBCL, and PSI indicates improvement. Time served as the independent variable, including baseline, pretest, midtest, and posttest points of measure. Data met all assumptions for running individual Friedman tests for each variable.

I established an alpha level of .05 to test for significant differences across time. To test for practical significance of the CPRT intervention, I calculated Cohen's d effect sizes for each dependent variable to determine the magnitude of the differences between baseline and pretest (no intervention) and pretest to posttest (intervention). I interpreted effect sizes using guidelines reported by Cohen (1988), .2 equals a small effect, .5 equals a medium effect, .8 equals a large effect.

Group Results

Group means, standard deviations, and range of scores are reported in Table C.1. The ranges indicate a large spread of data across participants at each data point, indicating that some participants scored higher or lower than other participants on the same assessment at the same data point. Mean scores are impacted by large variations between individual scores as indicated by range values. Change scores presented in Table C.2 demonstrate negligible change or worsening prior to CPRT on all dependent variables. Results demonstrate a decrease in MEACI Total Empathy scores of 11.46 from pretest to midtest and 7.84 from pretest to midtest, indicating overall improvement in parental empathy. Results in Table C.2 also demonstrate slight decrease in Total Behavior scores of 4.19 from pretest to midtest and 3.19 from pretest to

posttest. Results also demonstrate that on average parents reported an increase in parent-child stress of 11.27 from baseline to pretest, prior to CPRT, and a gradual reduction in parent-child stress of 22.09 from pretest to midtest and further improvement of 6.45 from midtest to posttest with an overall improvement of 28.54 from pretest to posttest.

The largest mean differences occurred between pretest to midtest data points for each dependent variable, suggesting parents experienced lower parental stress, lower child behaviors, and higher parental empathy between pre-session and Weeks 5 to 6 of CPRT when they were learning new skills and beginning play sessions.

Table C.1

Mean Scores of Each Dependent Variable across Time (N = 11)

		M	*SD*	Range
MEACI Total Empathy	Baseline	44.91	10.97	34 – 68
	Pretest	44.82	7.16	30.25 – 57
	Midtest	33.36	6.78	21.5 - 43.5
	Posttest	36.98	8.91	23.8 - 53
CBCL Total Problems	Baseline	62.82	8.49	46 - 74
	Pretest	64.55	8.55	46 - 74
	Midtest	60.36	9.89	38 - 73
	Posttest	61.36	10.49	36 - 72
PSI Total Stress	Baseline	246.18	40.16	207 - 340
	Pretest	257.45	43.15	206 - 350
	Midtest	235.36	43.58	181 - 301
	Posttest	228.91	48.00	162 - 316

Table C.2

Change in Mean Scores for Each Dependent Variable across Time (N =11)

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	-.09	-11.46	+3.62	-7.84
CBCL Total Problems	+1.73	-4.19	+1.00	-3.19
PSI Total Stress	+11.27	-22.09	-6.45	-28.54

Note. A decrease in mean scores means an improvement in CPRT participants.

Research Question 1: MEACI Total Empathy

A non-parametric Friedman test of differences among repeated measures was conducted to compare participants' MAECI Total Empathy scores across four points of measure: baseline (mean = 44.91), pretest (mean = 44.82), midtest (mean = 33.36), and posttest (mean = 36.98). Results demonstrated a statistically significant difference across time, $X^2(3) = 15.44$, $p = .001$.

With no intervention (baseline to pretest), participants demonstrated no change in parental empathy scores according to raters blinded to measurement time, with a mean change score of -.09 and a negligible effect size of $d = .009$. During intervention (pretest to posttest), participants demonstrated substantial improvement in parental empathy with a 7.84 mean score decrease and a large treatment effect of $d = .970$.

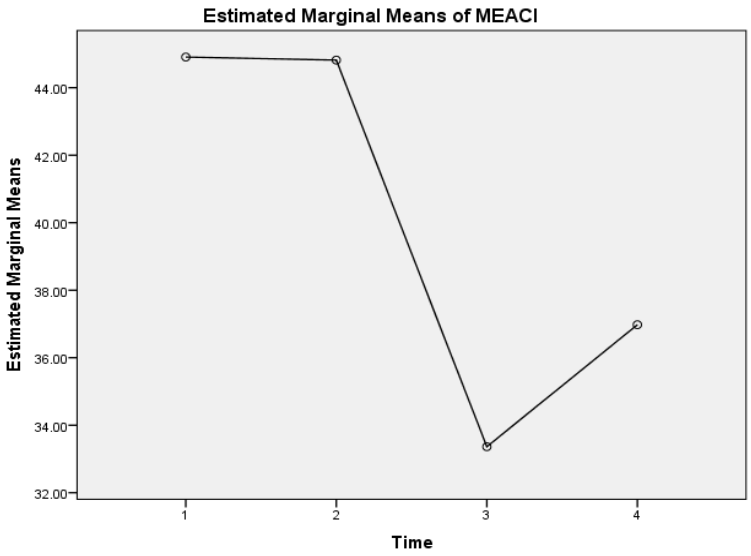

Figure C.1. MEACI Total Empathy group mean scores across time.

Research Question 2: CBCL Total Behavior

A non-parametric Friedman test of differences among repeated measures was conducted to compare participants' CBCL Total Behavior scores across four points of measure: baseline (mean = 62.82), pretest (mean = 64.55), midtest (mean = 60.36), and posttest (mean = 61.36). Results demonstrated a statistically significant difference across time, $X^2(3) = 14.62$, $p = .002$.

With no intervention (baseline to pretest), participant reports demonstrated worsening in child behavior, with a mean change score of 1.73 and a small negative effect size of $d = -.203$. During intervention (pretest to posttest), participants demonstrated improvement in child behavior with a 3.19 mean score decrease and a small positive treatment effect of $d = .333$.

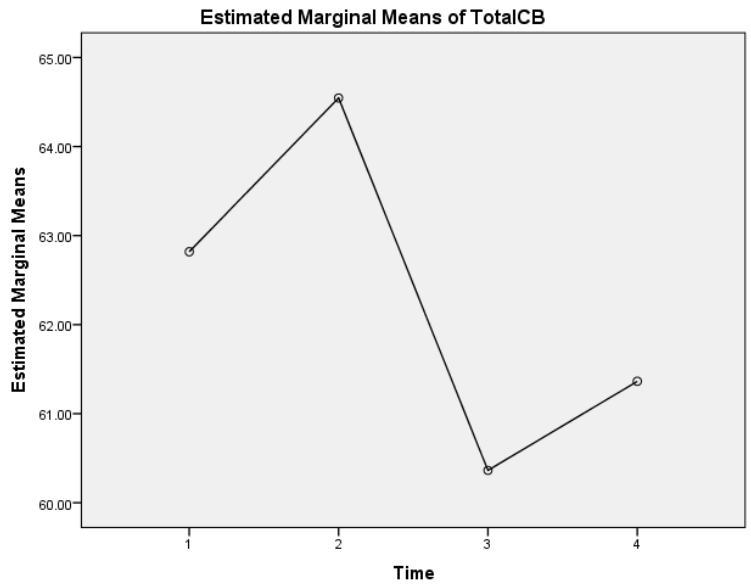

Figure C.2. CBCL Total Behavior group mean scores across time.

Research Question 3: PSI Total Stress

A non-parametric Friedman test of differences among repeated measures was conducted to compare participants' PSI Total Stress scores across four points of measure: baseline (mean = 246.18), pretest (mean = 257.45), midtest (mean = 235.36), and posttest (mean = 228.91). Results demonstrated a statistically significant difference across time, $X^2(3) = 10.75$, $p = .013$.

With no intervention (baseline to pretest), participant reports demonstrated increased parenting stress, with a mean change score of 11.27 and a small negative effect size of $d = -.270$. During intervention (pretest to posttest), participants demonstrated substantial reduction in parenting stress with a 28.54 mean score decrease and a medium treatment effect of $d = .626$.

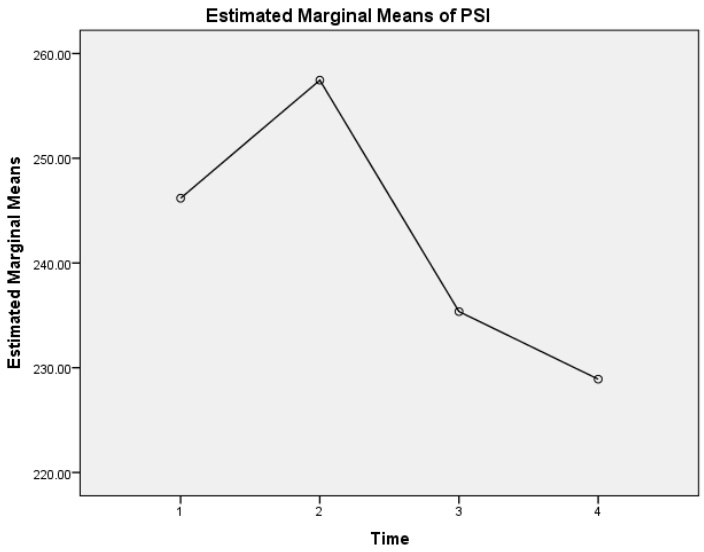

Figure C.3. PSI Total Stress group mean scores across time.

Individual Results

In order to address the mean change for each participant, Tables C.3-C.24 and Figures C.4-C.36 present the individual results on the MEACI, CBCL, and PSI for all adoptive parent-preadolescent dyads. Results for each participant are described in detail below, including results of self-identified goals for each participant. In order to protect privacy and confidentiality while describing individual results, I provided participants with pseudonyms.

Participant 1: Karen

Karen's child of focus during CPRT was her 12-year-old son. At intake, Karen described him as a quiet child with a good heart. Karen reported fear that, as her son gets older, he will follow his older brothers' examples of engaging in disruptive behaviors and delinquent activity. Karen also reported a desire to offer her son a responsive mother-child relationship that he can trust to get his needs met appropriately. Karen's self-identified goal was "to experience a more positive relationship" with her son. Karen completed a total of ten weekly ratings with a rating of 4 at pretest and 7 at posttest. In the last four weeks of CPRT, Karen rated a consistent 7 for her

weekly self-identified goal, indicating stability in her experiencing a more positive relationship with her son "most of the time" by the end of CPRT.

Over the course of the study, Karen demonstrated improvement in MEACI Total Empathy scores, indicating a slight increase in parental empathy toward her son. As represented by a 6.25 decrease in MEACI Total Empathy score from baseline to pretest, Karen demonstrated the greatest improvement in parental empathy toward her son between her intake appointment with lead researcher (baseline) and at the start of CPRT (pretest). Karen's total scores on CBCL and PSI from baseline to pretest indicate worsening prior to participation in CPRT intervention. Karen reported a decrease in CBCL Total Behaviors scores from pretest to posttest, indicating experiencing a slight reduction in child problematic behaviors. She reported decreased PSI Total Stress scores from pretest to posttest, indicating experiencing less stress in the parent-child relationship. Overall, Karen's scores demonstrated overall improvements in parent empathy, child behaviors, and parenting stress throughout participation in CPRT. Tables C. 3 and C.4 provide an overview of Karen's scores for each variable across time.

Table C.3

Karen's Mean Scores for Each Dependent Variable across Time

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	36.5	30.25	28.75	29.75
CBCL Total Behaviors	61	63	59	58
PSI Total Stress	238	234	226	230

Table C.4

Karen's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	-6.25	-1.50	+1.00	-.50
CBCL Total Problems	+2	-4	-1	-5
PSI Total Stress	-4	-8	+4	-4

Note. A decrease in mean scores means an improvement.

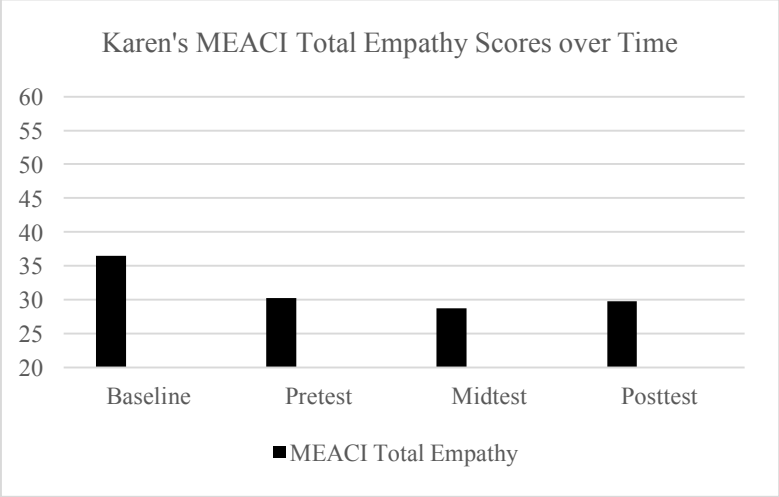

Figure C.4. Karen's MEACI Total Empathy scores over time.

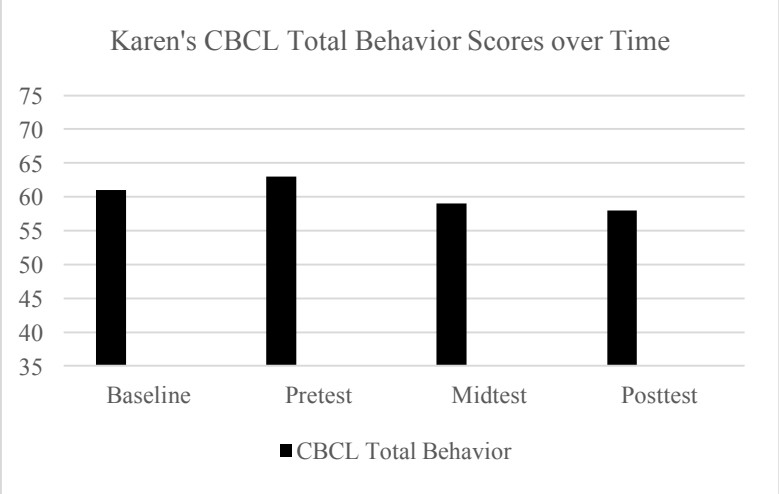

Figure C.5. Karen's CBCL Total Behavior scores over time.

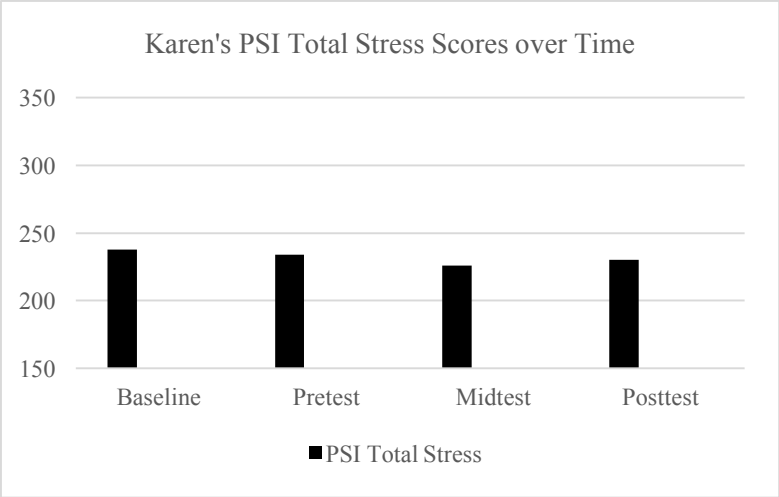

Figure C.6. Karen's PSI Total Stress scores over time.

Participant 2: Jacob

Jacob's child of focus during CPRT was his 8-year-old daughter. At intake, Jacob reported worry for his daughter's future relationships, especially wanting to provide her with the foundation of a healthy father-daughter relationship. Jacob reported a desire to remain connected to his daughter while she navigates preadolescent social and physical changes. Jacob's self-identified goal was "to increase communication and honesty" in relating with his daughter. Jacob completed a total of ten weekly ratings with a rating of 4 at pretest and 7 at posttest and a mode rating of 6 throughout CPRT.

