THE EXPERIENCE OF USING FILIAL PLAY THERAPY FROM THE PERSPECTIVE OF ADOPTIVE PARENTS: A CASE STUDY OF FAMILY ADJUSTMENT

by

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Adoption can consist of both positive experiences as well as challenges in parent-child relationship development. Research suggests that filial play therapy is helpful in fostering a secure attachment relationship. Given its potential role in establishing a parent-child bond, filial play therapy may an option for adoptive parents in building meaningful connection and a secure parent-child attachment relationship. The purpose of this study was to explore adoptive parents' experiences with using post-adoption filial play therapy in an effort to investigate the perceived usefulness of filial play therapy in improving attachment relationships between parent and child. Mixed-methods multiple case study methodology of three cases was used to explore adoptive parents' experiences with and perceptions about filial play therapy. Cross-case analysis revealed that adoptive families' experiences were highly complex. Parents had positive experiences using filial play therapy with their child and reported the development of emotional connection and a decrease frequency of adverse child behaviors. Given the positive outcomes of using filial play therapy in the adoption experience, parents suggested that more mental health providers be trained in filial play therapy to meet parent-child relationship needs within adoptive families.

Keywords: Filial play therapy, adoption, attachment, family adjustment, parent-child bond, case study

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CHAPTER 1: INTRODUCTION

"There is no friendship, no love, like that of the parent for the child."

-Henry Ward Beecher

The Impact of the Parent- Child Relationship

The parent-child relationship is possibly one of the most unique relationships one can have in life (Zeanah, Berlin, & Boris, 2011). The parent-child bond is so unique that it begins even before the child is born (De Cock et al., 2017; Condon & Condon, 1993). This prenatal connection is further developed throughout each stage of the child's life and can affect some outcomes for both the parent and child from birth to late adulthood (Doyle & Cicchetti, 2017). In fact, numerous research studies support the idea that some mental health outcomes are directly related to the quality of the parent-child relationship (Bucci, Roberts, Danquah, & Berry, 2015). For example, increased depression, anxiety, and mental health problems for children later in life were associated with poor parent-child relationship quality earlier in life (Morgan, Brugha, Fryers, & Stewart-Brown, 2012; Reitman & Asseff, 2010; Schimmenti & Bifulco, 2013).

Children who feel close to their parent, on the other hand, have been shown to have improved emotional functioning, social and behavioral adjustment, academic achievement, and even higher peer-rated social status (Barlow et al., 2016). Likewise, parents who are unable to bond with their child have reported more parental stress, marital struggles, depressive symptoms, and difficulty following through with parenting tasks (de Cock et al., 2017; Mason, Briggs, & Silver, 2011; Ponnet et al., 2013). Given these possible outcomes, it might be beneficial to intervene within the parent-child relationship in order to address these concerns.

Relevance of Attachment Theory

One theory that expanded our understanding of the parent-child relationship is attachment theory, originally developed by John Bowlby (1977). Essentially, its tenets are centered on the

need for children to use their primary caregivers as a foundation of safety, which they use to explore the world and learn to trust others. Bowlby (1988) posits that in a secure attachment relationship, a child can explore his surroundings and when things begin to feel unsafe, “he can return knowing for sure that he will be welcomed, when he gets there, nourished physically and emotionally, comforted in distress, reassured if frightened” (p. 11).

Bowlby, and later Mary Ainsworth (1982), determined that the parent-child bond becomes the main source of comfort for infants, and in times of trouble or distress the infant will seek their attachment figure. Over time, if the infant finds their figure is accessible, responsive, and engaged, then the relationship is strengthened and the individual is reassured that he or she can trust others with their needs as well. On the other hand, if the infant reaches for their attachment figure and the figure is inaccessible, unresponsive, or disengaged, then problems occur. Such problems are manifested in the form of one of these insecure attachment styles: anxious, avoidant, and disorganized (Ainsworth & Bell, 1970). Studies have found that within a secure parent-child relationship, children are more likely to develop, “a positive self-image, [a] capacity to manage distress, and comfort with autonomy and in forming relationships” (Bucci, Roberts, Danquah, & Berry, 2015, p. 2), while their securely attached caregiver experiences feelings of closeness and confidence, a decrease in stress, and greater marital satisfaction (de Cock et al., 2017; Mason et al., 2011; Vanfleet, Ryan, & Smith, 2005). When the attachment relationship is disrupted, however, children are likely to demonstrate psychological distress and behavioral problems (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010).

Adoptive families are one family type that may experience relationship disruptions. Research has demonstrated that these families might undergo parent-child relational stress

(Brabender & Fallon, 2013; Harris-Waller et al., 2016; Silverstein & Roszia, 1999), although the appearance of such stress is highly dependent upon when the child is adopted (Barth & Berry 1988; Rushton, Dance, & Quinton, 2000) and the circumstances surrounding the adoption (Brodzinsky, 1993; Grotevant et al., 2008). For example, children who are adopted commonly report a curiosity about their biological parents' decision to place them for adoption (Carnes-Holt & Bratton, 2014; Silverstein & Roszia 1999; Smit, 2002). For some adoptees, the biological parents' decision to place them for adoption may be internalized as rejection, leaving the child vulnerable to developing an insecure attachment to a subsequent parent figure based on how they see themselves and others (Carnes-Holt & Bratton, 2014; Smit, 2002). Whether they are involved in an open or closed adoption, research has shown that these children often wonder why they were placed for adoption and express feelings of loss and rejection to their new caregivers (Smit, 2002). In turn, these negative feelings could make it difficult for them to trust their adoptive parent and form a secure attachment relationship with them. However, if the parent is able to respond appropriately to their child's feelings, then this trajectory is likely to shift to a more positive attachment outcome (West, 2010).

In the face of attachment insecurity, adoptive parents may also feel rejected, as their continual efforts to encourage a secure relationship can seem in vain (Brabender & Fallon, 2013; Harris-Waller, Granger, & Gurney-Smith, 2016). Furthermore, these feelings of rejection are likely exacerbated by pre-existing feelings of insecurity as these adoptive parents attempt to navigate their new parental role (Harris-Waller et al., 2016). Parental insecurity possibly arises from the idea that biological ties are more valuable than adoptive ties, which could perpetuate feelings of illegitimacy for adoptive parents (Wiestra & Luke, 2017). These feelings may also be triggered when their child begins to discuss his or her own grief surrounding the perceived loss

of their biological parent. Depending on how the family navigates these conversations and emotions, both parent and child may find it difficult to establish a personal relationship with one another.

Although not all adoptive families experience difficulty in forming a secure attachment bond, some may find that certain factors inhibit them from developing such a relationship. For instance, children adopted later in life and those adopted internationally may find it more difficult to bond due to their life experiences prior to adoption (Brodzinsky, 1993; Mohanty & Newhill, 2006). As discussed previously in insecure attachment relationships, the child may voice a need but their caregiver may be unavailable to address that need, thus leaving the child feeling that their secure base is unreliable, therefore no one else is reliable. Likewise, some children who are adopted at a later age may have learned that their previous caregivers could not address their needs effectively, even when they voice such needs. They may therefore, be reluctant to share their needs with an adoptive parent. The cycle of unmet needs then makes it difficult for a child to connect with an adoptive parent. The adoptive parent may feel like they are not given an opportunity to connect with their child. Furthermore, depending on the child's relationship with his or her biological parents, this cycle can be even more complex as members of the adoptive family navigate those relationship dynamics as well (Brabender & Fallon, 2013; Smit, 2002).

Some of the adoption literature seems to capture these difficulties by documenting the negative outcomes that some adoptive families experience (Kobak, Little, Race, & Acosta, 2001; Miller, 2011; Wiestra & Luke, 2017). Ultimately, various factors can influence the difficulty of forming a secure attachment relationship. It may be helpful then to explore what services have helped adoptive families create a secure parent-child bond in the midst of their challenges. For

example, what is it like for adoptive families who use services, such as filial play therapy, to address some of their relationship concerns? Given the difficulties that some adoptive families face when establishing the parent-child relationship, the purpose of this study is to explore adoptive parents' experiences with post-adoption filial play therapy in order to investigate whether filial play therapy can be used as a possible intervention to improve the attachment relationship between parent and child.

Adopted Child Outcomes. According to the most recent report from the Children's Bureau, around 50,000 children are adopted in the United States in a given year (Children's Bureau, 2016). With so many adoptees in the U.S., it is important to investigate the challenges that adoptive families experience in order to offer them the support they need. Previous research has indicated that families with adopted children experience multiple stressors following adoption because of changing family dynamics (Harris-Waller et al., 2016; Smit, 2002). When compared to biologically related children, adopted children have been shown to undergo some unique challenges, which were originally identified by Silverstein and Roszia (1999) as loss, grief, rejection, and feeling guilt or shame, and struggling with identity and intimacy issues. These stressors can often be heightened by certain factors such as racial differences in families, disabilities, or a history of trauma and institutionalization (Petranovich, Walz, Staat, Chiu, & Wade, 2016; Welsh & Viana, 2012).

