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# Attachment Concerns Within Adoptive Families

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## DESCRIPTION OF THE PROBLEM

Both domestically and abroad, there are many children available for adoption (Intercountry Adoption, 2014). An essential therapeutic need for families who have adopted children is the development of healthy and secure relationships among family members. Adopted children sometimes present with a range of disruptive behaviors, which can complicate treatment. One meta-analysis of identified behavioral problems presenting in international adoptees, domestically adopted children, and non-adopted children, reported that adopted children demonstrated more behavioral problems, specifically increased issues related to negative internalizing and externalizing symptoms (e.g., aggression, oppositional behavior, and anxiety) than non-adopted children (Juffer & Van IJzendoorn, 2005).

Attachment is the "reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver. The child receives what she [sic] needs to live and grow through this relationship, and the caregiver meets her [sic] needs to provide sustenance and guidance" (James, 1994, p. 2). This attachment relationship develops the framework for the child's perception of the world, relationships, and self-concept. Children in adoptive and foster placements are at particular risk for forming insecure attachments as a result of factors such as numerous changes in primary caregivers and experiencing repeated traumas, such as neglect, abandonment, and abuse. Insecure parent-child relationship attachments contribute to children being at a higher risk for exhibiting disruptive behaviors, poor social adjustment, and an inability to self regulate feelings and behaviors (Hughes, 1999; Kottman, 1997; Verhulst, Althaus, & Beiman, 1992). Thus, it is critical to the long-term welfare of children to research and identify effective mental health interventions for adoptive families that focus on developing the parent-child relationship.

Resource: Adoption Practices: http://adoptioninstitute.org

## IDENTIFICATION/ASSESMENT STRATEGIES

Children who exhibit attachment difficulties commonly present with significant behavioral problems including impaired emotional regulation abilities, hoarding, stealing, oppositional behaviors, and educational struggles (Brodzinsky, 2013; Forbes & Post, 2006; Juffer & Van IJendoorn, 2005; Purvis, Cross, & Sunshine, 2007). Adopted children who have attachment issues may be diagnosed with Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, Bipolar Disorder, and/or Attention-Deficit Hyperactivity Disorder (American Psychiatric Association, 2013). Several assessment tools can be utilized with adopted children and caregivers to identify areas of concern, and these include: the Child Behavior Checklist (Achenbach, 2000); the Parenting Stress Index (Abidin, 1995); the Marschak Interaction Rating System (O'Connor et al., 2004); the Randolph Attachment Disorder Questionnaire (Randolph, 2000); and the Attachment Disorder Assessment Scale-Revised (Ziegler, 2008).

## INTERVENTION STRATEGIES

A wide array of approaches exist for addressing attachment difficulties within adoptive families. Dyadic Developmental Psychotherapy (DDP), Parent-Child Interaction Therapy (PCIT), Theraplay, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Child Parent Relationship Therapy (CPRT) are popular research-based treatment interventions and will be discussed further.

## Dyadic Developmental Psychotherapy

Becker-Weidman (2006) described dyadic developmental psychotherapy (DDP) as a therapeutic treatment intervention for use with children who have attachment disorders. Hughes (1999) originally developed this intervention for children who experienced an early separation from primary caregivers that resulted in the child experiencing emotional distress. The goal of DDP is to help the child develop a trusting and safe relationship with caregivers.

DDP is based on the following principles. The first is that experiential therapy is essential to the therapeutic process. Counselors use the acronym P.A.C.E. (playful, accepting, curious, and empathic) as the guideline for the techniques and interventions utilized in therapy. In addition, treatment must be family-focused. Caregivers are taught the additional acronym P.L.A.C.E., reminding caregivers of the need to provide a home environment that is playful, loving, accepting, curious, and empathic (Becker-Weidman, 2006).

The belief that trauma must be directly addressed is essential to DDP. The child's trauma is revisited in the context of a caring adult so that the child can integrate the trauma into his or her sense of self and build a healthier attachment relationship with the child's caregivers. In addition, an environment of safety and security is essential in the home and therapy setting. The therapy is consensual and never coercive (Becker-Weidman & Hughes, 2008). The structure of therapy sessions usually has three components: (a) meeting with caregivers for support and teaching attachment parenting methods; (b) facilitating therapy with the child to create attunement, cognitive restructuring, and psychodramatic reenactments (caregivers are present in the session or observe through a 2-way mirror); and, (c) meeting with the caregiver without the child present to process the session and continue treatment planning.