Jacob's baseline to pretest scores for all variables indicate worsening of parent empathy, child behaviors, and parenting stress prior to receiving CPRT intervention. Jacob demonstrated improvement in MEACI Total Empathy scores throughout participation in CPRT, pretest to posttest, indicating an increase in parental empathy toward his daughter. Jacob reported a decrease in CBCL Total Behaviors scores from pretest to posttest, indicating experiencing a reduction in his daughter's problematic behaviors. Jacob reported a decrease in PSI Total Stress, indicating experiencing less parenting stress in relationship with his daughter. Jacob's scores

demonstrated overall improvements in parent empathy, child behaviors, and parenting stress throughout participation in CPRT. Tables C.5 and C.6 provide an overview of Jacob's scores for each variable across time.

Table C.5

Jacob's Mean Scores for Each Dependent Variable across Time

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	40	41.25	28	30.75
CBCL Total Behaviors	66	70	62	62
PSI Total Stress	262	263	264	251

Table C.6

Jacob's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	+1.25	-13.25	+2.75	-10.50
CBCL Total Problems	+4	-8	0	-8
PSI Total Stress	+1	+1	-12	-12

Note. A decrease in mean scores means an improvement.

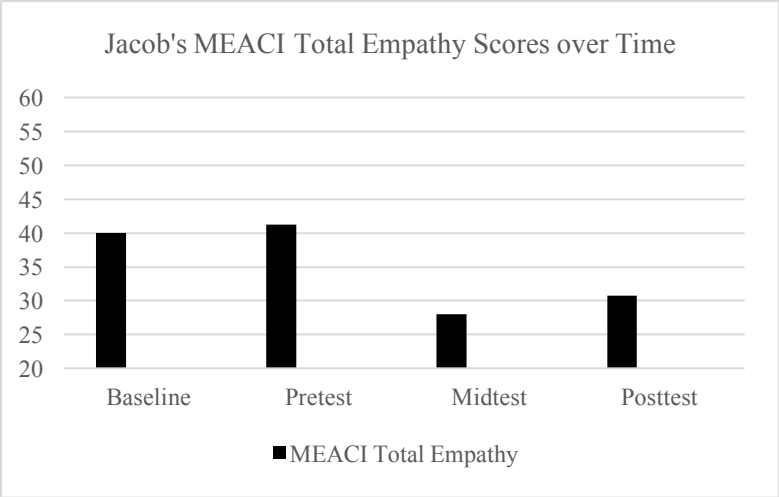

Figure C.7. Jacob's MEACI Total Empathy scores over time.

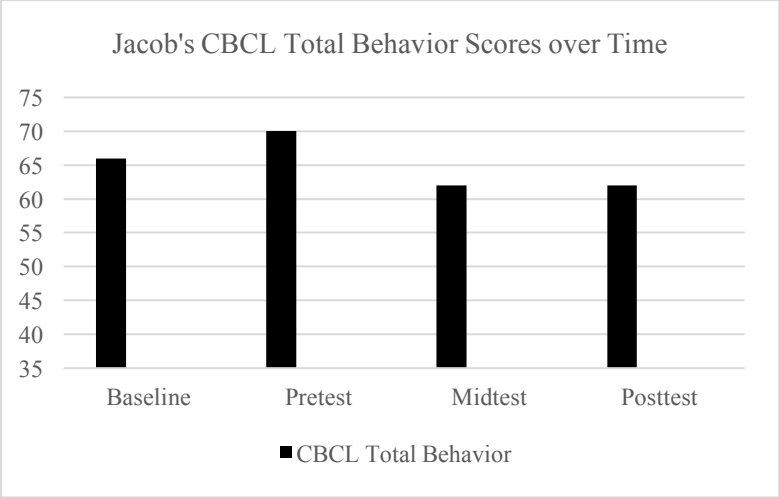

Figure C.8. Jacob's CBCL Total Behavior scores over time.

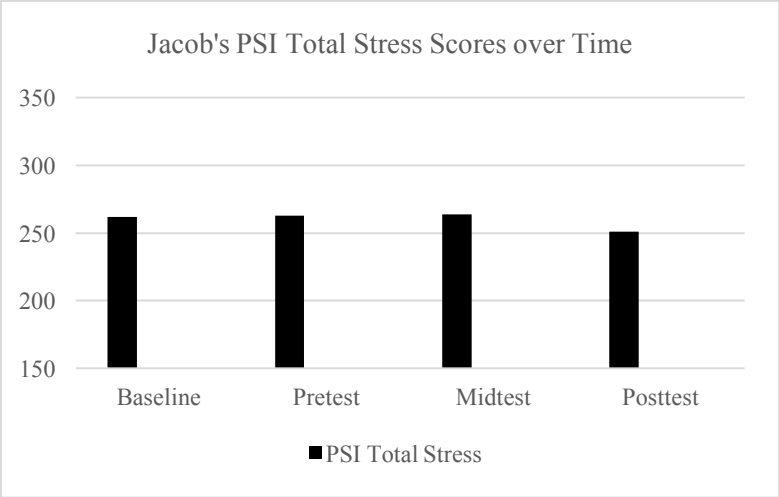

Figure C.9. Jacob's PSI Total Stress scores over time.

Participant 3: Craig

Craig's child of focus during CPRT was his 9-year-old son. At intake, Craig described his son as sweet and smart and also expressed worry related to his tendency to withdraw and internalize distressing emotions. Craig's self-identified goal was "to understand what motivates his son." Craig completed a total of eleven weekly ratings with a rating of 3 at pretest and 9 at posttest. In the last five weeks of CPRT, Craig rated a consistent 9 for his weekly self-identified goal, indicating stability of his self-reported improvement in understanding what motivates his son's behaviors by the end of CPRT.

Craig's scores from baseline to pretest on all variables demonstrate worsening or no improvement of parent empathy, child behavior, and parenting stress prior to receiving CPRT intervention. Craig demonstrated a decrease in MEACI Total Empathy scores from pretest to posttest, with the largest improvement occurring between pretest and midtest, indicating an increase in parental empathy toward his son. Craig reported a gradual decrease in CBCL Total Behaviors scores from pretest to posttest, indicating experiencing a reduction in his son's problematic behaviors. He reported a decrease in PSI Total Stress scores from pretest to posttest,

indicating experiencing less stress in the parent-child relationship. Craig's scores demonstrated overall improvements in parent empathy, child behaviors, and parenting stress throughout participation in CPRT. Tables C.7 and C.8 provide an overview of Craig's scores for each variable across time.

Table C.7

Craig's Mean Scores for Each Dependent Variable across Time

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	38	50.25	29.5	39
CBCL Total Behaviors	46	46	38	36
PSI Total Stress	207	213	204	205

Table C.8

Craig's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	+12.25	-20.75	+9.5	-11.25
CBCL Total Problems	0	-8	-2	-10
PSI Total Stress	+6	-9	+1	-8

Note. A decrease in mean scores means an improvement.

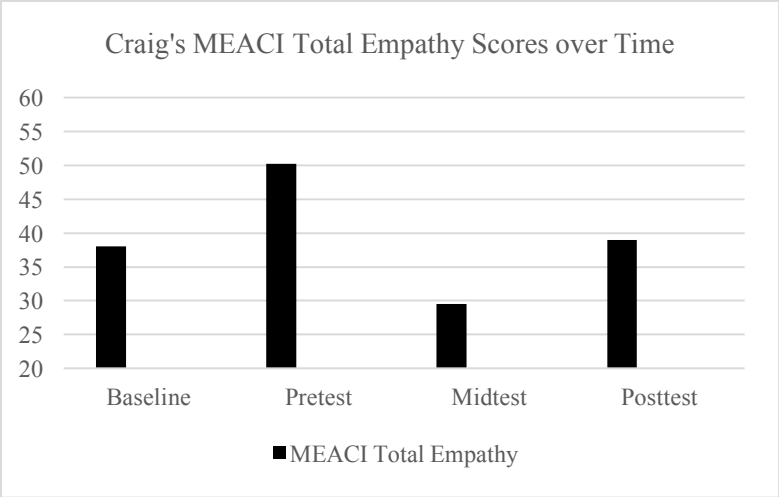

Figure C.10. Craig's MEACI Total Empathy scores over time.

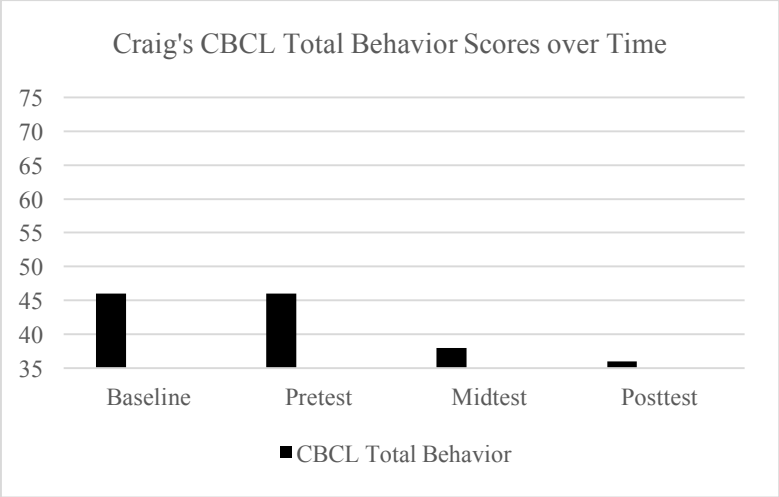

Figure C.11. Craig's CBCL Total Behavior scores over time.

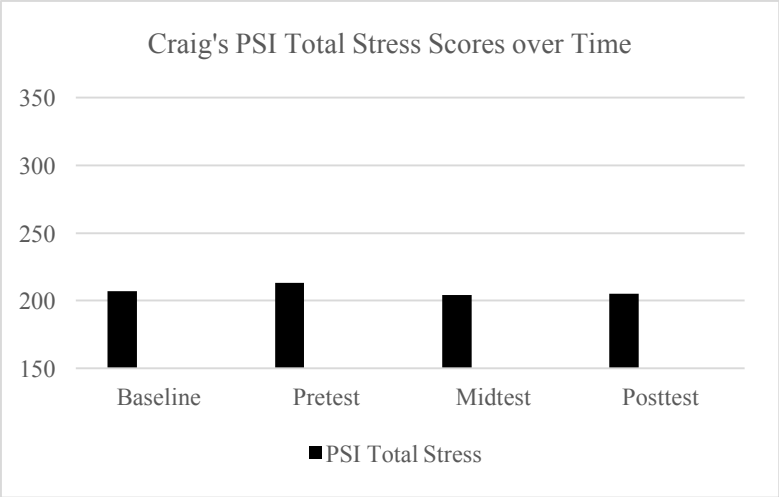

Figure C.12. Craig's PSI Total Stress scores over time.

Participant 4: Henry

Henry's child of focus during CPRT was his 9-year-old daughter. At intake, Henry described his daughter as nurturing and strong-willed. Henry reported high conflict in their parent-child relationship, characterized by frequent power struggles, and he expressed difficulty feeling emotionally connected to his daughter. Henry's self-identified goal was "to get along better and have more positive interactions" with his daughter. Henry completed a total of eleven weekly ratings with a rating of 3 at pretest and 6 at posttest and a mode rating of 6 throughout CPRT.

Henry's scores on MEACI Total Empathy demonstrated notable improvement between intake interview with researcher (baseline) and beginning CPRT intervention (pretest). Henry's MEACI Total Empathy score continued to demonstrated improvement by midtest, with a 12-point improvement between pretest and midtest, indicating an increase in parental empathy toward his daughter. By posttest, Henry's total empathy scores elevated back to pretest range. Henry's scores from baseline to pretest on CBCL Total Problems and PSI Total Stress demonstrated worsening of child behavior and parenting stress prior to receiving CPRT

intervention. Henry reported a decrease in child behavior pretest to midtest and a maintenance of behavior through posttest, indicating experiencing a reduction in his daughter's problematic behaviors. He reported an overall 21-point decrease in PSI Total Stress scores from pretest to posttest, indicating experiencing less stress in the parent-child relationship. Henry's scores demonstrated overall improvements in child behavior and parenting stress and moderate improvement in parental empathy through the midpoint of the CPRT intervention. Tables C.9 and C.10 provide an overview of Henry's scores for each variable across time.

Table C.9

Henry's Mean Scores for Each Dependent Variable across Time

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	59.75	43.5	31.5	45.5
CBCL Total Behaviors	63	67	62	62
PSI Total Stress	226	222	210	201

Table C.10

Henry's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	-16.25	-12	+14	+2
CBCL Total Problems	+4	-5	0	-5
PSI Total Stress	-4	-12	-9	-21

Note. A decrease in mean scores means an improvement.

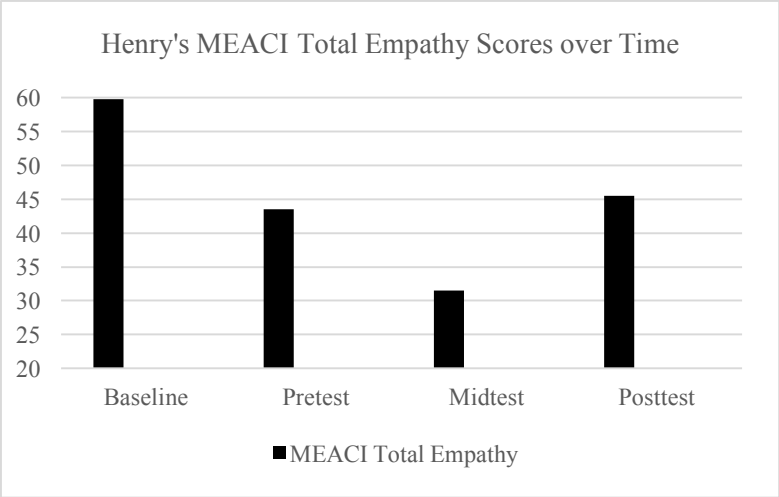

Figure C.13. Henry's MEACI Total Empathy scores over time.

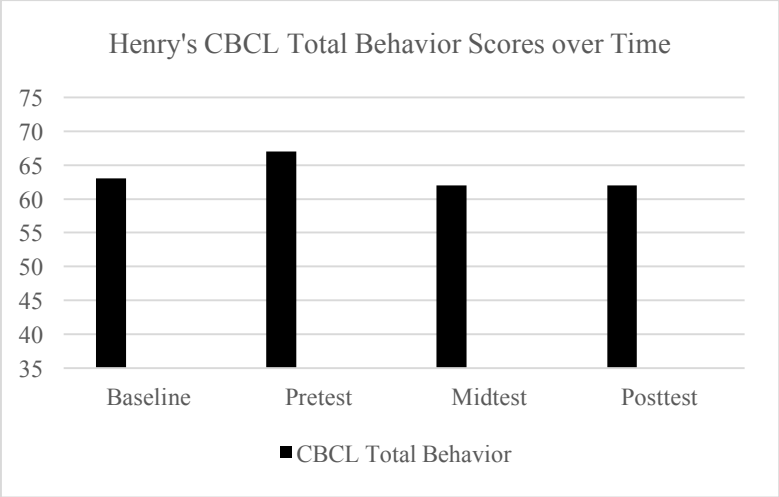

Figure C.14. Henry's CBCL Total Behavior scores over time.