Some research has also found that adopted children may demonstrate negative internalized and externalized behaviors in response to these challenges (Brodzinsky, 1993; Harris-Waller et al., 2016; Juffer & van IJzendoorn, 2005; 2007). For example, in some studies involving adopted participants, findings suggest that those children experience developmental problems. Such as diminished language acquisition, delayed motor development, and stunted

growth (Bruce, Tarullo, & Gunnar, 2009; Petranovich, Walz, Staat, Chiu, & Wade, 2016; Welsh & Viana, 2012). In addition to these developmental outcomes, socio-emotional difficulties occur, including disinhibited social behavior, emotion dysregulation, anxiety, impulsivity, and aggression (Bruce, Tarullo, & Gunnar, 2009; Harris-Waller et al., 2016; Petranovich et al., 2016). From an attachment perspective, these children may have a hard time regulating their emotions and experience anxiety because they have internalized the idea that they are unlovable and the world is unsafe, and as a result they have a hard time engaging meaningfully in relationships (Bowlby, 1979; Bucci et al., 2015; Pietromonaco & Barrett, 2000).

Adoptive Parent Outcomes. While various stressors contribute to negative outcomes in adopted children, adoptive parents also experience some unique challenges as they try to navigate the demands of being a parent to a child with different life experiences and may have increased emotional needs. In non-adoptive families, parents report having significant stress resulting from their child's internalized and externalized negative behaviors and mental or physical illness (Harris-Waller et al., 2016). For adoptive families sampled in some of these studies, stressors are often present *and* intensified by the pressures of parenting a vulnerable and sometimes unfamiliar child (if adopted at an older age) (Brabender & Fallon, 2013; Harris-Waller et al., 2016; Weistra & Luke, 2017).

In a literature review by Lionetti, Pastore, & Barone (2015), some parental outcomes included mental health problems such as depression, marital couple conflict, and physical health problems, however it was inconclusive if there were any moderating variables contributing to these outcomes. It is also suggested that adoptive parent stress is greatly impacted by the quality of the attachment relationship they have established with the child post-adoption (Follan & McNamara, 2014; Harris-Waller et al., 2016; Lionetti et al., 2015). However, due to the difficult

challenges the adopted child may be experiencing (i.e., loss, grief, rejection, guilt, shame, and issues with identity and intimacy), a secure attachment relationship can be more difficult to develop and sustain. In many ways, it appears that the family's post-adoption experience is contingent upon the quality of the parent-child relationship as well as other factors that preceded that relationship. Therefore, focusing on the parent-child bond may be most beneficial in treating adoptive families who experience relationship difficulties as they try to navigate their new roles and overcome obstacles. When considering the numerous stressors contributing to the outcomes of both adopted children and adoptive parents, a critical evaluation is warranted to focus on the availability and effectiveness of the services adoptive families are currently using and are being offered as part of their post-adoption experience.

Gaps in Adoption Services

Before adopting a child, parents must fulfill various requirements to ensure the safety and security of their child (American Adoption, 2017; American World Adoption, 2017). Although it differs by state and adoption-type, most pre-adoption requirements include an extensive background check, providing multiple references, and participating in basic trainings as well as an extensive home study (American Adoption, 2017; American World Adoption, 2017; National Adoption Center, 2017). Once the child has been placed in an adoptive home, the only service that is typically required is a second home study, wherein a social worker will evaluate the basic safety and satisfaction of the family (National Adoption Center, 2017). Although adoption agencies and communities may offer some online training post-adoption, services typically stop once the child has been placed in the home (Hartinger-Saunders, Trouteaud, & Johnson, 2015).

Furthermore, parents have reported that it was difficult to access clinical services for their family while adopting, and some were unaware such services even existed (Hartinger-Saunders

et al., 2015). In one study, Brooks, Allen, and Barth (2002) found that many adoptive parents desired more services to meet their needs during adoption, such as relevant workshops and seminars, and gaining more preemptive health and background information on their child. The researchers also found that when it came to post-adoption services, less than 30% of families actually used the services available to them (Brooks, Allen, & Barth, 2002). Whether this is because they were unaware of these services, declined to use them, or simply did not need them, these findings suggest that some adoptive parents acknowledge gaps in services, and may desire more helpful and accessible resources to meet their specific needs.

There are numerous services available to families in general that consist of support groups, counseling, seminars, and publications. Yet despite these resources, a subsection of adopted children are still experiencing difficulty adjusting after adoption, that may result in adopted children experiencing disinhibited social behavior (Bruce et al., 2009), anxiety, depression (Harris- Waller et al., 2016), impulsivity, aggression (Petranovich et al., 2016), emotion dysregulation (Lionetti et al., 2015; Petranovich et al., 2016), and developmental delays (Petranovich et al., 2016; Welsh & Viana, 2012). Some adoptive parents experience couple conflict, and physical health problems (Lionetti et al., 2015). When considering this discrepancy between the need for services and those readily available to adoptive families, it may be that the services offered to these families are simply insufficient. Furthermore, health care professionals outside of adoption agencies may not have adequate experience in treating adoptive families specifically, which makes it difficult for these families to seek services outside of their adoption agency. Thus, it may be more helpful to offer families specialized attachment-based services as a part of the post-adoption process where they can find ample support and information for healthy family adjustment.

The Potential Role of Filial Play Therapy

Thus far, the literature has pointed out that children who fail to securely attach to their caregivers are at risk for some negative outcomes (Doyle, & Cicchetti, 2017; Reitman & Asseff, 2010; Schimmenti & Bifulco, 2013). Some children who are adopted may be at an increased risk for relationship distress depending on the circumstances of their adoption and their age (Brabender & Fallon, 2013; Brodzinsky, 1993), and could demonstrate internalized and externalized behaviors as a result (Bruce et al., 2009; Brodzinsky, 1993; Harris-Waller et al., 2016). Furthermore, it can be difficult for adoptive parents to restore relationships with their adopted child due to the attachment strains the child experienced beforehand (Smit, 2002). When looking at empirically supported interventions, it appears that filial play therapy is one approach credited with helping to facilitate a secure attachment bond in family types such as adoptive families (Carnes-Holt & Bratton, 2014; Cornett & Bratton, 2015; VanFleet & Sniscak, 2003).

Essentially, filial play therapy posits that children express themselves and experience their world through play (Cornett, & Bratton, 2015; Ryan, 2005; 2007; VanFleet, 1992). Thus, engaging children through play can be a meaningful way to intervene during relational turbulence. In times of distress, children are in need of reconnecting with significant people in their lives. Parents may take their child to an individual therapist to try and help them effectively adjust. The potential issue with this approach is that the therapist is often temporary and not a permanent member of the family. The parent, however, plays a significant role of attachment figure, and thus can be a critical person to help the child adjust effectively. Filial play therapy recognizes the important role of parents and suggests they become the primary agents of change in therapy (Cornett, & Bratton, 2015).

Through an attachment theory lens, parents are the primary change agents because children use the parent-child bond to relate to their surroundings. By engaging with children through play a parent is able to a) show the child that they are willing to understand the child's worldview; b) attend to their emotional needs; and c) strengthen the parent-child relationship by responding in a manner that is accessible, responsive, and engaged, thus improving the chances of a secure attachment. Given the potential attachment strains experienced by adopted children and their caregivers, filial play therapy offers a compelling approach to family adjustment and is one focus of the current study.

Filial play therapy is designed to help parents learn basic ways of establishing attunement and structure, two hallmarks of attachment. Originally conceptualized by Bernard Guerney in 1964, filial play therapy has since been used with many different family types to increase the parent-child attachment relationship and improve various outcomes (Carnes-Holt & Bratton, 2014; Cornett & Bratton, 2015; Walker, 2002; West, 2010; Yuen, Landreth, & Baggerly, 2002). Through the use of structuring, empathetic listening, imaginary play, and limit setting, the parent is able to engage with their child in a meaningful way in order to promote appropriate social skills, a sense of autonomy, and self-confidence, while also decreasing behavioral problems, aggression, and withdrawal tendencies (Walker, 2002; West, 2010; Yuen et al., 2002). Thus, filial play therapy can be a potentially effective tool in adoptive family adjustment.