Resource: Dyadic Developmental Psychotherapy Institute - http://ddpnetwork.org

## Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT), developed by Sheila Eyeberg (Institute for Family Development, 2013), is an empirically supported and family-centered treatment approach that has been adapted for work with abused at-risk children, and children exhibiting attachment difficulties. PCIT is an intervention that continues to be researched and is gaining popularity with a wide variety of populations, particularly children with externalized disruptive behaviors (e.g., oppositional behaviors). Over 30 randomized clinical outcome studies have found PCIT to be useful in treating at-risk families and children with behavioral problems (Child Welfare Information Gateway, 2007). Foster parents and pre-adoptive parents have participated in this therapy intervention with children who have experienced interpersonal trauma (Fricker-Elhai, Ruggiero, & Smith, 2005; McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Timmer et al., 2006).

PCIT counselors coach parents utilizing a "bug in the ear" while the parent interacts with the child. PCIT has a strong behavioral component and trains parents in strategies to reinforce the child's positive behaviors. Play is utilized as the medium for teaching and reinforcing desired behaviors (Child Welfare Information Gateway, 2007).

PCIT has two components: Child Directed Interaction (CDI) and Parent Directed Interaction (PDI; Fricker-Elhai et al., 2005). The CDI portion of the treatment includes the use of positive parent attention: while the child chooses toys to play with, parents are coached to praise the child for appropriate play and behavior. During this time, parents use skills represented in the acronym P.R.I.D.E.: praise, reflection, imitation, description, and enthusiasm (Child Welfare Information Gateway, 2007). The parent or counselor may use selective ignoring for behaviors considered undesirable. The PDI component of the treatment focuses on creating consistency and predictability within the parent-child relationship. The counselor trains parents to give specific and positively worded commands to the child. Typically, the child's non-compliance results in time-outs and two-choice commands. Throughout the course of treatment, parents are also asked to initiate daily structured and uninterrupted 5-minute play times with the child to reinforce behaviors and new parenting skills.

Resource: PCIT International - http://www.pcit.org

## Theraplay

Jernberg developed Theraplay in the late 1960's as an attachment and play-based intervention for children between the ages of birth to 12 (Booth & Jernberg, 2010). The unique characteristics of Theraplay include components such as nurturing touch, physical play, counselor directed and structured play sessions, and parent engagement with the child to promote healthier relationships. Psychoeducational strategies combined with play and family therapy are facilitated to build secure attachments between parent and child (Booth & Jernberg, 2010; Weir, 2011).

Theraplay is built on several basic assumptions: (a) the primary motivating force of human behavior is to connect and be in relationships, (b) a positive relationship between a parent and child is an essential component for change, and (c) secure attachments are rooted in responsive and playful attunement interactions between primary caregivers and children. The overall goal of Theraplay is to "enhance attunement, trust, self-esteem, and joyful engagement to empower parents to continue on their own the health promoting interactions of the treatment sessions" (Booth & Jernberg, 2010; Booth, 2013).

A basic treatment plan for a family participating in therapy would typically include 18-26 weekly sessions and 4 follow-up sessions each quarter for the following year. Treatment protocol includes an initial intake with parents followed by 2 sessions utilizing the Marshack Interaction Method. Session 4 and 5 entail the counselors reviewing observations with the parents and sharing the treatment plan, rationale for selected play activities, and potential reactions of the child. Direct Theraplay activities with the family are facilitated during sessions 6 through 25. Each Theraplay session includes interactions that involve structuring, engaging, nurturing, and challenging activities related to the presenting issues of the child and family (Booth, 2013; Booth & Jernberg, 2010). Special considerations and adaptations are often included in treatment planning for adoptive families, which may include extended sessions and/or overall treatment period, incorporation of processing components of the child's history and adapting to new family, and increased parent education to support responsive and therapeutic parenting in the home (Booth, 2013).

Resource: Theraplay: www.theraplay.org

## Trauma-Focused Cognitive Behavioral Therapy

While not all adopted children with attachment issues experience trauma, many have and they will need to have their trauma symptoms addressed in counseling. Cohen, Mannarino, and Deblinger developed Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) with an emphasis on providing mental health support for children and youth ages 3 to 18, who have experienced traumatic experiences such as abuse or neglect. TF-CBT collaboratively joins the caregivers and child to learn specific skills to assist them in processing thoughts and feelings related to a wide variety of traumatic life events. Family communication, strategies to increase safety, and parenting skills are included in this treatment protocol (TF-CBTWeb, 2005).