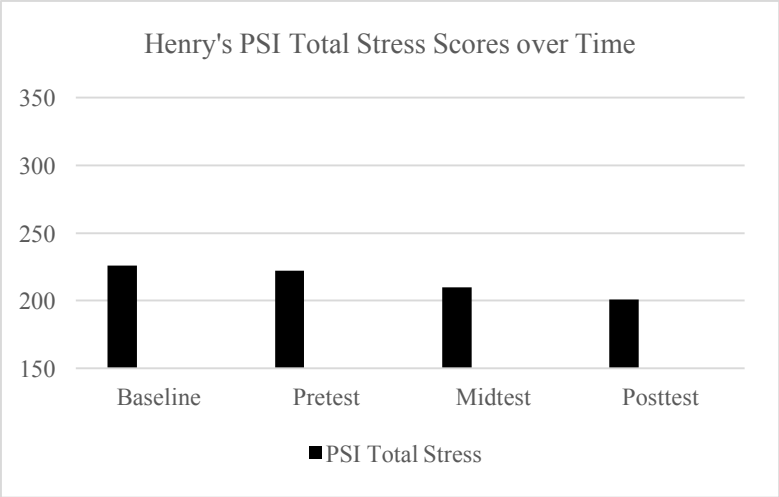

Figure C.15. Henry's PSI Total Stress scores over time.

Participant 5: Pamela

Pamela's child of focus during CPRT was her 12-year-old son. At intake, Pamela reported an eagerness to feel more connected with her son and to better understand his emotional needs. Pamela described her son as self-conscious and reported increasing concern related to his peer relationships. Pamela create two separate self-identified goals to rate each week: 1) "to have more positive communication with her son" and 2) "more hugs" between her and her son. Pamela completed a total of seven weekly ratings for each goal throughout CPRT. Pamela rated her first goal with a 4 at pretest and 9 at posttest. Pamela rated her second goal with a 4 at pretest and 10 at posttest ("all the time"). Pamela's ratings from pretest to posttest indicate Pamela's perception of experiencing more positive communication and increased physical affection in the parent-child relationship by the end of CPRT. During the last CPRT session, Pamela offered a subjective verbal self-report related to her surprise of her preadolescent son's increased desire to seek her out for hugs and emotional affection.

Pamela's scores from baseline to pretest on all variables demonstrated worsening of parental empathy, child behavior, and parenting stress prior to receiving CPRT intervention.

Pamela demonstrated a decrease in MEACI Total Empathy scores from pretest to midtest. However, throughout CPRT, her total empathy scores remained elevated in comparison to her baseline score, indicating a decrease in parental empathy toward her son. Pamela reported a reduction in CBCL Total Behaviors scores from pretest to midtest and pretest to posttest, indicating experiencing a slight reduction in her son's problematic behaviors. Child behavior scores remained at clinical level throughout study. She reported an 83-point reduction in PSI Total Stress scores from pretest to posttest, indicating experiencing less stress in the parent-child relationship. Overall, throughout her participation in CPRT, Pamela reported large improvements in parenting stress scores despite experiencing less change in parental empathy and child behavior. Tables C.11 and C.12 provide an overview of Pamela's scores for each variable across time.

Table C.11

Pamela's Mean Scores for Each Dependent Variable across Time

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	38.25	47.5	42.75	53
CBCL Total Behaviors	68	70	64	66
PSI Total Stress	235	291	199	208

Table C.12

Pamela's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	+9.25	-4.75	+10.25	+5.5
CBCL Total Problems	+2	-6	+2	-4

PSI Total Stress	+56	-92	+9	-83

Note. A decrease in mean scores means an improvement.

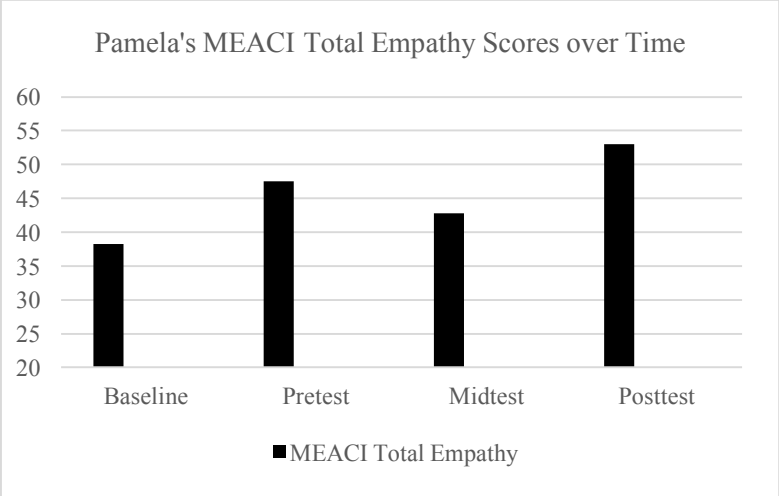

Figure C.16. Pamela's MEACI Total Empathy scores over time.

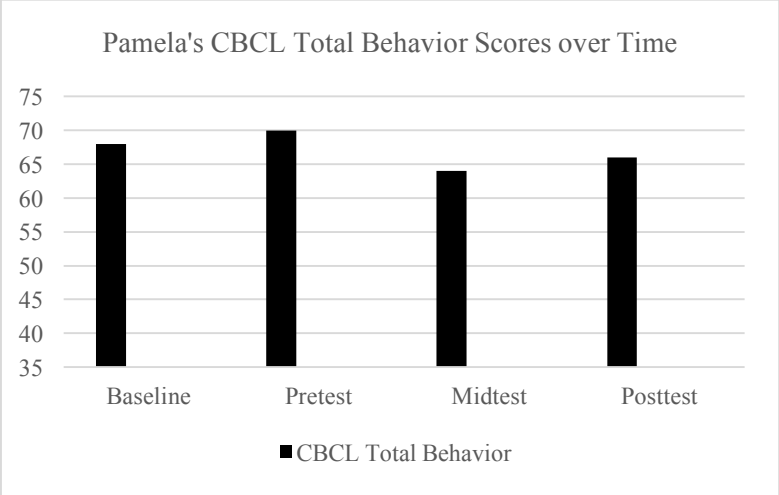

Figure C.17. Pamela's CBCL Total Behavior scores over time.

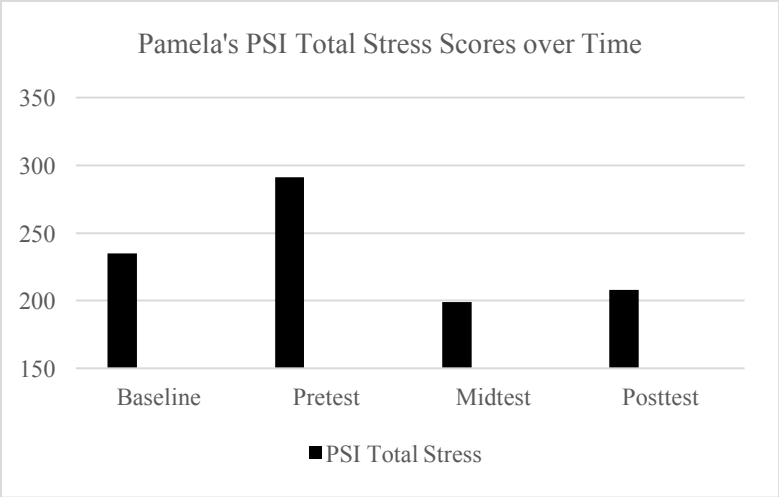

Figure C.18. Pamela's PSI Total Stress scores over time.

Participant 6: Joyce

Joyce's child of focus during CPRT was her 9-year-old son. At intake, Joyce described her son as having high emotional and attention needs, particularly in relationship with Joyce. Joyce described that she often felt exhausted in attending to his needs. Joyce's self-identified goal was "to feel more securely attached" to her son. Joyce completed a total of ten weekly ratings with a rating of 3 at pretest and 7 at posttest, indicating Joyce's perception of feeling securely attached to her son "most of the time" by the end of CPRT.

With no intervention, Joyce's scores from baseline to pretest on all variables demonstrate no demonstrable improvement or worsening of parent empathy, child behavior, and parenting stress prior to CPRT intervention. Following CPRT, Joyce demonstrated a decrease in MEACI Total Empathy scores from pretest to posttest, with the largest improvement occurring between pretest and midtest, indicating an increase in parental empathy toward her son. Joyce reported no demonstrable decrease in CBCL Total Behaviors scores from pretest to posttest, indicating experiencing no to slight reduction in her son's problematic behaviors. In regard to clinical significance, Joyce's pretest to posttest scores of her son's total problematic behavior remained

in the clinical range after CPRT. Joyce reported a decrease in PSI Total Stress scores from pretest to posttest, indicating experiencing less stress in the parent-child relationship. Despite a large difference in her reported parenting stress from pretest to posttest, her decreased parenting stress still remains at a high level.

Overall, Joyce's scores demonstrated improvements in parent empathy, child behaviors, and parenting stress throughout participation in CPRT. Tables C.13 and C.14 provide an overview of Joyce's scores for each variable across time.

Table C.13

Joyce's Mean Scores for Each Dependent Variable across Time

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	34	42.75	21.5	23.75
CBCL Total Behaviors	72	71	69	70
PSI Total Stress	340	350	301	316

Table C.14

Joyce's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	+10.75	-21.25	+2.25	-19
CBCL Total Problems	-1	-2	+1	-1
PSI Total Stress	+10	-49	+15	-34

Note. A decrease in mean scores means an improvement.

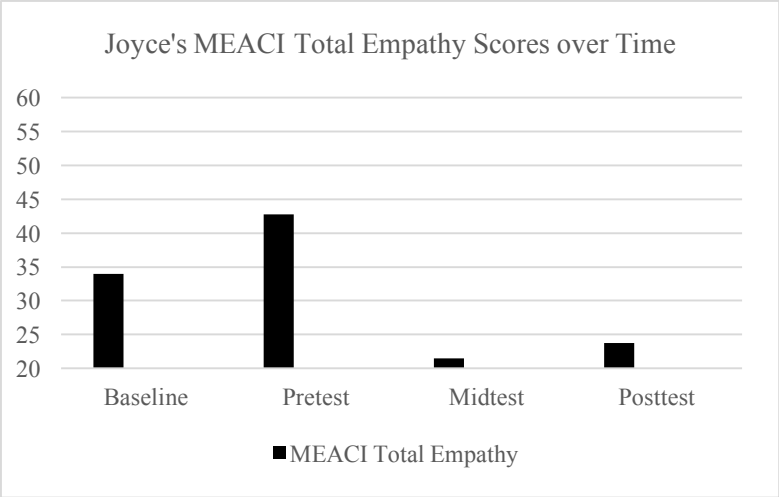

Figure C.19. Joyce's MEACI Total Empathy scores over time.

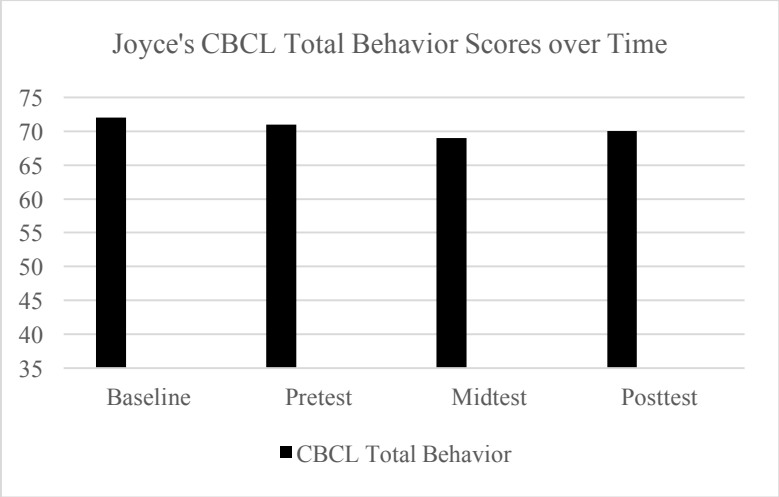

Figure C.20. Joyce's CBCL Total Behavior scores over time.

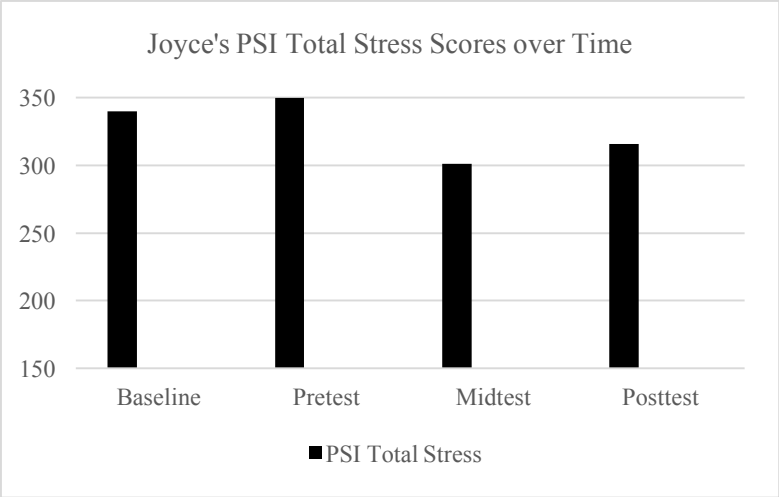

Figure C.21. Joyce's PSI Total Stress scores over time.

Participant 7: William

William's child of focus during CPRT was his 12-year-old daughter. At intake, William described his daughter as fun-loving and emotionally withdrawn at times. William reported concerns related to his daughter's future relationships, particularly with males, as she gets older and a desire to build a stronger father-daughter bond. William's self-identified goal was "to have more meaningful conversations" with his daughter. William completed a total of eight weekly ratings with a rating of 2 at pretest to 6 at posttest and mode ratings of 4 and 5 throughout CPRT.

With no intervention, William's scores from baseline to pretest on all variables demonstrate no improvement or worsening of parent empathy, child behavior, and parenting stress prior to CPRT intervention. Following CPRT, William demonstrated a decrease in MEACI Total Empathy scores from pretest to posttest, with the largest improvement occurring between pretest and midtest, indicating an increase in parental empathy toward his daughter. William reported a large decrease in PSI Total Stress scores from pretest to posttest, indicating experiencing less stress in the parent-child relationship. He reported a decrease in CBCL Total Behaviors scores from pretest to posttest, with the largest improvement occurring between

pretest and midtest, indicating experiencing a reduction in his daughter's problematic behaviors. William's pretest to posttest scores of his daughter's total problematic behavior decreased from clinical to normal levels after CPRT. Overall, William's scores demonstrated improvements in parent empathy, child behaviors, and parenting stress throughout participation in CPRT. Tables C.15 and C.16 provide an overview of William's scores for each variable across time.

Table C.15

William's Mean Scores for Each Dependent Variable across Time

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	37.75	46.25	30.5	34.25
CBCL Total Behaviors	55	64	52	52
PSI Total Stress	207	243	181	162

Table C.16

William's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	+8.5	-15.75	+3.75	-12
CBCL Total Problems	+9	-12	0	-12
PSI Total Stress	+36	-62	-19	-81

Note. A decrease in mean scores means an improvement.

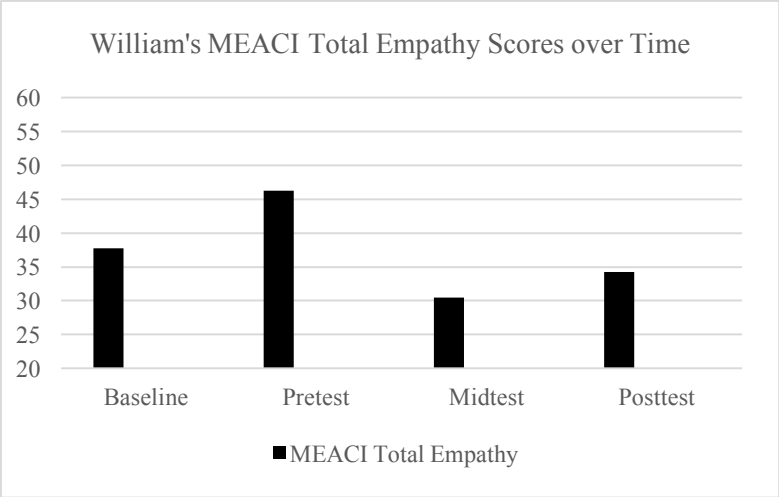

Figure C.22. William's MEACI Total Empathy scores over time.