Purpose and Design

While operating from the principles of attachment theory, the current study used a mixed-methods multiple case study approach to accurately explore and capture the lived experiences of parents who had participated in filial play therapy. The sample in this study was accessed through snowball sampling using email list serves and Facebook postings. Then, quantitative

data was acquired through online survey software (i.e. Qualtrics), and qualitative and observational data was collected via teleconferencing software (i.e. Webex). The research question asked was, what is the adoptive parent perspective on using filial play therapy as part of their family adjustment? The purpose of this mixed-methods case study was to explore adoptive parents' experience and perceptions of using filial play therapy after their adoption. In order to better understand the role of filial play therapy in adoption services, the following chapter will provide an overview of the theoretical approach as well as an extensive review of the literature regarding attachment-related problems and the function of filial play therapy in addressing those problems.

Chapter 2: Literature Review

Families with adopted children experience multiple stressors both leading up to and following adoption. These stressors often include changing family dynamics, experiences of loss and grief, and feelings that often include guilt, shame and rejection. Attachment theory provides insight into the adoptive experience and the difficulties associated with adoption for both children and their parents. It also lends insight into the usefulness of filial play therapy and why it might be a particularly effective model to use with adoptive families. This chapter will provide an overview of attachment theory and how it relates to adoptive families, as well as filial play therapy and how it can be used to enhance parent-child relationships during post-adoption.

Overview of Attachment Theory

John Bowlby pioneered attachment theory in 1958, although many of his ideas can be traced back to his experiences in the late 1930's as a psychiatrist in the London Child Guidance Clinic. It was here that Bowlby developed an understanding of parent-child relationships by observing the maladaptive behaviors of children who were abandoned during World War II (Holmes, 2014). At a critical time in Bowlby's training, Freud and Marx were leading the psychoanalytic movement, which was centered on what Bowlby considered to be "un-measurable" research (Bowlby, 1982). After spending a considerable amount of time studying parent-child interactions, and with much opposition, Bowlby began to develop his own ideas about the psychoanalytical approach. He considered the quality of a parent-child relationship dependent on the family's interpersonal experiences (Bowlby, 1982; Bretherton, 1992; Holmes, 2014). Taking on a more relational perspective, Bowlby conducted multiple studies where he explored parent-child interpersonal interactions, specifically focused on attachment behaviors between mothers and their children.

Extensive empirical findings eventually comprised Bowlby's attachment theory, wherein children used their relationship with their primary caregiver(s) to create a lens through which they evaluated and responded to their environment (Bowlby, 1982). Attachment theory is often described as a spatial theory, referring to the implications of proximity to a loved one. In other words, when an individual feels close to a loved one (usually a primary caregiver), they experience positive feelings of safety and trust. Conversely, when an individual feels their caregiver is unavailable or untrustworthy, they may feel that it is unsafe to trust others (Holmes, 2014). Feeling safe with a caregiver in a secure attachment relationship therefore, gives the child a "base" from which they can go out and explore the world, and a "haven" to which they can return in times of uncertainty. When a child recognizes their caregiver as a secure base, they are able to interact with their surroundings with confidence that their caregiver will be there to help them if needed. Eventually, the way their caregiver responds to their needs shapes the way they perceive themselves and others.

Internal Working Models. How children learn to view themselves and the world around them is what Bowlby (1979) describes as an internal working model. A child's internal working model is essentially a "mental representation of the self and others, formed in the context of the child-caregiver relationship" (Pietromonaco & Barrett, 2000, p. 155). Children with a positive attachment relationship that is characterized by love and trust will internalize that they are worthy of love and able to trust themselves and others (Cassidy & Shaver, 2016).

. On the other hand, if a child views their caregiver as unavailable, unloving, and untrustworthy, their internal working model might tell them that they are unworthy of love and support, thus prompting them to reject their attachment figure and have a poor view of self (Holmes, 2014). For example, several studies develop found that some adopted children

internalize their biological parent's absence as a form of personal rejection (even if this is not the case) and will create a schema that other people will reject them too (Carnes-Holt, & Bratton, 2014; Smit, 2002). This in turn can make it difficult for these children to form meaningful relationships later in their lives (Bucci et al., 2015; Pietromonaco & Barrett, 2000).

Further research has determined that an unhealthy attachment relationship can look different depending on the internal working model that an individual holds. An instrumental study that helped explain the different types of parent-child attachment relationships was Mary Ainsworth's Strange Situation experiment (Ainsworth & Wittig, 1969). During the Strange Situation, 26 infants were introduced to an unfamiliar room with an unfamiliar researcher, then their parent left the room. After some time, the parent returned to the room and, based on the infant's reaction to their parent's return, Ainsworth was able to categorize their attachment style. Ainsworth ultimately identified three main attachments styles in this experiment: secure, anxious, and avoidant (Ainsworth & Wittig, 1969).

In the secure attachment style, the infants were able to engage with their mother at her return and appeared happy. In the anxious attachment style, the infants attempted to engage with their mother but quickly turned away appearing distressed. Lastly, in the avoidant attachment style, the infants made no attempt to engage with their mother upon her return (Ainsworth & Wittig, 1969). Nearly two decades later, Main & Solomon (1986) identified a disorganized attachment style, wherein children behave in an unpredictable way in an attempt to soothe their fear. Children with a disorganized attachment style can demonstrate contradicting behaviors, such as running to their parent only to immediately turn away. Studies have found that this type of attachment style was often demonstrated in children who have experienced some form of

trauma (Duschinsky, 2015; Shemmings & Shemmings, 2014; Van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999).

Children in a secure attachment relationship have a positive internal working model of themselves and others, which helps them form close relationships. Those in an anxious attachment relationship are similar to one another in that they have a positive view of others, but view themselves negatively. They may then become preoccupied with forming relationships in order to feel validated. In the avoidant attachment relationship, children do not believe they can depend on others, so they rely on their own independence. Finally, in a disorganized attachment style, children long to depend on others and form close relationships, but also feel believe that they cannot trust others. Figure 1 depicts each attachment style in relation to the child's internal working model of the self and others.

Figure 1: Internal Working Model

Model of Others (avoidant)	Model of Self (anxiety): Positive (low)	Model of Self (anxiety): Negative (high)
Positive (low)	**Secure** Positive view of self Low anxiety Positive view of others Low avoidance "I can depend on others and they can depend on me."	**Anxious** Negative view of self High anxiety Positive view of others Low avoidance "I depend on others, but find that it is hard for others to depend on me"
Negative (high)	**Avoidant** Positive view of self Low anxiety Negative view of others High avoidance "I don't need anyone, I can get by on my own."	**Disorganized** Negative view of self High anxiety Negative view of others High avoidance "I want to be close to others, but find it difficult to trust them"

Primary Role of Attachment Relationships. There seems to be a systemic interplay of factors occurring through an attachment lens: as parents and their children interact, the internal

working model of the self and others is continuously formed, which then impacts the way they view and interact with other people. According to attachment theory, the primary role of a secure attachment is to have a safe base from which one can venture into various relationships knowing that it is possible to return and receive comfort when those relationships get difficult (Bowlby, 1988). In a secure attachment relationship, parents and children experience positive biological, psychological, and social outcomes (Barlow et al., 2016; de Cock et al., 2017; Mason et al., 2011; Ponnet et al., 2013). For example, children who experience a secure attachment with their caregiver are more likely to be able to manage stress, have increased self-esteem, and feel comfortable with forming relationships (Bucci et al., 2015). A securely attached caregiver also might experience more positive feelings towards their child (i.e., closeness, confidence, and trust), as well as less stress and greater marital satisfaction (de Cock et al., 2017; Mason et al., 2011; VanFleet, Ryan, & Smith, 2005). For adoptive families, a secure attachment is established when the child feels that he or she can trust and rely on their adoptive parent, despite his or her previous experiences.

Adoption can be difficult for a child (especially if they are older in age), because past attachment difficulties have already shaped their internal working model in some way (Brabender & Fallon, 2013; Brodzinsky, 1993; Holmes, 2014; Smit, 2002). Although some adopted children have had very positive relationships with caregivers prior to adoption, the literature suggests that many children have experienced prior adverse experiences (Brodzinsky, 1993; Brabender & Fallon, 2013; Grotevant et al., 2008; Silverstein & Roszia, 1999; Welsh & Viana, 2012). In the absence of a secure bond with a caregiver, research has revealed that parents and children tend to have a negative internal working model and may experience several negative outcomes (Bowlby, 1979; Bucci et al., 2015; Pietromonaco & Barrett, 2000).

Some children, for example, experience significant developmental delays (Petranovich et al., 2016; Welsh & Viana, 2012), emotional dysregulation (Petranovich et al., 2016; Harris-Waller et al., 2016), and psychosocial difficulties (Bruce et al., 2009). The parents of these children also express increased parental stress, marital struggles, and depressive symptoms (de Cock et al., 2017; Mason et al., 2011; Ponnet et al., 2013). Such negative outcomes seem to stem from insecure attachment relationships brought on by events that disrupt the parent-child bonding process early in a relationship (Holmes, 2014; Kobak et al., 2001).