The majority of TF-CBT research, including 8 randomized controlled trials, has focused on children who have experienced sexual abuse (TF-CBTWeb, 2005). TF-CBT was utilized for children in foster care at two agencies and compared to children in foster care at other agencies receiving treatment as usual. Results indicated that children who engaged in TF-CBT experienced a decrease in placement disruption and running away and an improvement in PTSD symptoms (The National Child Traumatic Stress Network, 2008).

Resource: Trauma-Focused Cognitive Behavioral Therapy- www.tfcbt.musc.edu

## Child Parent Relationship Therapy

"CPRT is based on the rationale that the relationship is the essential and curative therapeutic dimension for improving and correcting children's problems and preventing the development of future problems" (Landreth & Bratton, 2006, p. 16). Adopted children who struggle with attachment challenges often have difficulty maintaining close relationships. Parents have the responsibility to guide children in learning how to be in a mutually satisfying relationship with others (Forbes & Post, 2006; Purvis et al., 2007). CPRT is based on child-centered play therapy principles, including a relationship focused on unconditional acceptance, genuineness, warmth, patience, and empathy, and communicates the importance of four "be with attitudes" for the parent to exhibit during special play times with their children. These healing messages are "I am here," "I hear you," "I understand," and "I care" (Landreth & Bratton, 2006, p. 84). The acceptance of the child through these four healing messages creates a safe

haven for the child to initiate a secure attachment relationship at the unique developmental pace of the child. These principles are fundamental to developing secure attachments in adoptive families (Carnes-Holt, 2010, 2012).

Child-Parent Relationship Therapy (CPRT) is a 10-session filial therapy model that uses a group format weaving together didactic information and group process (Landreth & Bratton, 2006). Overall research on CPRT includes 40 studies with a variety of presenting issues; 32 of these studies are controlled-outcome studies involving over 1,000 participants (Landreth & Bratton, 2006). Bratton et al. (2005) conducted a meta-analysis of 93 outcome-controlled research studies examining the efficacy of play therapy. Meta-analytic results on the effectiveness of CPRT indicated an overall large treatment effect size for CPRT (ES = 1.25). Carnes-Holt (2010) conducted a randomized controlled study investigating the effects of Child-Parent Relationship Therapy (CPRT) with 61 adoptive parents. The results indicated statistically significant decreases in child behavior problems and parent child-relationship stress. Raters blinded to the study also reported statistically significant increases in parent empathy. CPRT demonstrated a moderate to large treatment effect on reducing children's behavior problems and parent-child relationship stress. In addition, CPRT demonstrated a large treatment effect on increasing parental empathy. Brodzinsky (2013) recently reported that CPRT is one of the most effective clinical interventions for working with foster and adopted children.

The model is designed for an average of six to eight caregivers meeting together in 2-hour groups for 10 weeks. Counselors with training and experience in group process, child-centered play therapy, and child development facilitate the group. Sessions 1 through 3 focus on the building of group cohesion, enhancing safety, and communicating the objectives of CPRT and the concepts of child-centered play. In addition, parents receive clear instructions on gathering a filial toy kit, structuring the play session in the home, and learning the basic do's and don'ts of play sessions. After session 3, each member of the group is expected to begin sessions at home with the child, record the session, and bring the recording to the group to be viewed for support and supervision. During sessions 4 through 10, a schedule is designed so that home play sessions are viewed and supervision is provided each week. Parent-child play sessions may also be facilitated at the mental health clinic location for parents who are struggling with skills or having difficulty conducting sessions in the home. It is expected that all group participants will provide a recording a minimum of one time throughout this process. Additional skills such as therapeutic limit setting, choice giving, esteem building, and using encouragement versus praise are taught, modeled, and practiced each week. Generalizing concerns outside of play sessions and additional parenting concerns are addressed in sessions 8 through 10. It is also recommended that plans are made for a follow-up meeting to discuss progress and additional concerns (Carnes-Holt, 2010, 2012; Landreth & Bratton, 2006).

Resource: Child Parent Relationship Therapy - www.cpt.unt.edu

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