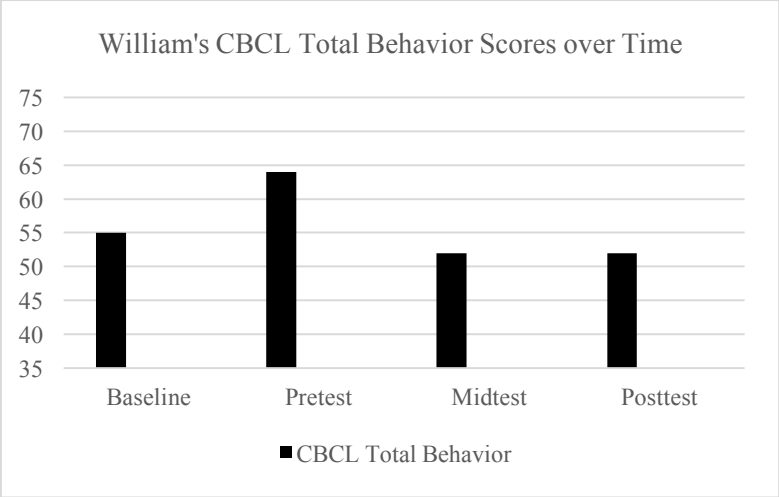

Figure C.23. William's CBCL Total Behavior scores over time.

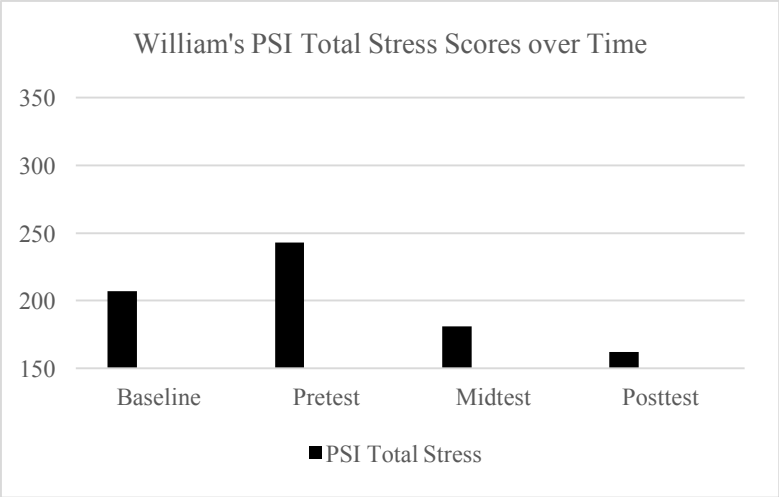

Figure C.24. William's PSI Total Stress scores over time.

Participant 8: Lena

Lena's child of focus during CPRT was her 14-year old son. Lena reported a high level of concern related to her son's lack of motivation, depressive symptoms, and academic difficulties. Lena reported that her son experienced multiple cycles of placement disruptions and reunification attempts prior to current adoption placement three years ago at the age of 11 years old. Lena's self-identified goal was for her son to "feel safer and more secure in the family." Lena completed a total of ten weekly ratings with a rating of 3 at pretest and 6 at posttest and modes of 5 and 7 comprising six of the ten ratings.

Lena's MEACI Total Empathy scores indicated improvement in parental empathy from intake meeting with lead researcher (baseline) and start of intervention (pretest). Lena continued to demonstrate improvements in MEACI Total Empathy scores with a 7.75-point improvement from pretest to posttest, indicating an increase in parental empathy toward her son. Lena's scores from baseline to pretest on CBCL Total Behaviors and PSI Total Stress demonstrated worsening of child behaviors and parenting stress prior to participation in CPRT. Lena reported a steady increase in child behavior problems throughout the study, indicating she experienced her son as

demonstrating increase problematic behavior. Lena reported a dramatic reduction in parenting stress throughout CPRT with a 78-point improvement in parenting stress from pretest to posttest, indicating experiencing less stress in the parent-child relationship.

At midtest, Lena's child disclosed information about his personal identity to his mother that, reportedly, impacted mother's awareness of her child's emotional struggles. Despite increase in child behavior, Lena offered increased parental empathy and experienced decreased parenting stress. Overall, throughout participation in CPRT, Lena's scores demonstrated an improvement in parental empathy and parenting stress and an increase child behavior. Tables C.17 and C.18 provide an overview of Lena's scores for each variable across time.

Table C.17

Lena's Mean Scores for Each Dependent Variable across Time

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	44.75	38.75	33.75	31
CBCL Total Behaviors	56	61	60	68
PSI Total Stress	259	282	222	204

Table C.18

Lena's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	-6	-5	-2.75	-7.75
CBCL Total Problems	+5	-1	+8	+7
PSI Total Stress	+23	-60	-18	-78

Note. A decrease in mean scores means an improvement.

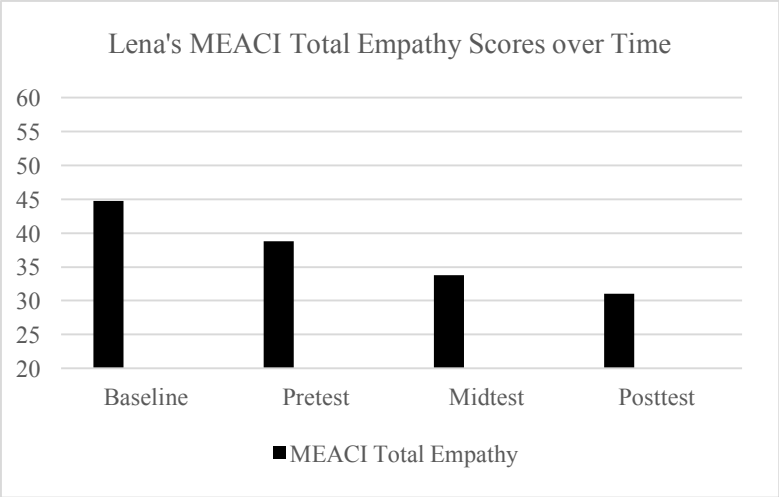

Figure C.25. Lena's MEACI Total Empathy scores over time.

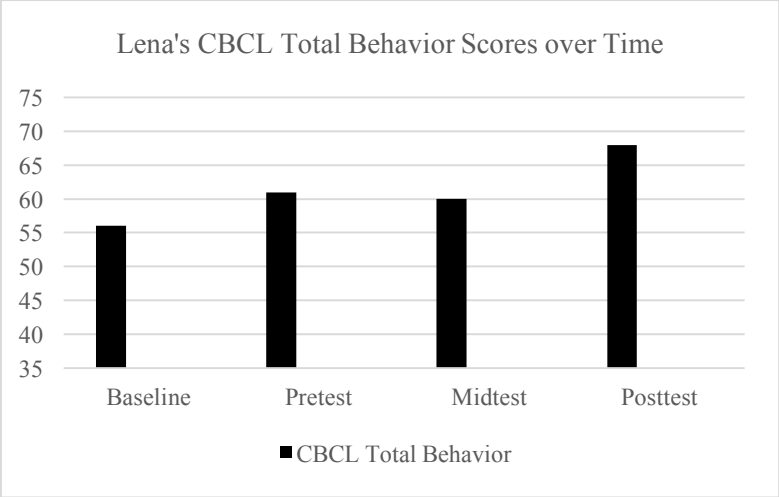

Figure C.26. Lena's CBCL Total Behavior scores over time.

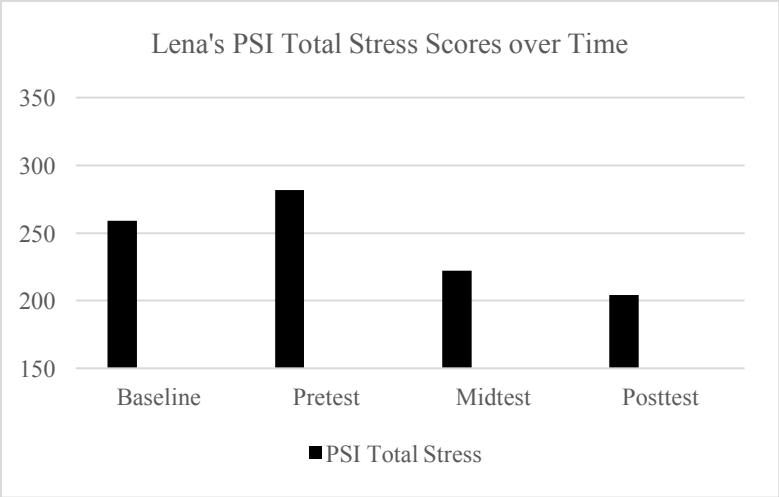

Figure C.27. Lena's PSI Total Stress scores over time.

Participant 9: Aaron

Aaron's child of focus during CPRT was his 14-year-old son. Aaron described his son as withdrawn and reported a desire to feel connected to his son and engage in mutually-interested activity. Additionally, Aaron expressed discipline concerns in the parent-child relationship. Aaron's self-identified goal was "to perceive his son as a good steward." Aaron completed a total of nine weekly ratings with a rating of 2 at pretest and 7 at posttest, indicating a self-reported change in Aaron perceiving his son as a good steward "most of the time" by the end of CPRT.

Aaron's MEACI Total Empathy scores indicated improvement in parental empathy from intake meeting with lead researcher (baseline) and start of intervention (pretest). Aaron continued to demonstrate improvements in MEACI Total Empathy scores over the course of the study, with a 19.75-point improvement from pretest to posttest, indicating an increase in parental empathy toward his son. Aaron's scores from baseline to pretest on CBCL Total Behaviors and PSI Total Stress demonstrated a maintenance of child behaviors and parenting stress prior to participation in CPRT. Aaron reported a slight 2-point decrease in CBCL Total Behavior scores from pretest to posttest. Child behavior remained at clinical level throughout CPRT, indicating

Aaron experiencing his son's problematic behaviors. Aaron's PSI Total Stress scores demonstrated a steady incline from pretest to posttest, indicating experiencing greater stress in the parent-child relationship. Overall, throughout the study, Aaron's scores demonstrated improvement in parental empathy, maintenance of child behavior, and increased parenting stress. Tables C.19 and C.20 provide an overview of Aaron's scores for each variable across time.

Table C.19

Aaron*'s Mean Scores for Each Dependent Variable across Time*

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	68	52.25	40	32.5
CBCL Total Behaviors	74	74	73	72
PSI Total Stress	291	292	322	315

Table C.20

Aaron's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	-15.75	-12.25	-7.5	-19.75
CBCL Total Problems	0	-1	-1	-2
PSI Total Stress	+1	+30	-7	+23

Note. A decrease in mean scores means an improvement.

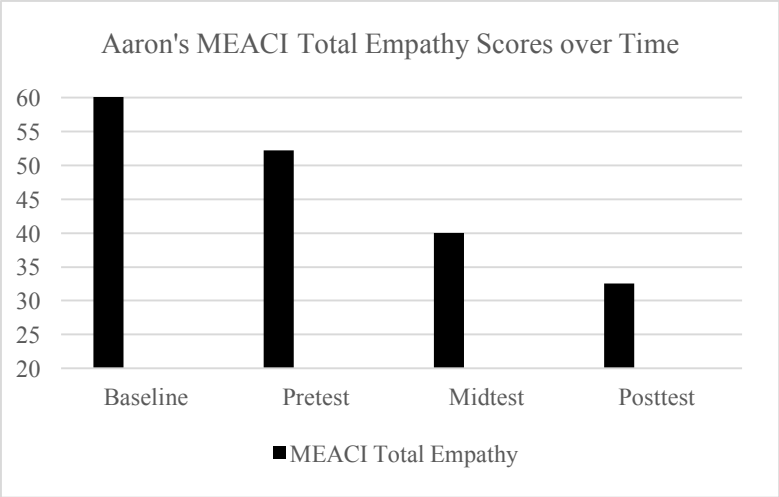

Figure C.28. Aaron's MEACI Total Empathy scores over time.

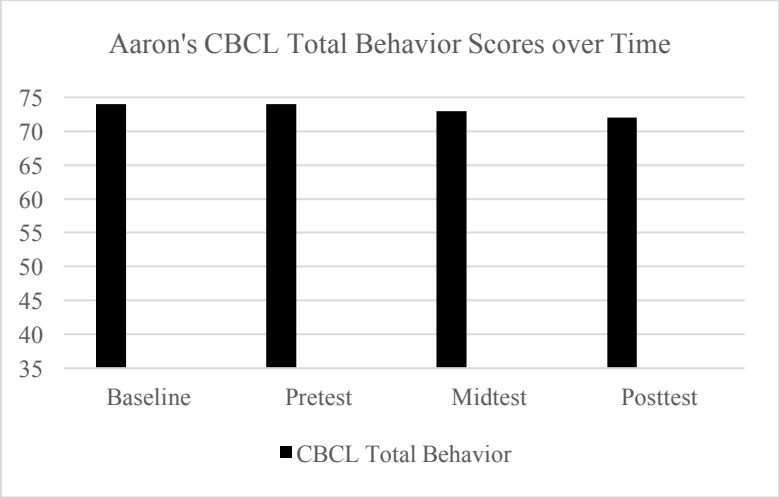

Figure C.29. Aaron's CBCL Total Behavior scores over time.

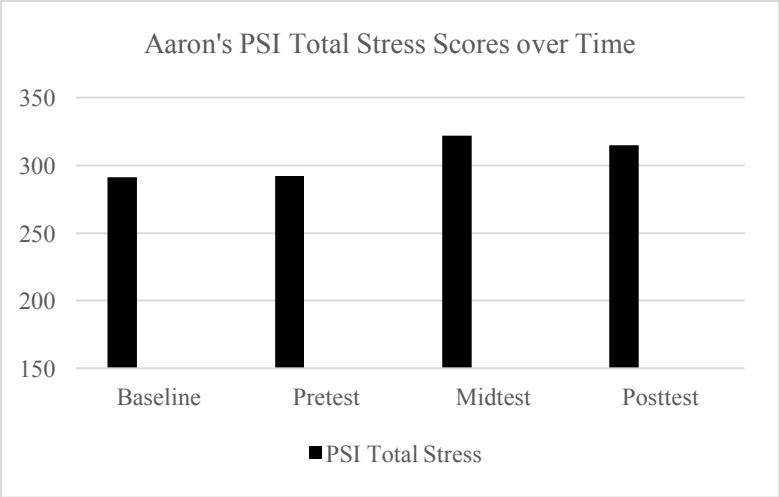

Figure C.30. Aaron's PSI Total Stress scores over time.

Participant 10: Christine

Christine's child of focus during CPRT was her 8-year old daughter. At intake, Christine reported specific concerns related to discipline and hygiene. Christine expressed that her daughter is less connected and more conflictual in relationship to her compared to her husband. Christine's self-identified goal was "to increase her ability to communicate and be in relationship" with her daughter. Christine completed a total of nine weekly ratings with a rating of 3 at pretest and 7 at posttest. By week 3 of CPRT, Christine consistently rated her goal at a 7, "most of the time," for her remaining six ratings until the end of CPRT.

Christine's CBCL Total Behavior scores remained constant across all four points of measure, indicating Christine experienced no change in her daughter's problematic behavior. Christine's MEACI Total Empathy scores from baseline to pretest demonstrated worsening of parental empathy prior to receiving CPRT intervention. Christine's MEACI scores demonstrated a steady improvement in parental empathy with an 18-point change pretest to posttest, indicating an increase in parental empathy toward her daughter.