Attachment Disruptions

Attachment theory suggests that children may conform to an anxious, avoidant, or disorganized attachment style because certain events, known as attachment disruptions, indicate to the primary caregiver is unable to provide stability and security (Holmes, 2014). Attachment disruptions are characterized by "prolonged and unplanned separation that shakes the child's confidence in the attachment figures availability" (Kobak et al., 2001, p. 245). Thus, children whose parents appear unavailable eventually develop an internal working model that tells them that they are unworthy of care and therefore should not trust others to fulfill their needs.

Cassidy and Shaver (2016) indicate two types of attachment disruptions that involve caregiver availability and responsiveness. Essentially, families can experience attachment disruptions in a variety of ways, including but not limited to divorce, domestic violence, or illness (Cassidy & Shaver, 2016; Cornett & Bratton, 2015; Lopez, Melendez, & Rice, 2000). These events can make it difficult for the caregiver to be available or responsive even when they wish they could be. As a result, their child might internalize these events as a direct response to their worth, thereby transforming the way they view themselves and the world. Throughout the literature, it appears that certain groups are at an increased risk for attachment disruptions

(Cornett & Bratton, 2015). For example, adoptive families may experience more disruptions due to the unique challenges they face throughout the adoption process, such as readjustment of roles, negotiating relationships with the biological family, and the stress that comes with legal and financial logistics (Brabender & Fallon, 2013; Silverstein & Roszia, 1999). The impact of such stress may also be affected by the age of the child and the child's circumstances prior to adoption (Brodzinsky, 1993; Grotevant et al., 2008; Rushton, Dance, & Quinton, 2000).

Attachment Disruptions in Adoption

Adoption can be a joyous and wonderful experience for families, and is often the beginning of a very meaningful time in a family's life (Brabender & Fallon, 2013; Weistra & Luke, 2017). While it may represent a meaningful transition for the family, it also can represent many difficult transitions. An adoptive family's experience is highly complex, and is not easily organized or explained through research. This is because so many people and systems are interacting with one another in the creation of that typically is a unique experience for each family (Brabender & Fallon, 2013; Brodzinsky, 1993; Weistra & Luke, 2017). For instance, some adoptive families may have a positive relationship with the birth family, while others may have never have met them; some adoptive parents may be related to their adopted child in some way while others may be completely different races or ethnicities; and some adoptive parents may know their child from birth while others meet them at an older age. Although many adoptive families have had a positive experience with family adjustment post-adoption, the complex and often stressful interactions within adoptive families can lead to difficulties in forming a secure parent-child bond.

Adopted Child Experience. The literature suggests that some adopted children, depending on their age, have experienced some type of attachment disruption prior to adoption

(Brabender & Fallon, 2013; Carnes-Holt & Bratton, 2014; Hodges, Steele, Hillman, Henderson, Kaniuk, 2003). Adopted children are likely vulnerable to attachment disruptions because the absence of their original caregiver may leave them with internalized feelings of loss and abandonment (Brabender & Fallon, 2013; Powell & Afifi, 2005; Smit, 2002). These feelings then form negative schemas of the self and others that shape the adopted child's internal working model (e.g. "I am not worthy of love and care and I cannot depend on others"). Over time, this model could potentially act as a barrier between the child and their adoptive parents, keeping them at a distance and decreasing the likelihood of forming a secure attachment relationship.

In addition to the stress of developing a new relationship with one or more adoptive parent(s), the adopted child may have also experienced some form of distress, or even trauma, prior to adoption (Grotevant et al., 2008; Kobak et al., 2001; Miller, 2011). Kobak et al. (2001) found that removing a child from his or her biological parents can cause serious trauma-like symptoms, and these symptoms are intensified depending on the circumstances of the removal. When the adopted child has had such distressing experiences prior to adoption, they may be more likely to internalize negative thoughts, which further prevents them from forming a meaningful relationship with their new caregiver(s).

The Role of Ambiguous Loss. The complex feelings that some children experience can be explained by the concept of ambiguous loss. Ambiguous loss occurs when one or both parent(s) is psychologically present but physically absent, or vise versa (Boss, 1999). Ambiguous loss can occur in situations such as military deployment, divorce, or even dementia, however research has shown that such a loss can occur in adoptive families as well (Boss, 2016; Powell & Afifi, 2005; Samuels, 2009). For example, for children with in an open adoption agreement, the biological parents may be psychologically present but physically absent. This in turn may elicit

feelings of loss for the child even though their adoptive parent is both physically and psychologically present. What complicates this situation further is that children may be reluctant to share their feelings with their adoptive caregiver(s) in fear that they might offend them (Powell & Afifi, 2005). Thus, the child keeps their feelings of distress to themselves therefore preventing an opportunity to emotionally connect with their adoptive parent(s).

Adoptive Parent Experience. Not only are adopted children impacted by adoption, but their adoptive parents may also experience some difficulties. First, the adoptive parent likely worries about their child's ability to adjust to their family, and may be preoccupied with fulfilling parental expectations upon adoption (Miall, 1987; Weistra & Luke, 2017). One study found that adoptive parents are specifically concerned with the child's self-esteem, identity development, and capacity to form a meaningful relationship with them (Brabender & Fallon, 2013). Furthermore, these concerns can be heightened by a lack of confidence that an adoptive parent may experience, especially for first time parents (Weistra & Luke, 2017).

Other factors to consider include the adoptive parent's reasons for adopting. For instance, some adoptive parents have spent years unsuccessfully trying to conceive their own child naturally and likely feel a sense of loss themselves (Brabender & Fallon, 2013). In addition to experiencing psychological strains prior to adoption, adoptive parents also may undergo a long and stressful process leading up to the adoption, such as "long waits, reversals of decision by birth parent(s), and political upheavals in countries in which adoption applications are made" (Brabender & Fallon, 2013, p. 3). Furthermore, depending on the type of adoption, the birth parents may still be involved in the adopted child's life, possibly creating more stress for the adoptive parents as they try to navigate familial boundaries and roles (McLaughlin, Feehan, Coleman, & Reynolds, 2013).

Ultimately, adoptive parents are perhaps battling two responses. One, they may be going through their own grief (either from trying to conceive children biologically or from trying to adopt unsuccessfully) and therefore they may have built their own emotional walls (Brabender & Fallon, 2013). Two, adoptive parents may feel an anxious need for their child to express love towards them because they might be dealing with their own sense of loss and uncertainty around what it means to be an adoptive parent (Tollemache, 1998; Weistra & Luke, 2017). Therefore, when the adoption finally occurs there could be a clash of competing needs; the parent needs the child to engage, to reassure a need to be valued as a parent, while the child is pulling away because the adoption and familial environment is a new and unknown environment for them. If such issues are not addressed in a sensitive and effective manner, resulting interpersonal interactions may leave the parent and child feeling disconnected and uncertain about their relationship.

Resources for Adoptive Families. While there are various supports in place to help families during and after adoption, some parents still report wishing there were more resources available to them particularly after an adoption (Brooks et al., 2002). Pre-adoption requirements and resources vary by state, but usually entail a home study and sometimes parenting classes or trainings (American Adoption, 2017; American World Adoption, 2017). After adoption, however, services typically stop, unless the family seeks out support groups, seminars, or counseling (Hartinger-Saunders et al., 2015). It appears that despite the available resources offered to these families, some children and parents still experience significant difficulty with family adjustment post-adoption (Brodzinsky, 1993; Harris-Waller et al., 2016; Lionetti et al., 2015). Given some of the challenges for families involved in adoption, it is imperative to consider therapeutic services, like filial play therapy, that will address both the experiences and

needs of the adopted child and the adoptive parent(s) after the legal adoption process has successfully occurred.

Origins of Filial Play Therapy

As more parents seek out family-based therapy for their children with behavioral, emotional, and mental health concerns, filial play therapy has become a prevalent approach for treatment (Bratton, Ray, Rhine, & Jones, 2005; Foley, Higdon, & White, 2006). Bernard Guerney first developed filial play therapy in the early 1960's as a way for parents to engage in the therapeutic process. Since parents are already an influential figure in a child's life, filial play therapy sought to capitalize on this relationship through play. Guerney believed that children express themselves through play; therefore using play to conduct therapy is a meaningful way to connect with children. In other words, play becomes an outlet for children to communicate when it is difficult for them to do so verbally (Bratton et al., 2005).