Christine's PSI Total Stress scores demonstrated reduction in parenting stress from intake meeting with lead researcher (baseline) to start of intervention (pretest). Christine reported an increase in parenting stress from pretest to midtest and then a reduction in parenting stress from midtest to posttest returning to slightly below pretest level by posttest. Fluctuation in her PSI Total Stress scores indicated that Christine experienced greater parenting stress during the beginning of CPRT, in which she was learning play therapy attitudes and skills, and then less stress in the parent-child relationship during the second half of CPRT, in which she was facilitating one-on-one times with her daughter. Overall, Christine's scores demonstrated overall improvements in parental empathy and parenting stress and maintenance of child behavior throughout participation in CPRT. Tables C.21 and C.22 provide an overview of Christine's scores for each variable across time.

Table C.21

Christine*'s Mean Scores for Each Dependent Variable across Time*

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	54.24	57	42.75	39
CBCL Total Behaviors	71	71	71	71
PSI Total Stress	219	206	222	204

Table C.22

Christine's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	+2.76	-14.25	-3.75	-18
CBCL Total Problems	0	0	0	0

PSI Total Stress	-13	+16	-18	-2

Note. A decrease in mean scores means an improvement.

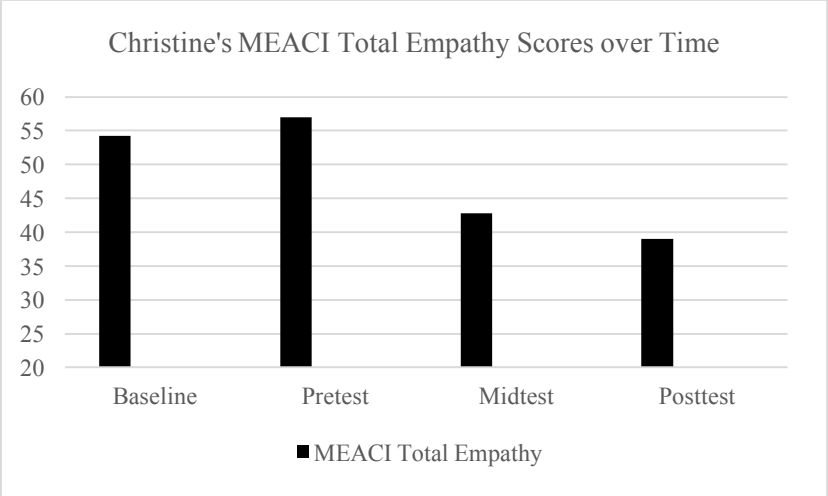

Figure C.31. Christine's MEACI Total Empathy scores over time.

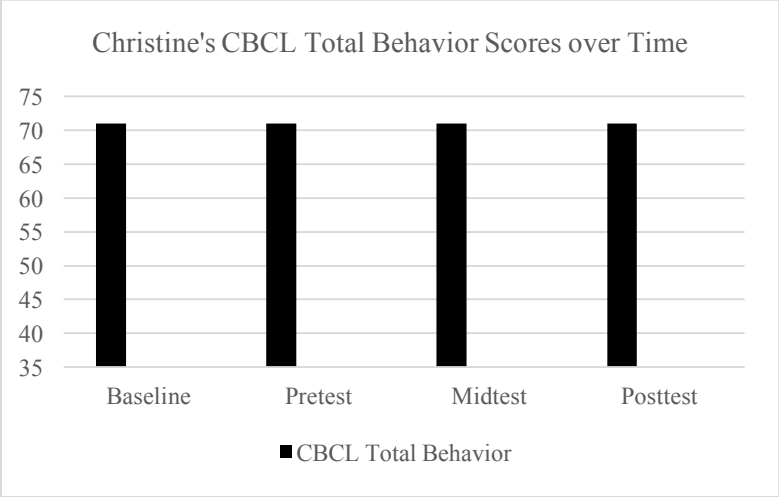

Figure C.32. Christine's CBCL Total Behavior scores over time.

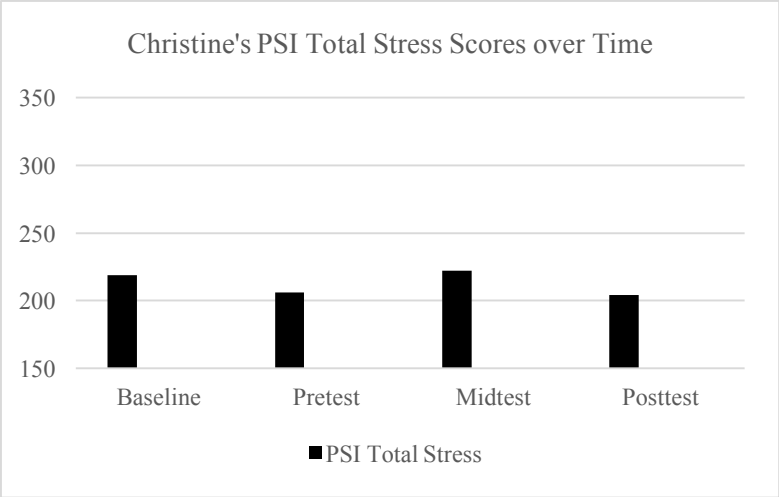

Figure C.33. Christine's PSI Total Stress scores over time.

Participant 11: Ronald

Ronald's child of focus during CPRT was her 8-year old daughter. Ronald described Elena as energetic and nurturing. At intake, Ronald reported experiencing a strong bond with his daughter and expressed concerns related to his daughter's behaviors in relationship with her mother. Ronald's self-identified goal was "to experience improvement in handling Elena's behaviors." Ronald completed a total of nine weekly ratings with a rating of 4 at pretest and 7 at posttest and a mode rating of 6 throughout CPRT.

Per CBCL Total Behavior scores, Ronald reported a decrease in his daughter's problematic behaviors baseline to pretest prior to CPRT intervention. Throughout CPRT, Ronald reported child behavior scores in normal range on the CBCL. Ronald's baseline to pretest scores demonstrated worsening of parental empathy and parenting stress prior to receiving CPRT intervention. Ronald's MEACI Total Empathy scores fluctuated throughout CPRT. From pretest to midtest, Ronald's parental empathy scores demonstrated a 5.25-point improvement, indicating an increase in parental empathy toward his daughter at midpoint. Ronald demonstrated a reduction of parental empathy at posttest. Ronald reported a decrease in PSI Total Stress scores

from pretest to posttest, indicating experiencing less stress in the parent-child relationship. Tables C.23 and C.24 provide an overview of Ronald's scores for each variable across time.

Table C.23

Ronald*'s Mean Scores for Each Dependent Variable across Time*

	Baseline	Pretest	Midtest	Posttest
MEACI Total Empathy	42.75	43.25	38	48.25
CBCL Total Behaviors	59	53	54	58
PSI Total Stress	224	236	238	222

Table C.24

Ronald's Change in Mean Scores for Each Dependent Variable across Time

	Base to Pre	Pre to Mid	Mid to Post	Pre to Post
MEACI Total Empathy	+.5	-5.25	+10.25	+5
CBCL Total Problems	-6	+1	+4	+5
PSI Total Stress	+12	+2	-16	-14

Note. A decrease in mean scores means an improvement.

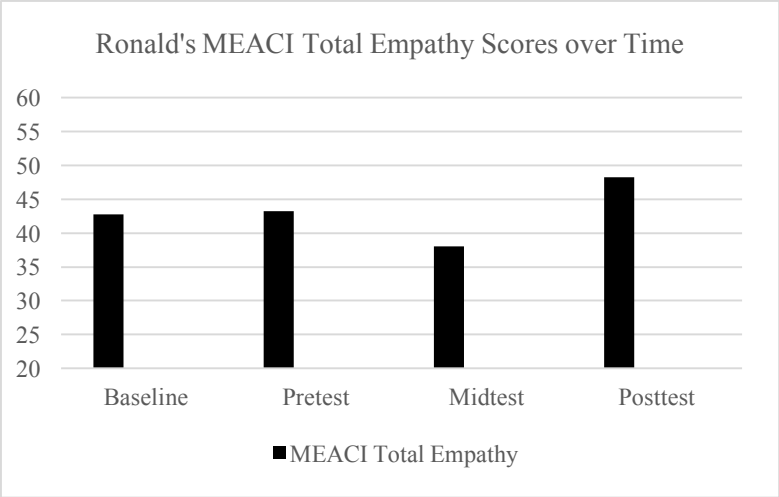

Figure C.34. Ronald's MEACI Total Empathy scores over time.

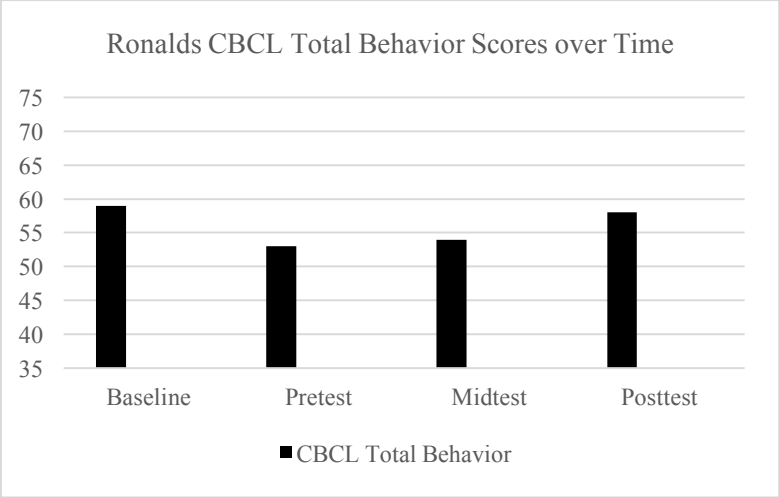

Figure C.35. Ronald's CBCL Total Behavior scores over time.

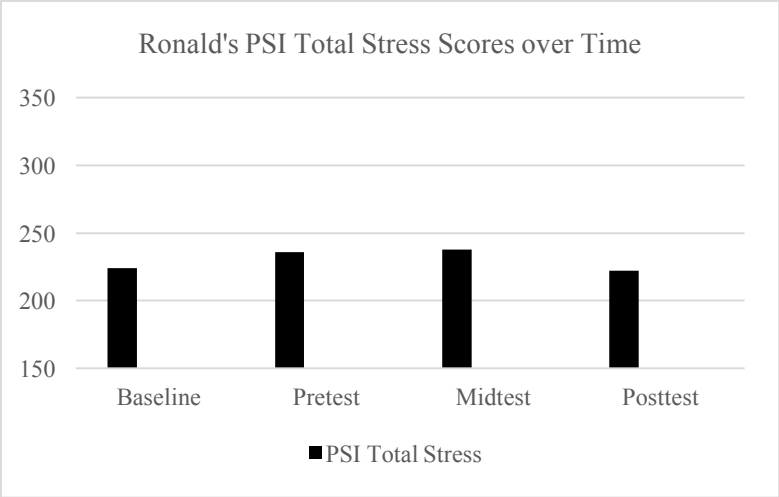

Figure C.36. Ronald's PSI Total Stress scores over time.

APPENDIX D

EXTENDED DISCUSSION

By conducting this study, I sought to explore the effect of CPRT as a group parenting intervention for adoptive parents of preadolescents. Additionally, I sought to pilot the preadolescent-adapted CPRT protocol (Ceballos et al., in-press) and explore specific research and clinical implications specific to utilizing CPRT as an intervention with adoptive parents of preadolescents. CPRT is an evidence-based mental health intervention shown particularly effective to reduce child disruptive behavior and to improve family cohesion, including stress in the parent-child relationship (Bratton et al., 2017; CEBC, 2017; SAMHSA, 2017), and for adoptive families of young children (Brodzinsky, 2014; Carnes-Holt & Bratton, 2014; Opiola & Bratton, in-press). To date, no published CPRT studies investigated the effect of CPRT on preadolescent-parent relationships.

Overall, results from this present study were positive in demonstrating CPRT as a mental health intervention for adoptive parents of preadolescents. Results demonstrated statistically significant differences across time for improving parental empathy, child behavior, and stress in the parent-child relationship. During the baseline phase prior to receiving CPRT, parents reported no change or worsening in functioning across all variables. During intervention, as measured by pretest to posttest scores, a large treatment effect for parental empathy, a medium treatment effect for parenting stress, and a small effect for child behavior were observed.

Parental Empathy

Adoptive parents who participated in CPRT reported a statistically significant improvement in parental empathy over time. Results showed that during the baseline phase parents' levels of empathy remained unchanged, whereas during the intervention phase CPRT demonstrated a large treatment effect on parents' empathic behavior and interactions with their children of focus, as reported by independent observers. These findings reinforce a goal of CPRT

to increase parents' abilities to respond empathically to the emotional worlds of their children. Results of the current study relate to the findings of previous randomized, controlled CPRT studies with adoptive families that also reported increases in parental empathy as a result of participation in CPRT (Carnes-Holt & Bratton, 2014; Opiola & Bratton, in-press). CPRT identifies the relationship between parent and child as essential to the healing process. Older adopted children may not have experienced a responsive, empathic attachment relationship with a caregiver or parent prior to adoption. CPRT offers parents a new way of attuning to their children's experiences by teaching parents to reflect their children's feelings, allow their child to lead discussion when sharing with their parents, therapeutically communicate limits to behavior, and enjoy mutually satisfying connection and activity during special times. These new parenting skills helped parents to cultivate deeper connection and empathy in relationship with their adopted preadolescent child, fostering relational healing for both parents and preadolescents.

The improvement in MEACI Total Empathy scores are also noteworthy because the MEACI was not a self-report instrument. The MEACI was scored by raters, independent from the research study and blinded to time of measure (baseline, pretest, midtest, or posttest). The results of the MEACI Total Empathy scores, provided by raters' scores after viewing segments of video-taped one-on-one times between parents and their preadolescent children of focus, offer a non-biased observation of parents' increased empathy toward their children throughout CPRT. Further, results of the MEACI provide increased credibility in assessing the impact of CPRT as an intervention to support adoptive parents in connecting with their preadolescent children.

The largest improvements in parental empathy, according to group analysis, were reported between pretest and midtest. During the first half of CPRT, parents learn a new way of being with their children, relationally attuning to their children's emotional needs, and practice

new skills in responding to and communicating with their preadolescents. Parents verbally reported intentionality in how they responded to their children during one-on-one times. CPRT facilitators observed parents' commitment to strict adherence to utilizing the skills they were learning. Special one-on-one times provided a new and safe platform for parents and preadolescents to connect. Fostering a greater sense of security in the parent-child relationship allows parents and children to mutually enjoy each other's company during preadolescent years (Seifert & Hoffnung, 2000), compared to higher conflict relationships. Learning new relational skills and processing parenting challenges during group allowed parents to more intentionally respond to their children's needs.

Although visual analysis of Figure 3 from pre to midtest indicates improvement in parental empathy, mid to posttest scores shows a slight reduction in parental empathy, according to raters blinded to time of measurement. During the last half of intervention, between midtest and posttest, parents reported and demonstrated increased desire and comfort to more authentically integrate their new CPRT attitudes and skills into their natural way of being with their children. Developmentally, it was important for parents to be able to offer genuineness and flexibility in relationship with their preadolescent children. Although clinically beneficial and developmentally appropriate, parents' adjustments and process of embodying the CPRT attitudes and skills may have influenced the slight decrease in the rating of observable parental empathic behaviors as rated by blinded raters on MEACI scores from midtest to posttest.

It is likely that the timing of post data collection, occurring at the end of spring semester with naturally higher stress family schedules and academic stress for children, influenced posttest parental empathy scores as well. Additionally, examination of the raw MEACI scores showed that the trend of one parents' MEACI scores impacted the group totals. Removing this

one participant's scores and reanalyzing data confirmed that this one participant caused worsening of group MEACI scores that is evident in current results. If this one participant was removed, parental empathy scores continued to decrease from mid to posttest. Although this indicates that one participant's scores impacted the group posttest mean, this participant met all inclusion criteria and remained in group data analysis.

Child Behavior

Adoptive parents who participated in CPRT also reported a statistically significant improvement in child behavior over time. Results showed that during the baseline phase parents observed child behavioral concerns worsened, whereas during the intervention phase CPRT demonstrated a small treatment effect on child behavior. The preadolescents in this study continued to demonstrate high emotional needs throughout development and over the course of the study. Despite statistically significant reductions as a group across time, average CBCL Total Behavior scores remained at borderline level at the end of the study phase. Additional exploration of the changes in mean scores of individual participants across time revealed that 8 parents reported decreases in CBCL Total Behavior scores pretest to posttest, indicating perceived reduction of preadolescent problematic behaviors as a result of participation in CPRT. These results are especially meaningful given that parents reported high levels of distress and worry specifically related to their preadolescents' continued behavioral concerns.

This overall promising finding parallels the hopes of training parents in CPRT as a means of facilitating their children's improved holistic functioning including behavioral functioning. Consistent with CCPT theory, a fundamental belief in CPRT is that the parent-child relationship is the mechanism of change, in which children can feel safe to fully express and explore their feelings, thoughts, and experiences. Furthermore, through an attuned and secure relationship

parents help co-regulate children's emotions and behaviors. Of particular note for this population of adoptive families, all the children in the current study experienced relational trauma and attachment disruptions in their early relationships. The majority of the preadolescents in this study were adopted over the age of 7 out of foster care and as part of a sibling group. Compared to prior research of CPRT with adoptive parents of young children, the preadolescent children of focus in this study experienced a greater number of years of relational disruptions and inconsistent care, and their prior experiences provoked expectations of mistrust and inconsistency in relationship. Many of the parent-child dyads in the current study were just beginning to build relational foundations of safety, permanency, and trust. I recommend CPRT as an early intervention and preventative model, offering families, such as the parents and preadolescents in this study, attachment-related support to begin building relational security as early as possible in these children's lives.

Based on the premise of CPRT, as the children in this study experienced their parents offering unconditional positive regard, empathy, and genuineness in their parent-child relationship, the children were able to internalize a sense of worth, relational safety and trust in the permanency of their parents' love, all prerequisites to the development of emotional and behavioral regulation. Through this process, children can begin to develop an internal valuing system with which they can utilize to engage in more prosocial behaviors. In CPRT, adoptive parents can become the agents of change in helping their preadolescents develop an increased capacity for emotional regulation and communication of their internal feelings. Relational healing allows children a new outlet for processing their experiences in relationship with their parents, which, therefore, reduces their need to externalize their feelings through maladaptive behavior. Specific to this population of preadolescents with histories of attachment disruption

and adverse pre-adoptive experiences, behavioral change may take longer to externally observe due to the need for children to first establish a foundation for relational safety and trust in parent.

Experiencing parental warmth and low levels of physically punitive discipline during childhood is associated with a greater capacity to self-regulate during middle childhood (Colman, Hardy, Albert, Raffaelli, & Crockett, 2006). Anecdotally, one parent described herself as "losing it" during a special time with her child, in which she become frustrated with her son's lack of communication with her. She reported to group that week that she was able to recognize her own emotional dysregulation in the moment, pausing before utilizing her new CPRT responses of recognizing her child's emotions, for example "you're mad at me." Due to the extremes of their preadolescent children's behavior at times, even small moments of connection impacted their overall relationship.

Another parent described her preadolescent, prior to beginning special times, as "not wanting to have anything to do with me." After their second special time, this parent proudly announced to the group that her daughter had initiated a hug with her mom for the first time ever. Several other parents reported similar observations of their preadolescents more freely engaging in or initiating physical affection with their parents following individualized one-on-one special times. Relatedly, despite parents' initial concerns that their preadolescents would not engage in activity during special times, all preadolescents in this study demonstrated a level of anticipation for the special times and were active in directing activity and discussion with their parents.

Although visual analysis of Figure 3 from pre to midtest indicates improvement in child behavior problems, mid to posttest scores show a slight increase in parent observed child behavioral concerns. The timing of this study, rather than clinical effect, may have contributed to this observed fluctuation in scores at the end of CPRT. During this phase of the study, end of the

school year contributed to increased stress and pressure for preadolescent children and family schedules. Parents anecdotally described end of the school year (at posttest) as contributing to increased child behavior problems.

Additionally, given the demographic information for the preadolescents included in this study, all experienced pre-placement adverse childhood experiences and the majority of preadolescent children of focus were adopted during late childhood. To provide optimal, holistic post-adoption services, I recommend that some preadolescent adoptees can benefit from receiving individual counseling services while their parents receive CPRT.

Parenting Stress

Adoptive parents who participated in CPRT reported statistically significant reduction in parenting stress over time. Results show that during the baseline phase parents reported increased stress in the parent-child relationship, whereas during the intervention phase CPRT demonstrated a medium treatment effect on parenting stress. Visual analysis of Figure 3 from pre to midtest indicates marked improvement in parenting stress and mid to posttest scores show that parents continued to report reduction of stress in the parent child relationship at the end of intervention. Reduction in parenting stress throughout CPRT may be impacted by parents' increased confidence in responding to and setting limits in relationship with their children. While their parent-child connections became more stable and parents had a structured, planned time and place in which to focus relational attention to their children during special times, parents may have felt less pressure to maintain constant emotional regulation. Parents' new skills provided them with alternative methods for discipline to decrease power struggles and increase confidence; this may also contribute to reduction in parenting stress over time.

Parents described being an adoptive parent as stressful and isolating at times. Decreases in parenting stress over time may illustrate the benefits of the group process component of CPRT (Landreth & Bratton, 2006). A large portion of group time each week was devoted to providing a space for parents to engage in self-reflection and processing of common experiences in being an adoptive parent of a preadolescent. The majority of parents seemed to experience group as a place to support other adoptive parents, reminisce about important family occasions, including regularly sharing photos and laughing as a way to connect, and increase personal wellness and emotional well-being. The group became a special place of support to parents, paralleling the importance of the special times to their children.

Relatedly, supervision of parents' video-taped one-on-one times with their children is a critical component of the CPRT process (Landreth & Bratton, 2006) and may have contributed to reducing parent-child relationship stress in this study. During the weekly supervision component of CPRT, parents were able to offer support and validation to one another related to observing peers' attunement and connectedness with their children. In one example, demonstrating the benefits of gaining feedback from other group members, I observed one group member become emotionally touched by a new softness he witnessed in another parent's video-taped special time with his son. Seeing the other parent grow in relationship with his son impacted this parent and he connected with his peers' initial fears of vulnerability and difficulty relating to his preadolescent child and validated his peer's growth in empathy and attunement. The parent receiving supervision and group feedback appeared to gain confidence in his ability to relate to his son and feel emotionally understood by the group. During CPRT, supervision also provided an important opportunity for parents to observe their own interactions with their children from a neutral stance, providing them a format to notice their children's experience, most notably their

children's enjoyment, of their special times together, engage in self-reflection, and practice new ways of responding without the pressure of immediate feedback from their preadolescent children.

In this current study, parent and child schedules contributed to fluctuating consistency in special times each week. Several parents opted to conduct their special times at our clinic with the researcher's activity kits in order to ensure consistency and predictability of their special times. Because the families in this study demonstrated high emotional needs, my offering to set up and record parent-child special times each week at the clinic or group site contributed to these parents reported reduced stress in planning their special times. Another consideration when constructing a group for adoptive parents is homogeneity of group (i.e., all adoptive parents). The families in this study presented to CPRT with high interpersonal needs and attending to parents' concerns sometimes took priority during CPRT over learning new parenting skills or focusing on their children's needs. I recommend that adoptive parents and preadolescent children may benefit from receiving individual counseling services prior to or while attending CPRT.

Limitations and Opportunities for Future Research

As a pilot study to investigate the impact of CPRT for adoptive parents of preadolescents, numerous limitations and confounding variables presented which can be considered to improve future research. No published research studies of adapting CPRT for preadolescents exist to which I can compare the results and conclusions of the current study. When initially designing this study, I anticipated low attrition rates and high treatment adherence by parents, based on previous CPRT research with adoptive parents (Carnes-Holt & Bratton, 2014; Opiola & Bratton, in-press). Attrition was higher than expected in the current study. I recommend that future researchers consider beginning intervention phase in the fall semester or beginning of January to

avoid the end of the school year and sports season that can impact intervention completion and data collection.

Family schedules during preadolescence are often busy with academic and social events. In order to support parent's ability to fully invest in the CPRT process, I recommend providing childcare with developmentally-appropriate activities and snacks while parents are attending groups and creating preadolescent-adapted filial kits available for parents to rent for use during their special times. Due to the high emotional and behavioral needs demonstrated by preadolescents in this study and the wide age range of siblings in the families, I recommend that childcare workers receive initial training and ongoing support from counselors with childcare-relevant topics for this population of children including, activities, impact of adoption and development, choice giving, and limit setting.

Due to recruitment and sample size, this pilot study utilized a single group repeated measures research design in effort to explore the effect of CPRT for adoptive parents of preadolescents. Although randomized controlled trials (RCT) are the gold standard for research, the use of a baseline phase in this study allowed participants to serve as their own control group and provided greater rigor over a pre-post single group design. The use of RCTs in future research is needed to investigate the effectiveness of CPRT with this population. Another important limitation to the current study was the lack of preadolescent-report measures included in data analysis. The current study did not include a measure of preadolescents' perceptions of their behaviors and parent-child relationship dynamics. CBCL and PSI data were parent-report data. Parent report data in this study were supported by findings demonstrated from MEACI data which is not a self-report measure, using observers blinded to time of measurement to rate parental empathic behavior.

Additional qualitative explorations of both parent and preadolescent experiences during CPRT would contribute to a greater depth of understanding of the current study's initial results. A larger sample size with randomization is needed to isolate the tested variables. Timing of posttesting and assessment fatigue are possible confounding variables in this study. This study was conducted during the child's academic spring semester when parents and children's schedules were hectic with end of school year activities and final exams which are especially stressful for the children in this study, the majority of whom struggled academically. Parents reported reluctance to complete the fourth point of measurement. I recommend that future researchers utilize a design that requires fewer data collection points. The external stressors impacting these families likely impacted their scores later in the semester (midtest and posttest). Additionally, this study was conducted in one geographic location in the United States which limits the generalizability of the results. I served as the lead researcher in this study and also as the lead counselor who facilitated the CPRT groups with participants. My significant time and relational involvement with participants as their counselor poses valid threat of researcher bias.

Conclusion

Examining these findings holistically, parents demonstrated greater parental empathy and decreased parenting stress with medium to large effect sizes despite the continuation of their preadolescents' emotional and behavioral concerns. Parents were able to feel more confident and attuned with their preadolescent children who are continuing to need their parents as relational supports as they navigate preadolescence and attachment-related concerns. CPRT helped to equip parents with new ways to respond to and interact with their preadolescent children in a way that supports their continually growing relationship. As anticipated, these findings also support the recommendations made by Carnes-Holt and Bratton (2014) and Opiola and Bratton

(in-press) to extend the CPRT model to include a greater number of sessions for families with higher needs, such as many adoptive families who report attachment and behavioral concerns.

Based on the results of this single group repeated measures study, CPRT is a promising intervention for adoptive parents and preadolescent children. The adoptive parents in this study reported statistically significant improvements in parental empathy, child behavior, and parenting stress over four points of measure. Adoptive parents and/or adopted preadolescents may benefit from receiving individual counseling prior to or during participation in CPRT to maximize clinical impact and increase their ability to fully engage in learning CPRT attitudes and skills. Further research is needed to examine effectiveness of CPRT with adoptive parents of preadolescents and to provide additional support for clinical and research use of preadolescent-adapted CPRT protocol (Ceballos et al., in-press).

APPENDIX E

RECRUITMENT FLYER

The University of North Texas, Department of Counseling is conducting a research study: 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

Parenting Your Adopted Child Can Be Challenging…

Are you a parent of an adopted child who is 9 to 13 years?
Are you aware that your preadolescent is struggling emotionally or relationally?
Would you like your relationship to be less stressful and closer/more enjoyable?
Do you find yourself feeling out of control and at a loss for how to respond?

Learn ways to connect and strengthen your 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 impact of adoption experiences and relationship disruptions on your child's current functioning
Become more attuned to your adopted child's emotional needs and developmental changes
Communicate more effectively with your preadolescent child
Feel closer and more connected to your preadolescent
Effectively discipline & limit inappropriate behavior
Help your child develop self-control and regulate their emotions

In 10 weeks, parents report:

Decrease in child behavioral and emotional problems
Reduction in stress in the parent-child relationship
Closer relationship with their child and improved communication
Greater confidence in parenting skills

Child Parent Relationship Training is a 10-session program adapted for parents/caregivers of adopted/fostered preadolescent children ages 9-13 years developmentally

CHILD CARE and age appropriate activities and snacks will be provided

Parenting Groups begin early January 2017
hosted throughout the DFW metroplex

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

Call Alyssa Swan, M.S., LPC-Intern or Sue Bratton, Ph.D., LPC-S, RPT-S
at UNT's Center for Play Therapy at (940) 565-3864
Email: Alyssa.Swan@unt.edu or Sue.Bratton@unt.edu

APPENDIX F

PARTICIPANT CONSENT FORM

University of North Texas Institutional Review Board

Parent 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.

Student Research Assistant: Alyssa Swan, M.S., Licensed Professional Counselor-Intern (LPC-I), 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 9 to 13 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.

In addition to participating in Child Parent Relationship Therapy (CPRT), you are being asked to participate in a small group interview designed to explore the process and impact of CPRT. The purpose of the Post Interviews is to explore the perceived impact of CPRT on adoptive parents, children and the overall family system. We also seek to examine parents' perceptions of the content and structure of CPRT, including its applicability for adoptive families.

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 planned one-on-one time 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.

After you complete the CPRT intervention, you will be asked to participate in an audio-recorded individual interview that will take about 45 minutes of your time. The interviews will be audio-recorded for transcription purposes.

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 time 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.

APPROVED BY THE UNT IRB
FROM 5/31/16 TO 5/30/17

OR

Group 2: Individual Parent Consultation: You will meet with a counselor to receive support regarding the concerns you have with your adopted child. The weekly consultation sessions will last 45 minutes. 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 activity 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, at your 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

APPROVED BY THE UNT IRB
FROM 5/31/16 TO 5/30/17

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

APPROVED BY THE UNT IRB
FROM 5/31/16 TO 5/30/17
gm

APPENDIX G

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: _____ Occupation: _____
Street City State Zip

*** INFORMATION ON PARENTS ***

Mother's Name: _____
Last First MI

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.*

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:*_____ *Date of Birth* ____/____/____
Last First MI

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 prior to adoption?*

_____

If your child biologically related to you? (i.e., grandparent) Yes No *(if yes, describe)*

_____

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 _____

Child's relationships with other children living in home:

Name of Sibling(s)	*Age*	*Ethnicity*	*Gender*	*Biologically related? (Y/N)*	*How would you describe their relationship?*

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

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

Would you describe your child as developmentally regressed in any way? (i.e., social, emotional, cognitive, physical) Yes No *If yes, how so?*

_____

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

Diagnosis	**Current** (list dates)	**Past** (list dates)	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____
ADHD	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____
Bipolar	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____
Tics	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____
Seizures	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____
Other	_____	_____	_____	_____

What other medication is your child currently taking?