The foundation of filial play therapy places the parent-child relationship at the center of therapeutic change and family health. Therefore, by focusing on the parent and child's relationship during play, filial play therapy is able to help enhance their bond and even heal attachment disruptions standing in their way (Carnes-Holt, & Bratton, 2014; Cornett, & Bratton, 2015; Reynolds & Schwartz, 2003). This is made possible through the use of specific therapeutic skills and child-directed play, which is a type of play in which the child determines how he or she wishes to play rather than the adult. Child-directed play is said to help children communicate their needs, problem solve, and improve their self-esteem by giving them structure and a sense of control (Foley et al., 2006). For children of adoption, who often experience decisions outside of their control, having an environment where they are able to have control, with a caring and nurturing adult as their witness and partner, can often be very therapeutic

(VanFleet & Sniscak, 2003). Through child-directed play in filial play therapy, parents are encouraged to use four main therapeutic skills:

1. Verbally structure the beginning and end of playtime in order to help the child identify that this playtime will be different than others they have previously experienced.
2. Demonstrate empathetic listening, where the parent verbally reflects what the child might be thinking, feeling, and doing. This helps the child see that their caregiver is attuned and attempting to understand his or her perspective.
3. Engage in imaginary play when invited by the child. The parent will accept whatever role their child asks them to take on in order to help the parent play in a way that is most meaningful to the child.
4. Set appropriate limits to keep everyone safe, but not override a child's preferred play. This establishes boundaries necessary for safe and effective play without taking away from the child-directed role (VanFleet, 2000).

Training parents in filial play therapy skills has been shown to significantly improve the parent-child relationship. More specifically, verbally structuring the playtime offers a sense of stability to the child; the use of empathetic listening shows the child that their caregiver is attentive to his or her feelings; participating in child-led imaginary play gives children the freedom and control that they need to make sense of their experiences; and limit-setting gives children clear boundaries and expectations. All of these skills interplay to create feelings of trust and connectedness that are needed to develop a secure bond between the parent and child (Bratton et al., 2005; VanFleet & Sniscak, 2003).

Various research studies have identified filial play therapy as an effective form of family therapy (Bratton et al., 2005; Carnes-Holt & Bratton, 2014; Smith & Landreth, 2003; Yuen et al., 2002). For example, Bratton and colleagues (2005) conducted a meta-analysis of 93 filial play therapy studies and found that filial play therapy was more effective than traditional play therapy methods. This study recognized filial play therapy as a viable option to improve outcomes for both children and parents and enhance their relationship (Bratton et al., 2005). For example, filial play therapy has been shown to improve the child's behavior and the parent-child relationship, decrease parental stress, and improve the marital relationship (Carnes-Holt & Bratton, 2014; Foley et al., 2006; Kinsworthy & Garza, 2010; West, 2010). Therefore, filial play therapy may be considered as an appropriate intervention method when working with adoptive families, although additional research is needed.

Using Filial Play Therapy with Adoption

The Parent-Child Bond. There are several reasons why filial play therapy could be an effective intervention for adoptive families. First and foremost, it has been shown to strengthen the parent-child bond (Carnes-Holt, & Bratton, 2014; Cornett, & Bratton, 2015). This bond can be especially difficult to form for adoptive families due to their unique risk factors, such as a history of trauma (Kobak et al., 2001), experiencing a sense loss for both the parent and the child (Brabender & Fallon, 2013), or increased parental stress (Harris-Waller et al., 2016). In addition to the logistical and often times financial stress of adoption, the aforementioned risk factors can cause even more difficulties for adoptive families, specifically relating to the parent-child relationship.

Bratton et al. (2005) conducted a meta-analysis addressed the effectiveness of filial play therapy. After analyzing 93 controlled studies, Bratton et al. (2005) found that parents who were

trained and conducted the therapy delivered more effective treatment than trained mental health professionals. Other studies have supported this idea and found no significant differences between the skill levels of parent and professional groups in the provision of filial play therapy (Elling, 2003; Smith & Landreth, 2003). These results not only demonstrate that filial play therapy is an effective therapeutic modality, but it also underscores to the meaningful role that parents can play in the delivery of such therapy.

One important reason why filial play therapy should be used with adoptive families is the ability of such therapy to repair attachment disruptions and improve parent-child relationships (Bratton et al., 2005; Reynolds & Schwartz, 2003; Ray, Bratton, & Brandt, 2000; VanFleet, 1992). Since children in the adoption system are likely to have experienced some form of attachment disruption (Capps 2012; Kobak et al., 2001; Miller, 2011), it is crucial that therapeutic interventions used with these children address past disruptions. This is especially true for children who express symptoms related to trauma, which commonly occurs after the sudden absence of a parent or being removed from the home (Kobak et al., 2001; Miller, 2011). Fortunately, filial play therapy has even shown to be effective with extreme trauma cases, such as family violence (Kinsworthy & Garza, 2010), incarcerated parents (Landreth & Lobaugh, 1998), chronic illness (Tew, Landreth, Joiner, & Solt, 2002), and sexual abuse (West, 2010). These studies have demonstrated that filial play therapy can be used in treating a wide range of attachment disruptions and is capable of encouraging a healthy attachment bond despite past trauma.

Furthermore, researchers have suggested that filial play therapy has the potential to prevent attachment disruptions from occurring in the future (Bratton et al., 2005; Capps, 2012; Cornett & Bratton, 2015; VanFleet & Sniscak, 2003). Filial play therapy is thought to help

prevent future attachment difficulties because it impacts the family system, rather than the individual (Cornett & Bratton, 2015). Meaning, filial play therapy is able to create change within a family system, thereby giving the family the skills it needs to tackle future problems as they arise. This is different from other therapeutic approaches that encourage families to seek out professional support after a problem has established itself in the family system. Studies have shown that filial play therapy significantly impacts the parent-child relationship, and it is made more effective when parents are involved (Bratton et al., 2005; Cornett & Bratton, 2015; Smith & Landreth, 2003). Therefore, filial play therapy can be used with adoptive families even before the adoption is finalized to help prevent possible future attachment difficulties.

Supporting the Child. Perhaps what makes filial play therapy so conductive to forming attachment relationships within adoptive families is its use of four child management skills (Ryan, 2004). These research based skills address specific attachment needs for both the parent and the child (VanFleet, 2005). For example, verbally structuring the playtime is aimed to provide more structure to the children's lives, enabling them to feel a sense of predictability and stability, and therefore increased feelings of safety with their caregiver. Next, the use of empathetic listening and reflecting shows children that their new caregiver can offer them emotional support, thus increasing feelings of trust and connectedness. Third, participating in child-led imaginary play shows the child that they are free to play in a way that is meaningful to them, which gives them a sense of control that may not have existed prior to the adoption. Child-led imaginary play also allows the child to see that their new caregiver is willing to engage with them on their level. Lastly, limit setting gives the child clear boundaries, within which they can explore and express themselves safely. These boundaries not only help establish the parental role, but also give the child further clarity regarding what is expected of them. Each of these

skills interacts to create a safe, consistent, and emotionally warm environment needed to strengthen the parent-child bond, which is why filial play therapy could be useful in improving family adjustment after adoption.

Supporting the Parent. Studies have revealed that parents reported positive outcomes after participating in filial play therapy with their child (Cornett & Bratton, 2014; Foley et al., 2006; Kinsworthy & Garza, 2010; West, 2010). For example, parents who conduct filial play sessions with their child have reported being more aware of their child's needs and feeling increased empathy (Foley et al., 2006; Kinsworthy & Garza, 2010), more self-awareness and patience (Foley et al., 2006), less frustration with themselves and their child (Garza, Kinsworthy, & Watts, 2009), and overall more perceived self-confidence as a parent (Foley et al., 2006; Garza et al., 2009; West, 2010). For adoptive parents, experiencing these outcomes can be quite meaningful as they work hard to connect with their adopted child. Since parents are viewed as agents of change in filial play therapy, adoptive parents are likely to feel needed in the process and capable of making a difference in their child's life. Overall, filial play therapy has been shown to elicit positive outcomes for both children and their parents, and can be especially helpful for the parent-child relationship among adoptive families.

Relevance of this Study

Through the attachment theory lens, it appears that the parent-child relationship is an integral part of children's psychosocial development (Ainsworth & Wittig, 1969; Bowlby, 1969). Given the importance of establishing a secure bond between parent and child, filial play therapy seems to be a good option for families experiencing difficulties related to the parent-child relationship. The literature suggests that adoptive families are at risk for parent-child relationship difficulties due to the unique challenges they face before and after an adoption

(Brabender & Fallon, 2013; Harris-Waller et al., 2016; Kobak et al., 2001). Filial play therapy presents a potentially effective therapy intervention for these families. Unfortunately, very few studies thus far have investigated filial play therapy with adoption populations (Cornett & Bratton, 2014; VanFleet 1992; Ryan & Madsen, 2007), and virtually none have implemented case study research to understand the effects of filial play therapy on these populations. Therefore, the current study aims to fill this gap in the literature by interviewing three parents about their experience using filial play therapy after adopting.

To understand the perspective of adoptive parents who use filial play therapy for family adjustment, the purpose of this study was to use a multiple case study approach to explore adoptive parents' experiences with using filial play therapy post-adoption. This study has also supplemented qualitative interview data with quantitative measures and observational data of study participants interacting with their adopted children as a means of describing the parent-child attachment relationship. By analyzing a video interaction between the parent and child, I was able to gain an even deeper insight into the parent-child emotional connection that parents reported during the interviews. Ultimately, the aim of the study was to better understand the experience of adoptive parents using filial play therapy to improve their parent-child relationships.

CHAPTER 3: METHODOLOGY

Given the complexity associated with adoptive families it was important to use a methodological approach that is designed to help adoptive families share their story in a way that provides depth and richness in the data. Quantitative approaches that rely on measuring specific variables may help to understand certain aspects of the adoption experience but they often require researchers to narrow down the research question to a few concepts that can be quantified and measured, and are thus unable to document key qualitative aspects of the experience. Qualitative designs, while often lacking an ability to generalize to the larger population, provided an in-depth understanding of the experience. The purposes of this chapter is to provide an overview of the quantitative and qualitative design used, and describe how they were used to explore the experiences of the adoptive parents in this study.

Design

A multiple case study design was used to accurately capture the perceived experiences of three adoptive parents who engaged with their child filial play therapy post-adoption. Robert Yin (1994) describes case study methodology as a comprehensive research strategy that "investigates a contemporary phenomenon within real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (p. 13). Essentially, contextual experiences are used to explain a given phenomenon when the two are seemingly indistinguishable. In other words, lived experiences can help explain *why* certain outcomes occur; therefore, a case study is useful in developing an explanation for a given phenomenon such as adoptive parent-child relationships. For the purposes of the current study, the phenomenon being explored is adoptive parents who were trained using filial play therapy.

This particular research design was chosen for several reasons; first, there have been virtually no case studies like this within the field of adoption, and I sought to expand the literature on this topic through the use of case study research. Second, gaining access to many participants within this vulnerable population is difficult without someone within the system acting as a “gate-keeper” willing to afford access. Indeed, conducting research with any type of vulnerable population requires intense socio-cultural sensitivity (Wilson & Neville, 2009). Multiple factors make it difficult to access adoptive families for research. The literature describing this population tends to pathologize adoption, underscoring negative aspects of adoption. When adoptive parents believe that their adoption experience may be portrayed in a negative light, they may be hesitant to participate in research, especially if they are working hard to make adoption a positive experience for their child. Worried that the complexity of their situation will not be adequately captured, adoptive parents may be less inclined to have their family’s experience minimized to a few findings.

In addition to this population being difficult to access through parental consent, adopted children make up about 1% of the total children in the U.S. (Public Broadcasting Services, 2010), and parents with filial play therapy training reduce the population even more. In fact, the Association for Play Therapy database revealed only 302 approved play therapy providers in the U.S. (2016), with a small portion of those trained in filial play therapy specifically. Considering these obstacles, a promising place to focus research with the adoption population is to provide them with an opportunity to explain their unique experiences in depth so that they can tell their story from their own perspective.

Finally, since case studies are shown to be effective in exposing detailed perceptions of a given experience (Carlson, Ross, & Stark, 2012), the primary methodology used in this study

will allow us to understand if *and* why filial play therapy may be a helpful service to offer these families after the adoption. Answering *why* is a critical step in empirical investigation, because it offers researchers a platform to further understand *what* is behind a given phenomenon (Yin, 1994). In the current study, we hope to understand why using filial play therapy post-adoption is helpful, so that future research can investigate what types of outcomes occur as a result of using filial play therapy with adoptive families. Prior to initiating the study, approval was received from the Institutional Review Board (IRB). For IRB approval form, refer to Appendix A.

Quantitative Component. Yin (2009) suggests supplementing qualitative data with a quantitative element to enhance the validity of the study. In this mixed-methods design, I chose to incorporate a quantitative competent in order to improve the vigor of the case study. More specifically, a demographic survey, an adult attachment questionnaire, and an emotion connection observation (i.e. parent-child playtime) and coding procedure were used to evaluate the context of the parent-child attachment relationship within each family. These quantitative components are further described later in this chapter.

Qualitative Component. The qualitative component used was a semi-structured interview. In the interview, adoptive parents were asked to describe their typical interactions with their adopted child as well as how they perceive their child's attachment style. Next, the participant was asked to describe their experience of adoption, family adjustment, and their use of filial play therapy. The semi-structured interview questions are also provided later in this chapter.

Data Collection

Participants. Data collection began upon contact with the first participant and was completed upon reaching the end of the recruitment timeframe. The final sample included a total

of 3 parent participants (*n* = 3) and their adopted children (*n* = 4). In order to participate in this study, the following selection criteria was adhered to:

1) Participants must be an adoptive parent. Given an interest in understanding the experience of parents with adopted children, only parents who officially adopted at least one child were included in this study.
2) Their child must currently be between the ages of 3 and 12, which is within the age range of using filial play therapy skills
3) Adoptive parents needed to have received previous filial play therapy training. More specifically, participants needed to have been trained in a minimum of 8 to 10-week model of filial play therapy, which was the most common training program at time of the study.
4) Parents need to have used the filial play therapy training with their adopted child within the past five years. This time frame helped ensure that parents' experiences with using filial play therapy skills was recent enough to provide a clear description of their experience.
5) Participants must be English speaking.

Recruitment. A total of three adoptive parents were recruited for this study via snowball sampling. Snowball sampling is useful in research, particularly with vulnerable populations (Baltar & Brunet, 2012). This specific recruitment method allowed for a wider range of participants from various areas in the United States. In order to recruit participants, I asked adoption and filial play therapy professionals to distribute an invitation to participate in their email list serves (see Appendix B for email script). Additionally, we received permission from a significant developer in filial play therapy, Dr. Risë VanFleet, to post on her Filial Play Therapy

Facebook page (see Appendix C for Facebook script). Postings on other personal Facebook pages were also used for recruitment. Using these recruitment channels, I gave a description of the study, the selection criteria, and an email address for potential participants to inquire about participating. Recruitment through these channels took place one to two times per week until the goal of three adoptive parent participants.

Procedures. After recruitment had taken place, interested participants contacted myself through the email that was provided to them in recruitment materials. Then I called each potential participant and conducted an initial screening. Once participants were selected, I emailed a consent form and a link to the quantitative measures via Qualtrics. These measures included demographic questions, informative questions about their adoption, and the Relationship Scales Questionnaire (these measures are further discussed later on in this chapter). Once I received the signed consent form and participants completed the Qualtrics survey, I conducted the teleconference in-depth qualitative interview with each participant. At the beginning of this interview, I read the child assent form and the participant and their child were offered an opportunity to ask any questions before giving additional verbal consent. Thereafter, the child and parent were asked to engage in a 10-minute playtime together where the parent was asked to play freely and use filial skills if it felt appropriate. Immediately after the parent-child playtime, the child was dismissed and the participant engaged in a semi-structured interview. Each interview lasted approximately 1 hour and was recorded using teleconference software (i.e. Webex) and a voice recorder.

Parent-Child Playtime. Yin (2009) advocates using multiple methods of data collection to gain a deeper understanding of the phenomenon being studied. Using multiple data sources enhances the credibility of the data, improving the accuracy of analytic generalizations, which is

essentially a general conclusion that can be applied to a similar population of cases (Baxter & Jack, 2008; Creswell, 2007). Observational data is considered a viable option to enhance case study research because it can offer valuable insights that self-report measures cannot (Morgan, Pullon, Mcdonald, McKinlay, & Gray, 2017). I chose the parent-child playtime as an observational data source for this study in order to further understand the nature of play and evidence of emotional connections between each adoptive parent and their child.

During the parent-child playtime, I asked the adoptive parent and their adopted child to engage in a playtime that represents their typical playtime together. It was a concern that telling parents to use the filial play therapy skills specifically may heighten their anxiety, especially if had been some time since they used their skills and felt they were being evaluated on their proficiency. Since the purpose was not specifically to measure the use or accuracy of the filial play therapy skills, but rather the nature of their play and evidence of emotional connections, parents were encouraged to use the skills if they believed they were helpful in the moment. The playtime was recorded on the teleconference software, WebEx, and stored on a secure server.

Semi-structured interview. At the beginning of the interview, each participant was asked to choose a pseudonym for themselves and their child. Then, I re-reviewed the informed consent, affirmed agreement for participating in the study, and began the interview. As part of the in-depth semi-structured interview, each participant was asked to expand on some responses. The following questions comprised the interview guide and were used flexibly during the interview:

1. Please tell us about how it was for you doing the parent-child playtime?
    a. In what ways, if any, was this representative of your interactions at home?
2. How does your child typically engage with other people?

a. On a scale of 1 to 5 (1 = not at all, 5 = very much so) how do these statements represent your child?

    i. He/she can get emotionally close to others and does not typically have a difficult time being away from you.

    ii. He/she has a difficult time getting close to others and is reluctant to engage with you, often doing things independently.

    iii. He/she shows a desire to be close others but is unsure of how to do so and will express feeling of anxiety.

    iv. He/she appears upset most of the time, and it is difficult to predict their behavior and feelings.