Medication	Taken for what reason?
_____	_____
_____	_____
_____	_____

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)

_____

Does your child have any known allergies? Yes No (If yes, explain)

_____

*** FAMILY INFORMATION ***

Child's current household:

Adoptive mother only ____ Adoptive Father only ____ Adoptive Parents _____

Foster- to- Adopt Parents ____ Other _____ *Please Specify* _____

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

Name	Age	Gender	Relationship to child of focus (ex. biological, step, half, foster,)

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

If applicable, number of disrupted placements your child has experienced: _____

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.**

Problems Related to Abuse

Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
History of family domestic violence

Academic/School Problems

Learning difficulties
Problems with peers
Problems with teachers
Speech Problem

Mood-related Concerns

Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal ideation
Sadness
Depression
Feelings of guilt and shame
Excessive worrying
Anger/Irritable

Family Relationship Concerns

Difficulty adjusting to family changes
Discipline concerns
Parent-child relationship problems
Sibling concerns
Divorce/Separation
Religious/Spiritual Concerns

Rule-Breaking/Behavior Problems

Aggression toward others
Drug/alcohol use
Fire-setting
Intentionally hurting animals
Running away
Stealing

Other Behavioral Concerns

Sexual identity concerns
Inappropriate sexual behavior
Overeating/refusal to eat
Bedwetting or soiling
Hyperactive/Inattentive

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 H

PREADOLESCENT ADAPTED CPRT/FILIAL KIT CONTENTS

Nurturing/Real Life

Adapted medical kit (thermometer, stethoscope, large wooden sticks, band-aids, gloves, mask, ACE bandage- important they aren't fake/toys, all real/working)
2 baby dolls (1 white, 1 ethnic)
Barbie families (2 girls, 2 boys, 2 children)
Baby bottle, pacifier
Food, dishes
Brush, hair ties, bobby pins
2 puppets (1 aggressive, 1 nurturing)
Animal families, including at least one larger shark or snake

Make-Believe/Release/Aggressive

2 masks
Money
2 cell phones
Handcuffs (stretchy, hard)
Dart guns (foam, hard)
Knife
Army men
Binoculars
Bopbag
2 foam swords

Creative/Expressive

Dry erase board, markers
Wand
Musical instrument
CPT toy baggie (sand tray miniatures)
Sand + small sand tray
Creative arts bag (contents include feathers, noodles, foam, scrap material, tin foil, stickers, balloons, wooden sticks)
Markers, crayons
Paper (4 pc. white, 2 scrapbook, 1 foam or felt, 3 pc. lined notebook)
Scissors, tape, glue (stick, tacky), glue dots
2 packages of model magic (air dry clay)
Play-doh
Beads and thread

Mastery

Ball toss game
Ring toss game
Wooden blocks or fiddlesticks
Jump rope
Marbles
Wood-working
Craft kits

APPENDIX I

PREADOLESCENT ADAPTED MEACI SCORING DIRECTIONS

Measurement of Empathy in Adult-Child Interaction – Directions for Scoring

(Scoring examples are attached)

Note: 1 = Highest Score, 5 = Lowest Score

Communication of Acceptance of Child (Score highest and lowest level)	**Allowing Child Self-Direction:** (Score lowest level only)	**Adult's Involvement with Child:** (Score most characteristics level)
1. Non-verbal (voice tone/facial expression/body language conveys acceptance and/or mutual enjoyment of time together/activity/ conversation or Verbal recognition of child's feeling/intent/wishes in an accepting way (voice tone matches): *You really like…, That surprised you, It's important to you; you wish that…, that's how you want it to go*	1. Shows willingness to follow child's lead (no indication to the contrary: Ex: solicited praise or answering a question that child has overtly asked for would not detract from 1; Appropriately set limits would not detract from score of 1; mutual decision making would not detract from a score of 1; ok to ask question to keep child in the lead); no verbal comment necessary; *You'd like me to…, I'm supposed to…, Show me what you want me…,(whisper technique- how should we do it?), you can decide how you want us to do it.*	1. Full attention to child, more attention to person of the child than activity; emotionally present; *involved verbally and with "eyes" and physically when invited by child;* (joint participation with the child where the parent concentrates heavily on the activity does not detract from a score of 1, e.g., in role playing, certain games, parallel play or creating separate creations
2. Verbally or nonverbally Recognizes & Accepts Behavior Only; no attention to underlying intent or importance (tracking, giving credit): *You got it that time.., You're hitting the…, You stabbed…that one has red shoes on now.*	2. Allows child option for lead-taking, but asks questions/gives information/ makes suggestions with choice genuinely left to the child, gives solicited aid or instructions, gives unsolicited praise; *"Good", You can shoot this (without ACE), teaches in connecting way "That could be dangerous so those soldiers need protection"; gives answers when child questions for direction. (joining in playfully during role-play would not detract from score of 1)*	2. High level of attention, but parent concentration almost exclusively on activities, per se, rather than being with or experiencing their child *relationally*
3. Parent-led social conversation or No Conversation: How was school today?, *These are nice toy, did you know that your great-grandpa was in the army?; how was school today?; parent flat affect; humor/joking used to connect (developmentally-appropriate social conversation that enhances child's felt sense of being seen would not detract from higher score)*	3. Adult takes lead without giving child an option (e.g., unsolicited instruction on how to do or accomplish something, "teaching," praise accompanying a suggestion, question with intent to guide the child)*: Are you sure that's how.., Take your time and aim, It might work better if, Let's do….; no, remember you do it like this…*	3. Marginal attention. No joint activity; Involved in own activity to a degree that partially interferes with attention to child (i.e., not emotionally present for child during parallel play; if child-directed or perceived as in response to child not wanting to be overly watched, would not detract from higher score)
4. Slight or moderate verbal criticism or unenjoyment stated or strongly implied: *No, not that way. That's cheating. You'll ruin that; the head you made is too big; that's not how I would do it (joking used to invalidate rather than connect)*	4. Directs or instructs child to do something (initiates new activity when no evidence that child is anxious or does not play): *Put that sword away first. Why don't you…, Let's play…, Don't put the…*	4. Partially emotionally or physically withdrawn or preoccupied (fails to attend to child or engage in child-led discussion or activity, but responds when alerted or questioned by child); i.e., parent distracted by own objectives or play
5. Strongly Critical / Preaching / Rejecting: *(may be conveyed through stronger voice tone); I told you to do it the other way, It's not nice to feel/say…; How stupid!; I did it better than you; you don't know how to do that*	5. Persuades, Demands, Interrupts, Interferes, Insists (interferes in child's activity other than to end the session): *No, take this one, That's enough, I told you not to…, Give me that…No, let's play with the cards now, why don't you… (nonverbal tone conveys parent in control of decision or direction)*	5. Completely preoccupied, self-involved, or emotionally shut off/disconnected from child (child ignored, child must repeat or repeatedly prompt to get response or attention from parent)

This form was developed by Bratton, S. (1993) from information obtained from Stover, L., Guerney, B, & O'Connell, M. (1971) and personal communication with Dr. Louise Guerney (April 12, 1992).

Further adapted for preadolescents by Swan, A., & Bratton, S. (2017) with permission from Bratton, S.

COMPREHENSIVE REFERENCE LIST

Abidin, R. R. (1995). *Parenting Stress Index: Professional manual.* Lutz, FL: Psychological Assessment Resources.

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA preschool forms & profiles.* Burlington: University of Vermont, Research Center, Youth & Families.

Adams, G. (2000). *Adolescent development: The essential readings.* Malden, MA: Blackwell publishers.

Adoption History Project. (2012). *Topics in Adoption History.* Retrieved from http://darkwing.uoregon.edu/~adoption/

Al-Yagon, M. (2016). Perceived close relationships, teachers, and peers predictors of social, emotional, and behavioral features in adolescents with LD or comorbid LD and ADHD. *Journal of Learning Disabilities*, 1-19.

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology.* New York, NY: W & W Norton & Company, Inc.

Baril, M., Crouter, A., McHale, S. (2007). Processing links adolescent's well-being, marital love, and co-parenting. *Journal of Family Psychology, 21(4),* 645-654.

Barth, R., Crea, T., John, K., Thoburn, J., Quinton, D., & Daniels, F. (2005). Beyond attachment theory and therapy: Towards sensitive and evidenced-based interventions with foster and adoptive families in distress. *Child and Family Social Work, 10*, 257-258.

Baruch, D. W. (1949). *New ways in discipline: You and your child today.* New York, NY: McGraw Hill.

Bowlby, J. (1980). *Attachment and loss* (Vol. 3). *Loss*. New York, NY: Basic Books.

Bowlby, J. (1982). *Attachment* (2nd ed.), Vol. 10. New York: Basic Books.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York, NY: Basic Books.

Bratton, S. (1993). *Filial therapy with single parents*. Unpublished doctoral dissertation, University of North Texas, Denton.

Bratton, S., Dafoe, E., Swan, A., Opiola, K., McClintock, D., & Barcenas, G. (2017). *Play Therapy Outcome Research Database.* Evidence-based Child Therapy. Retrieved from: http://evidencebasedchildtherapy.com/research/

Bratton, S. C., Dillman Taylor, D., & Akay, S. (2013). *Expressive arts in play therapy*. In E. Green & A. Drewes (Eds.), Integrating Expressive Arts and Play Therapy: A Guidebook for Mental Health Practitioners and Educators. Hoboken, NJ: Wiley.

Bratton, S., & Ferebee, K. (1999). *The Use of Structured Expressive Art Activities In Group Activity Therapy With Adolescents.* In D. S. Sweeney & L. E. Homeyer (Eds.), The handbook of group play therapy: How to do it, how it works, whom it's best for (pp. 192-214).

Bratton, S., & Landreth, G. (1995). Filial therapy with single parents: Effects on parental acceptance, empathy and, stress. *International Journal of Play* Therapy*, 4*(1), *61-80.*

Bratton, S., Landreth, G., Kellam, T., & Blackard, S. (2006). *Child parent relationship therapy (CPRT) treatment manual: A 10 session filial therapy model for training parents.* New York, NY: Routledge.

Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of the outcome research. *Professional Psychology: Research and Practice, 36*(4), 376-390. doi:10.1037/0735-7028.36.4.376

Bretherton, I., & Munholland, K. A. (1999). Internal Working Models in Attachment

Relationships: A Construct Revisited. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory, Research, and Clinical Applications* (pp. 89-114). New York: Guildford Press.

Brodzinsky, D. (2013). *A need to know: Enhancing adoption competence among mental health professionals*. New York: Donaldson Institute. Retrieved from http://adoptioninstitute.org/old/publications/2013_08_ANeedToKnow.pdf.

Brodzinsky, D. (2015). *The modern adoptive families study: An introduction.* The Donaldson Adoption Institute. Retrieved from: http://adoptioninstitute.org/publications/the-modern-adoptive-families-study-an-introduction/

Brodzinsky, D., Schechter, M., & Marantz, R. (1992). *Being adopted: The lifelong Search for Self.* New York, NY: Random House, Inc.

Bronfenbrenner, U. (1989). Ecological systems theory. *Child Development, 6*, 187- 249.

Brown, C. J. (2005). Activity filial therapy with adolescents. *Play therapy with adolescents*, 48.

California Evidence-Based Clearinghouse. (2016). *The California Evidence-Based Clearinghouse for Child Welfare.* Retrieved from http://www.cebc4cw.org

Capps, J. E. (2012). Strengthening Foster Parent–Adolescent Relationships through Filial Therapy. *The Family Journal*, *20*(4), 427-432.

Carnes-Holt, K. (2012). Child–parent relationship therapy for adoptive families. *The Family Journal*, *20*(4), 419-426. doi: 10.1177/1066480712451242

Carnes-Holt, K., & Bratton, S. C. (2014). The efficacy of child parent relationship therapy for adopted children with attachment disruptions. *Journal of Counseling & Development*, *92*(3), 328-337. doi: 10.1002/j.1556-6676.2014.00160.x

Carnes-Holt, K., Meany-Walen, K., & Ceballos, P. (2015). *Child-Parent Relationship Therapy with preadolescents.* In C. Schaefer & A. Drewes. (Eds.). Play Therapy in Middle Childhood. Washington, DC: American Psychological Association.

Chau, I., & Landreth. G. L. (1997). Filial therapy with Chinese parents: Effects on parental empathy, parental acceptance, and parental stress. *International Journal Play Therapy*, *6(*2), 275-92.

Ceballos, P. L., & Bratton, S. C. (2010). Empowering Latino families: Effects of a culturally responsive intervention for low-income immigrant Latino parents on children's behaviors and parental stress. *Psychology in the Schools, 47(8),* 761-775.

Child Welfare Information Gateway. (2015). *Adoption Statistics.* Retrieved from https://www.childwelfare.gov/topics/systemwide/statistics/adoption/

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Colman, R. A., Hardy, S. A., Albert, M., Raffaelli, M., & Crockett, L. (2006). Early predictors of self-regulation in middle childhood. *Infant and Child Development*, *15(4),* 421-437.

Costas, M. B. & Landreth, G. L. (1991). Filial therapy with nonoffending parents of children who have been sexually abused. *International Journal of Play Therapy, 8(1) 43-66.*

Damon, W., & Hart, D. (1992). Self-understanding and its role in social and moral development. In M. H. Bornstein, & M. E. Lamb (Eds.). *Developmental psychology: An advanced textbook* (3rd ed). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Demidenko, N., Manion, I., & Lee, C. (2015). Father-daughter attachment and communication in depressed and nondepressed adolescent girls. *Journal of Child and Family Studies, 24(6),* 1727-1734.

De Vries, S., Hoeve, M., Stams, G., & Asscher, J. (2016). Adolescent-parent attachment and externalizing behavior: The mediating role of individual and social factors. *Journal of Abnormal Child Psychology, 44,* 283.

Dhami, M., Mandel, D., & Sothmann, K. (2007). An evaluation of post-adoption services. *Child and Youth Services Review, 29(2),* 162-179.

Duchesne, S. and Larose, S. (2007). Adolescent parental attachment and academic motivation and performance in early adolescence. *Journal of Applied Social Psychology, 37*, 1501–1521.

Engels, R. C., Finkenauer, C., Meeus, W., & Deković, M. (2001). Parental attachment and adolescents' emotional adjustment: The associations with social skills and relational competence. *Journal of Counseling Psychology, 48(4),* 428-439.

Erikson, E. H. (1950). *Childhood and society*. New York, NY: Norton.

Evan B. Donaldson Adoption Institute. (2007). *Research: Adoption facts.* Retrieved from http://www.adoptioninstitute.org/research/adoptionfacts.php

Feeney, J. A., Passmore, N. L., & Peterson, C. C. (2007). Adoption, attachment, and relationship concerns: A study of adult adoptees. *Personal Relationships, 14*, 129-147. doi: 10.1111/j.1475-6811.2006.00145.x

Forbes, H., & Post, B. (2006). *Beyond consequences logic, and control: A love based approach to helping attachment-challenged children with severe behaviors.* Orlando, FL: Beyond Consequences Institute, LLC.

Freeman, H., & Brown, B. (2001). Primary attachment to parents and peers during adolescence: Differences by attachment style. *Journal of Youth and Adolescence, 30(6),* 653-674.

Freud, S. (1959). Analysis of a phobia five-year-old boy. In *Collected papers* (vol. 3., pp. 149-289). New York, NY: Basic Books.

Fuchs, N. (1957). Play therapy at home. *Merrill-Palmer Quarterly, 3*, 89-95.

Gemelli, R. (1996). *Normal child and adolescent development.* Washington, D.C.: American Psychiatric Press.

Gleitman, I., & Savaya, R. (2011). Adjustment of adolescent adoptees: The role of age and adoption and exposure to pre-adoption stressors. *Child and Youth Services Review, 33,* 758-766.

Glover, G. J., & Landreth, G. L. (2000). Filial therapy with Native Americans on the Flathead reservation. *International Journal of Play Therapy, 9(2),* 57–80.