3. Please tell us about your adoption experience as it relates to family adjustment?
4. Please tell us about your filial play therapy experience?
    a. In what ways, if any, did filial play therapy therapy help your family post-adoption?
    b. How has filial play therapy been helpful for your relationship with your child?
5. At what point in your adoption process did you receive filial play therapy training?
    a. What, if anything, would you change about this experience/timing?
6. Is there anything else you would like to add that would help us better understand your experience?

Post-interview notes. Immediately following each interview, I completed a field journal entry that described my thoughts, feelings, and observations during the interview. Each post-interview note was designated with a "P-I" before the date (see Appendix D). These notes were kept in the field journal in order to log any biases that emerged from the interviews. Post-

interview notes were also used as a reference during the internal and external auditing process, and during the development of themes in the analysis phase.

Measures

Demographics. The demographic questionnaire included traditional questions regarding the participants' age, gender, ethnicity, number of children, marital status, and socio-economic status (see Appendix E). Demographic questions were also asked about the participant's other children, as well as basic questions about their child who was adopted:

1. What is your adopted child's age, gender, and ethnicity?
2. How long ago was your child adopted?
    a. What age were they when you started the adoption process?
    b. How old were they when the adoption was finalized?
3. How old was your child when you started the adoption process?
    a. How old was your child when the adoption was finalized?
4. Is the adoption domestic or international?
    a. Is it an open or closed adoption?
    b. Is your adopted child biologically related to you?
        i. If so, how?

Attachment. The Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994) is a 30 item self-report questionnaire used to measure attachment styles (see Appendix F). The RSQ has a highly reliability coefficient ranging from .81 to .84 for the elf reports (Griffin & Bartholomew, 1994). I asked participants to rate each statement to reflect how they believe the items describe their feelings about close relationships. Items are placed on a 5-point Likert-style rating scale, ranging from 1 (not at all like me) to 5 (very much like me), and correspond to the

four attachment styles, providing a score for each style. Additionally, the instrument measures the participants' internal working model of their view of self and others, which is categorized as positive or negative. Therefore, the four attachment patterns were a combination of the two dimensions: secure (self-positive, other-positive), preoccupied/anxious (self-negative, other-positive), dismissing/avoidant (self-positive, other-negative), and fearful/disorganized (self-negative, other-negative). Participants were asked to complete the RSQ once in regards to their own attachment relationships, and then answer two questions to determine the focus of their typical primary adult attachment relationship:

1. As you answered these questions, who were you thinking most about? (For example, a spouse, parent, close friend, etc.)
2. When you need to talk to someone about an important problem you're having, who do you typically turn to first? What is their relationship to you?

The purpose of this data was not to perform statistical analyses to assess differences among participants, but rather as descriptive data that helped provide additional understanding of the participants' experiences. Ultimately data was collected using four different strategies: demographic and adoption questionnaire, adult relationship scales questionnaire, 10 minutes video-recorded parent-child play time, and in-depth semi-structured parent interview.

Data Analysis

Yin (2009) contends that case study research helps to tell a detailed story of a given experience, and in order to tell this story accurately researchers must 1) attend to all the evidence, 2) address rival interpretations, 3) focus on the most significant aspects of the study, and 4) use your own prior, expert knowledge to make sense of the study. In order to address these four components of a reliable case study, a researcher can consider using one of four

analytic strategies (Yin, 2009). The strategy used in this study was one that relies on theoretical propositions. The use of this strategy involved identifying and relying on propositions found in the literature. Propositions are often based in theory and used to "organize the entire case study and to define alternative explanations" (Yin, 2009, p. 131). I used the following overarching proposition for the current study: Based on the literature related to attachment theory and filial play therapy (Bowlby, 1988; Cornett, & Bratton, 2015), families that used filial play therapy post-adoption will generally report positive experiences of family adjustment. This proposition is divided into three specific propositions for analysis: a) past experiences shape the way people interact with their environment (Bowlby, 1982; Pietromonaco & Barrett, 2000), b) parents who are available, responsive, and engaged are likely to have children who exhibit secure attachment style behaviors (Ainsworth & Wittig, 1969; Barlow et al., 2016), and c) caregivers who are not as available, responsive, or engaged may have children who exhibit insecure attachment style behaviors (Ainsworth & Wittig, 1969; Bowlby, 1988; Fearon et al., 2010).

Once an appropriate analytic strategy is chosen, there are various techniques that a case study researcher can use for analysis. In order to understand the complexity of each experience, I conducted a cross-case synthesis technique of analysis. It is suggested to use a cross-case synthesis when the goal of the study is to understand each experience individually before comparing them to seemingly similar experiences (Yin, 2009). Consistent with this strategy, interviews were conducted one time, transcribed, and then analyzed. After data collection had taken place, a trained graduate assistant, who agreed to confidentiality of the data, transcribed the interviews verbatim within one week of data collection, and the process of cross-case analysis took place.

Observed Parental Emotion Coaching and Dismissing Emotion. Emotion coaching and dismissing variables were based on work by Gottman and colleagues (1997), and operationally defined using attachment theory propositions. Variables in the parent-child playtime were coded as present if the parent used a coaching or dismissing behavior during three separate time frames of the playtime (beginning = first 3 minutes, middle = next 4 minutes, end = last 3 minutes). I coded for coaching and dismissing behaviors using these three time frames to organize the data in a way that captured the tempo of the playtime. For example, the beginning of the playtime was typically slower as the participant and their child established their play, the middle of the playtime was generally characterized by more movement and engagement in play, and the end consisted of more structuring as the play time was nearing an end.

I coded emotion coaching behaviors using five coding items: "the degree of structuring that the parent provides (teaching, reflecting and problem-solving to facilitate emotion understanding), level of sensitivity and acceptance of the child, validation and encouragement shown towards the child, parents' enthusiasm and interest for the task, and the degree of parental intimacy, warmth and affection displayed during the interaction" (Hurrell, Houwing, & Hudson, 2017, p. 573). I coded emotion dismissing behaviors using four coding items: "parental derogation of the child, the degree of intrusiveness during the task, the amount of minimization and/or discouragement of child's emotion, and parental detachment and/or disinterest during the task" (see Appendix G) (Hurrell, Houwing, & Hudson, 2017, p. 573).

The total frequency of dismissing behaviors were then subtracted from the total frequency of coaching behaviors to produce a final "emotion connection" score. This score was used as a quantitative representation of the emotional connection that the parent and child shared during their typical play. In order to accurately capture this, we also used question 1a of the

semi-structured interview to better understand how representative the playtime was for each dyad (i.e. "In what ways, if any, was this representative of your interactions at home?"). Accounting for this question allowed me to essentially crosscheck the emotion connection score, and gave the participant an opportunity to explain how their emotion connection may actually look different on a normal day.

Initial Screening of Transcript. Three theological propositions were used to screen the data in each transcript before identifying main themes. Consistent with Yin (2009), I used propositions to help focus attention on certain data while ignoring other data that may not be as relevant for analysis. The first proposition was that past experiences shape the way people interact with their environment (Bowlby, 1982; Pietromonaco & Barrett, 2000). The second was that parents who are available, responsive, and engaged are likely to have children who exhibit secure attachment style behaviors (Ainsworth & Wittig, 1969; Barlow et al., 2016). Conversely, caregivers who are not as available, responsive, or engaged may have children who exhibit insecure attachment style behaviors (Ainsworth & Wittig, 1969; Bowlby, 1988; Fearon et al., 2010). During this analytic step, I screened the transcript line by line and highlighted any statements that were relevant to one of the three propositions (Appendix H).

Condensed Interviews. Once propositional statements were highlighted, I identified main themes in the margins of the transcript to prepare for between-case comparisons. Before comparing cases however, it was important to "treat each individual case study as a separate study" (Yin, 2009, p. 156). Therefore, in an effort to further understand and organize main themes within each case, I wrote a synthesis of the main themes that emerged from each interview question in the form of a condensed transcript. Along with the synthesis, specific quotes from the interview were recorded that supported each theme. Lastly, 3 to 4 theme words

were identified in the margins of the condensed transcript that captured the main idea associated with each theme (see Appendix I). The theme words from each synthesis were then used as a reference for developing a chart of themes.

Chart of Themes. As suggested by Yin (2009), I developed a table to organize the data in order to compare the themes associated with each case (Yin, 2009). Yin (2009) claims that this step allows researchers to determine if:

> Different groups of cases appear to share some similarity and deserve to be considered instances of the same 'type' of general case. Such an observation can further lead to analyzing whether the arrayed case studies reflect subgroups or categories of general cases – raising the possibility of a typology of individual cases that can be highly insightful (p. 160).