Guerney, B., Stover, L., & Demerit, S. (1968). A measurement of empathy for parent-child interaction. *Journal of Genetic Psychology, 112*, 49-55.

Guerney, B. (1969). Filial therapy: Description and rationale. *Journal of Consulting Psychology, 28* (4), 304-310. doi: 10.1037/h0041340

Guerney, L. (2000). Filial therapy into the 21st century. *International Journal of Play Therapy, 9*(2), 1-17. doi: 10.1037/h0089433

Guerney, L., & Guerney, B (1989). Child relationship enhancement*. Person-Centered Review, 4,* 344-357.

Hall, G. S. (1904). *Adolescence: Its psychology and its relations to physiology, anthropology, sociology, sex, crime, religion, and education*. New York, NY: Appleton & Co.

Harris, Z. L., & Landreth, G. L. (1997). Filial therapy with incarcerated mothers: A five-week model. *International Journal of Play Therapy, 6(2),* 53–73.

Haugaard, J. J. (1998). Is adoption a risk factor for the development of adjustment problems. *Child Psychology Review, 18,* 47-69.

Hawk, B., & McCall, R. (2010). CBCL behavior problems of post-institutionalized international adoptees. *Clinical Child and Family Psychology Review, 13(2),* 199-211.

Helping Hand Home. (2016). *Foster to Adopt.* Retrieved from: http://www.helpinghandhome.org/IMAGES/Foster_to_Adopt.pdf

Helker, W. P., & Ray, D. C. (2009). Impact of child teacher relationship training on teachers' and aides' use of relationship-building skills and the effects on student classroom behavior. *International Journal of Play Therapy, 18(2),* 70-83.

Hershenberg, R., Davila, J., Yoneda, A., Starr, L. R., Miller, M. R., Stroud, C. B., & Feinstein, B. A. (2011). What I like about you: The association between adolescent attachment security and emotional behavior in a relationship promoting context. *Journal of adolescence*, *34(5),* 1017-1024.

Hopkins, J. (2000). Overcoming a child's resistance to late adoption: How one new attachment can facilitate another. *Journal of Child Psychotherapy, 26(3),* 335-347. doi: 10.1080/00754170003633

Howard, M. S. & Medway, F. J. (2004), Adolescents' attachment and coping with stress. Psychol. Schs., 41: 391–402. doi: 10.1002/pits.10167

Jones, L., Rhine, T., & Bratton, S. (2002). High school students as therapeutic agents with young children experiencing school adjustment difficulties: The effectiveness of a filial therapy training model. *International Journal of Play Therapy, 11(2),* 43-62.

Juffer, F., & van Ijzendoorn, M. H. (2005). Behavior problems and mental health referrals of international adoptees: A meta-analysis. *Journal of the American Medical Association*, 293,2501-2515. Doi: 10.1001/jama.293.20.2501.

Kale, A. L., & Landreth, G. L. (1999). Filial therapy with parents of children experiencing learning difficulties. *International Journal of Play Therapy, 8*(2), 35-56. doi: 10.1037/h0089430.

Kamphaus, R. W., & Reynolds, C. R. (2009). *PRQ parenting relationship questionnaire*. Minneapolis, MN: Pearson.

Kidron, M., & Landreth, G. (2010). Intensive child parent relationship therapy with Israeli parents in Israel. *International Journal of Play Therapy, 19(2),* 64-78.

Klahr, A., Rueter, M., McGue, M., Iacono, W., & Burt, A. (2011). The relationship between parent-child conflict and adolescent antisocial behavior: Confirming shared environmental mediation. *Journal of Abnormal Child Psychology, 39,* 683-694.

Kocayoruk, E., Altintas, E., Icbay, M. (2015). The perceived parental support, autonomous-self and well-being of adolescents: A cluster-analysis approach. *Journal of Child and Family Studies, 24(6),* 1819-1828.

Kornhonen, M., Luoma, I., Salmelin, R., & Tammien, T. (2012). A longitudinal study of maternal prenatal, postnatal, and concurrent depressive symptoms and adolescent well-being. *Journal of Affective Disorders, 136(3),* 680-692.

Koh, B., & Rueter, M. (2011). Contributions of Parent–Adolescent Negative Emotionality, Adolescent Conflict, and Adoption Status to Adolescent Externalizing Behaviors. *Journal of Clinical Child & Adolescent Psychology, 40(6),* 825-836.

Laible, D. (2007). Attachment with parents and peers in late adolescence: Links with emotional competence and social behavior. *Personality and Individual Differences, 43(5),* 1185-1197.

Landreth, G. L. (1991). *Play therapy: The art of the relationship*. New York, NY: Routledge.

Landreth, G. L. (2002) *Play Therapy: The art of the relationship* (2nd ed.). New York, NY: Routledge.

Landreth, G (2012). *Play therapy: The art of the relationship* (3rd ed.). New York, NY: Routledge.

Landreth, G. L., & Bratton, S. C. (2006). *Child parent relationship therapy (CPRTt): A ten session filial therapy model.* New York, NY: Routledge.

Landreth, G. L., & Lobaugh, A. F. (1998). Filial therapy with incarcerated fathers: Effects on parental acceptance of child, parental stress, and child adjustment. *Journal of Counseling & Development, 76,* 157–165.

Lee, M., & Landreth, G. L. (2003). Filial therapy with immigrant Korean parents in the United States. *International Journal of Play Therapy, 12(2),* 67–85.

Livingston Smith, S. (2014). *Keeping the Promise: The Case for Adoption Support and Preservation.* The Donaldson Adoption Institute. Retrieved from: http://adoptioninstitute.org/wordpress/wp-content/uploads/2014/04/Keeping-the-Promise-Case-for-ASAP-Brief.pdf

Li, Y., & Warner, L. (2015). Parent-Adolescent conflict, family cohesion, and self-esteem among Hispanic adolescents in immigrant families: A comparative analysis. *Family Relations, 64,* 579-591.

Lin, Y., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling and Development, 93(1),* 45-58.

Ma, C. Q., & Huebner, E. S. (2008), Attachment relationships and adolescents' life satisfaction: Some relationships matter more to girls than boys. *Psychology in the Schools, 45(2)*, 177–190.

Maskew, T. (1999). *Our own: Adopting and parenting the older child.* Morton Grove, IL: Snowcap Press.

McGue, M., Sharma, A., & Benson, P. (1996). The effect of common rearing on adolescent adjustment: Evidence from a U.S. adoption cohort. *Developmental Psychology, 32(4),* 604-613. doi:10.1037/0012-1649.32.4.604

Meany-Walen, K., Carnes Holt, K., Ceballos, P., Michero, E. (2014). Child Parent Relationship Therapy: A model for preadolescents. *British Journal of Play Therapy, 10*, 6-19.

Miller, Fan, X., Christensen, Grotevant, & Van Dulmen. (2003). Comparisons of adopted and nonadopted adolescents in a large, nationally representative sample (vol 71, pg 1458, 2000). *Child Development, 74*(3), 965-965.

Morrison, M. O., & Bratton, S. C. (2010). Preliminary investigation of an early mental health intervention for Head Start programs: Effects of child teacher relationship training (CTRT) on children's behavior problems. *Psychology in the Schools, 47(10),* 1003-1017.

Morrison, M., & Bratton, S. C. (2011). The effects of child teacher relationship training on the children of focus: A pilot study. *International Journal of Play Therapy, 20(4),* 193-207.

Mothander, P., & Wang, M. (2011). Parental rearing, attachment, and social anxiety in Chinese adolescents. *Youth and Society, 46(2),* 155-175.

Moustakas, C. E. (1959). *Psychotherapy with children: The living relationship.* New York, NY: Harper & Row.

Nalavany, B., Glidden, L., & Ryan, S. (2009). Parental satisfaction in the adoption of children with learning disorders: The role of behavior problems. *Family Relations, 58(5),* 621-633.

Nalavany, B., Ryan, S., & Hinterlong, J. (2009). Externalizing behavior among adopted boys with preadoptive histories of child sexual abuse. *Journal of Child Sexual Abuse, 18(5),* 553-573.

Nilsson, R., Rhee, S. H., Corley, R. P., Rhea, S., Wadsworth, S. J., & DeFries, J. C. (2011). Conduct Problems in Adopted and Non-Adopted Adolescents and Adoption Satisfaction as a Protective Factor. *Adoption Quarterly, 14(3),* 181-198. doi:10.1080/10926755.2011.608030

Ojiambo, D., & Bratton, S. C. (2014). Effects of group activity play therapy on problem behaviors of preadolescent Ugandan orphans. *Journal of Counseling and Development, 92(3)*, 355-365.

Pace, C., Di Folco, S., Guerriero, V., Santona, A., & Terrone, G. (2015). Adoptive parenting and attachment: Association of the internal working models between adoptive mothers and their late-adopted children during adolescence. *Frontiers in Psychology, 6,* 1433.

Packman, J., & Solt, M. D. (2004). Filial Therapy for Preadolescents. *International Journal of Play Therapy, 13 (1),* 57-78.

Pascuzzo, K., Cyr, C., & Moss, E. (2013). Longitudinal association between adolescent attachment, adult romantic attachment, and emotion regulation strategies. *Attachment and Human Development, 15(1),* 83-103.

Perry, B. D. (2008). *The neurosequential model of therapeutics. Retrieved from www.childtrauma.org*

Phaik Ooi, Y., Ang, R., Fung, D., Wong, G., & Cai, Y. 92006). The impact of parent-child attachment on aggression, social stress, and self-esteem. *School Psychology International, 27(5),* 552-566.

Post, P., McAllister, M., Sheely, A., Hess, B., & Flowers, C. (2004). Child-centered kinder training for teachers of pre-school children deemed at-risk. *International Journal of Play Therapy, 13(2),* 53-74.

Purvis, K., Cross, D., & Sunshine, L. (2007). *The connected child: For parents who have welcomed children from other countries and cultures, from troubled backgrounds, with special behavioral or emotional needs*. New York, NY: McGraw-Hill.

Purvis, K., Cross, D., Dansereau, D., & Parris, S. (2013). Trust-based relational intervention (TBRI): A systemic approach to complex developmental trauma. *Child and Youth Services, 34(4),* 360-386.

Ray, D. (2016). *A Therapist's Guide to Child Development: The Extraordinarily Normal Years*. New York, NY: Routledge.

Robin, A. L., & Foster, S. L. (1989). *Negotiating parent adolescent conflict.* New York, NY: Guilford Press.

Robison, M., Lindaman, S., Clemmons, M.P., Doyle-Buckwalter, K. & Ryan, M. (2009). "I deserve a family": The evolution of an adolescent's behavior and beliefs about himself and others when treated with Theraplay in residential care. *Child and Adolescent Social Work Journal*, *26(4),* 291-306.

Roisman, G., et al. (2010). Is adolescence-onset antisocial behavior developmentally normative. *Development and Psychopathology, 22,* 295-311.

Sánchez-Sandoval, Y., & Palacios, J. (2012). Stress in adoptive parents of adolescents. *Children and Youth Services Review*, *34*(7), 1283-1289.

Seifert, M., & Hoffnung, R. (2000). *Child and Adolescent Development* (5th ed.). Houghton Mifflin Harcourt.

Siegel, D. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* Guilford Press.

Siegel, D., & Hartzell, M. (2004). *Parenting from the inside-out: How a deeper self-understanding can help you raise children who thrive.* New York, NY: Jeremy P. Tarcher/ Putnam.

Sharma, A.R., McGue, M.K. and Benson, P.L. (1996). The emotional and behavioral adjustment of United States adopted adolescents: An overview. *Children and Youth Services Review*, 18, 83-100.

Sheely, A. I., & Bratton, S. C. (2010). A strengths-based parenting intervention with low-income African American families. *Professional School Counseling, 13(3),* 175-183.

Shokouhi, A., Limberg, D., & Armstrong, S. (2014). Counseling preadolescents: Utilizing developmental cues to guide therapeutic approaches. *International Journal of Play Therapy, 23(4),* 217-230.

Siu, A.F.Y. (2009). Theraplay in the Chinese world: An intervention program for Hong Kong children with internalizing problems. *International Journal of Play Therapy*, *18(1),* 1-12.

Siu, A.F.Y. (2014). Effectiveness of Group Theraplay® on enhancing social skills among children with developmental disabilities. *International Journal of Play Therapy*, *23(4),* 187-203.

Smith, D. M., & Landreth, G. L. (2004). Filial therapy with teachers of deaf and hard of hearing preschool children. *International Journal of Play Therapy, 13(1),* 13-33.

Smith, N., & Landreth, G. (2003). Intensive filial therapy with child witnesses of domestic violence: A comparison with individual and sibling group play therapy. International Journal for Play Therapy, 12(1), 67–88.

Stover, L., Guerney, B., & O'Connell, M. (1971). Measurements of acceptance, allowing self-direction, involvement, and empathy in adult-child interaction. *Journal of Psychology, 77*, 261-269.

Tambelli, R., Laghi, F., Odorisio, F., & Notari, V. (2012). Attachment relationships and internalizing and externalizing problems among Italian adolescents. *Children and Youth Services Review, 34(8),* 1465-1471.

Theraplay Institute. (2016). W*hat is Theraplay*. Retrieved from http://www.theraplay.org/index.php/what-is-theraplay-parents/17-faq-what-is-theraplay/169-is-theraplay-an-evidence-based-treatment

Tronick E. Z. (2003). Things still to be done on the still-face effect. *Infancy 4,* 475–482.

U.S. Children's Bureau. (2016). *Adoption.* Retrieved from http://www.acf.hhs.gov/cb/focus-areas/adoption

U.S. Census Bureau. (2010). *Adopted children and stepchildren*. Retrieved from http://www.census.gov/topics/population/children.html

Warren, S. B. (1992). Lower threshold for referral for psychiatric treatment for adopted adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *31(3),* 512-517.

Waruszewski, V. (2012). A study of the utilization of brief, biblically integrated child parent relationship therapy with mothers from Christian families and their 11-14 year old children*. Unpublished dissertation,* Western Michigan University.

Weir, K.N., Lee, S., Canosa, P., Rodrigues, N., McWilliams, M., & Parker, L. (2013). Whole Family Theraplay: Integrating family systems theory and Theraplay to treat adoptive families. *Adoption Quarterly, 16(3-4)*, 175- 200.

Wettig, H. G.; Coleman, A. R.; Geider, F. J. (2011). Evaluating the effectiveness of Theraplay in treating shy, socially withdrawn children. *International Journal of Play Therapy*, *20*(*1),* 26-37.

Whittle, S., Yap, M. B. H., Yücel, M., Fornito, A., Simmons, J. G., Barrett, A, Sheeber, L., Allen, N. B. (2008). Prefrontal and amygdala volumes are related to adolescents' affective behaviors during parent–adolescent interactions.*Proceedings of the National Academy of Sciences of the United States of America*, *105*(9), 3652–3657. http://doi.org/10.1073/pnas.0709815105

Wright, L., & Flynn, C. (2006). Adolescent adoption: Success despite challenges. Children and Youth Services Review, 28(5), 487-510.

van den Dries, F., Juffer, M., van IJzendoorn, H., & Bakermans-Kranenburg, M. (2009). Fostering security: A meta-analysis of attachment in adopted children. *Children and Youth Services Review, 31,* 410-421.

van der Kolk B. A., & Courtois C. A. (2005). Editorial comments: Complex developmental trauma. *Journal of Traumatic Stress, 8,* 385–388

Vandivere, S., & McKlindon, A. (2010). The well-being of U.S. children adopted from foster care privately from the United States and internationally. *Adoption Quarterly, 13(4),* 157-184. doi:10.1080/10926755.2010.524871

Yuen, T., Landreth, G., & Baggerly, J. (2002). Filial therapy with immigrant Chinese families. *International Journal of Play Therapy, 11(2),* 63-90.