For this study, I created a chart to document the themes in each interview before comparing them to each other. Each participant's data was organized in a column, and each interview question was presented in a row (see Appendix J).

Similarities and Differences. At this point in analysis, cases were compared to one another for similarities and differences. A case-oriented approach was taken during this phase of analysis, which gives special attention to the commonalities of the cases so that an analytic generalization can be drawn from the data (Miles & Huberman, 1994). In other words, the similarities that the cases present helped to form a general conclusion that can be applied to a similar population of cases (Creswell, 2007). Similar theme words were highlighted in the same color across the "adoption experience", "filial play therapy experience", and "timing and suggestions" rows.

Evaluation of Research

I undertook various strategies to improve the trustworthiness of this case study, such as participant feedback, internal and external auditors, reflexivity, and bracketing. Results from

participant feedback and auditors will be discussed here, as well as the process of bracketing and evaluating assumptions.

Internal and External Auditors. It is suggested to use a crosscheck method to improve the internal validity of a case study (Riege, 2003; Yin, 1994). In this study, I used auditors to crosscheck findings and ensure an accurate analysis. Therefore, in an effort to improve the trustworthiness of the study, I included both an internal and external auditor for evaluating the analytical products. Both auditors were knowledgeable about research and the topic of adoption and play therapy. The internal auditor was a committee member, and the external auditor was a doctoral level student. I provided both auditors with field notes, transcripts, condensed transcripts, the cross-case synthesis chart, and the results section. In order to avoid any biases in distributing participants to the auditors, participant information was randomly assigned to each auditor. The internal auditor was asked to review documents for Sarah and Tracey, and the external auditor reviewed documents for Tracey and Jasmine. Both auditors reported that my analysis was accurate and had no further suggestions regarding the analytical data.

Participant Feedback. It has been suggested to implement participant feedback throughout qualitative analysis (Strauss & Corbin, 1998). Such feedback allows the participants to confirm if conclusions were accurate to their experience. After the interview, each participant received a summary of the interview via email. I called each participant within a week after her interview and asked her to correct any inaccuracies. All three participants confirmed that the summaries accurately represented their experiences and had no further changes or concerns. Once participants confirmed their interview summary, I was able to proceeded in writing the study findings.

Reflexivity. The process of reflexivity is viewed as an essential piece in qualitative research to improve the trustworthiness of the study and promote a sense of openness and curiosity for the researcher (Berger, 2015; Finlay, 2002). Reflexivity is essentially "the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Beger, 2015, p. 220). This process begins from the very beginning when the research topic is conceived, and carries out until the researcher is able to "bracket", or separate, any biases that may get in the way of analysis. In the current study, I performed reflexivity in my field journal to critically evaluate where some of my beliefs and feelings were coming from so that my biases would not interfere throughout the study (refer back to Appendix D for field journal example). This journal began immediately after proposing the study and ended after data analysis was completed. Personal reflections were primarily used to address these biases, and are documented below.

Personal Reflections. Throughout the study, I found myself exploring my values surrounding adoption. I realized that I admired the principles of adoption so much that I assumed all adoptive families had experienced some sort of fairytale transformation, where a difficult adjustment immediately after the adoption quickly transforms into a happy, healthy, cohesive family. I quickly recognized this was a naïve image of adoption, and that I desperately needed to hear the lived experiences of adoptive parents in order to provide a more accurate picture of adoptive family life.

What I learned was two-fold. First, although some children experience difficulties prior to and immediately following an adoption, their internalized and externalized behaviors may not necessarily be a direct result of the adoption. Second, adoptive families' development happens

slowly over time and is much more complex than what may be anticipated. I was confronted with the many layers of influence on each family's experience. For example, William's visual impairment impacted his ability to engage in play, a language barrier affected communication with Melody, and the various diagnoses that contributed to Kate's behaviors. Ultimately considering these layers helped to understand the experiences of these families from a broader, more systemic lens.

Another aspect of reflexivity that came up during the study was my previous experience using filial play therapy. As I began to conceptualize each family's experience using filial play therapy, I noticed that I was attributing my past experiences with filial play therapy to their own unique experiences. Since I had seen so many positive reactions to filial play therapy in the past, I expected to hear a resounding positive report from these parents as well. Other past experiences and personal values that may have influenced the study were also documented:

> As I begun reflecting on my motives for this study, I realized that my passion for adoptive family research comes from a very intimate place. First, I've always been curious about my father's adoption. He has always had a positive relationship with his adoptive parents, and I've wondered what has made his experience that way? Second, as I've grown up and developed my own religious beliefs, I've realized how special the concept of adoption is to me. Perhaps this is explained best through Romans 8:15 "For you have not received a spirit of slavery leading to fear again, but you have received a spirit of adoption as sons by which we cry out, 'Abba! Father!'".

These reflections helped motivate me to be intentional about the purpose behind this study, and it helped me evaluate where some potential biases may come from. Special attention was given to the entries regarding the participant interviews, as I attempted to manage any biases interfering with my conceptualization of the interview. As I began to realize my biases, I had to be intentional about recognizing and setting aside my preconceived ideas and treating each parent's experience individually. Doing this allows me to approach each interview with greater

attention and curiosity, and eventually gave each family an opportunity to describe exactly *how* they felt filial play therapy had helped their family.

Bracketing. After reflexivity has taken place, another way to address any biases interfering with analysis is the process of bracketing (Gearing, 2004; Tufford & Newman, 2010). In qualitative research, bracketing is used "to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research" (Tufford & Newman, 2010, p. 81). In other words, bracketing aids the researcher in objectively evaluating the research by managing his or her own biases and feelings that arise throughout the study. This step was important for the validity of the study, because it allowed me to separate my biases so that I could understand each experience as it was described without my own personal experiences interfering.

One method of bracketing involves keeping a running journal of reactions, values, observations, questions, and decisions (Tufford & Newman, 2010). Along with elements of reflexivity, I also recorded elements of bracketing in my field journal. For example, I noted any assumptions that were made in order to separate them from the actual experience of each participant.

Assumptions. Throughout the course of this study, I recognized three main reoccurring assumptions. The first assumption was that all adoptive families experienced difficulties with child behavior, which I attributed to the effects of their adoption (e.g. internalizing the adoption, asking questions about birth parents, negative experiences prior to the adoption, etc.). After conducting the interviews, however, I realized that some of the problems that these participants discussed were similar to problems experienced by non-adopted children. For example, Sarah, Tracey, and Jasmine observed their children engaging in "tantrums" when they believed their

children felt over-stimulated, which is a common response to over-stimulation even for non-adopted children (Potegal, Kosorok, & Davidson, 2003).

The second assumption on my part was that any improvements experienced by these families were a direct result of filial play therapy. The more I spoke with these parents, the more I realized that the topic of conversation was centered on filial play therapy, therefore any outcomes these parents spoke about were related to filial play therapy. This may mean that I may not have provided participants with adequate opportunities to speak about other factors contributing to the progress they saw in their family. In fact, Jasmine briefly spoke about the intersection between Kate's need for filial play therapy as well as Kate's need for a psychological diagnosis so that they could receive help from various sources,

> People don't want to give [diagnoses] to little children. I wasn't fighting for [help]. I don't care about the label, but I do need help. So call her whatever you want, but give me the help that goes with it.

This conversation told me that although filial play therapy was helpful for these families, the children had other needs other than those addressed in therapy. In other words, the complexity of adoptive families' experiences may require complex multifaceted solution.

The third pre-existing assumption I had was that communicating with adoptive parents would be difficult due to the stigma associated with some adoption research (Miall, 1987). This assumption required me to approach conversations with sensitivity and gentleness in an effort to honor each participant and her experiences. However, as I began asking participants more personal questions, I was surprised to see how willing and comfortable they seemed in answering these questions. Their responses may suggest that more adoptive parents would be willing to participate in research when they feel their perspective being honored.

Conclusion

While quantitative research is useful in studying specific aspects of an experience, the context, richness, and personal perspective of one's story can be lost. Qualitative designs such as case study methodology can provide an in-depth understanding of the experience and honor one's story. Given the complexity of each adoptive family's experience, qualitative research approaches such as case studies can aid adoptive families in sharing their story in a way that is rich and meaningful. Therefore, exploring and understanding complex experiences such as parent-child relationships post-adoption can benefit from findings gathered from a case study approach.

The current study used a mixed methods multiple case study methodology to explore and describe the experiences of adoptive parents using filial play therapy with their adopted child. Participants completed a demographic and adoption history questionnaire, a relationship scales questionnaire, and participated in a parent-child playtime as well as a semi-structured interview as part of this research study. Data analysis consisted of the analytic strategy using pre-determined propositions and a cross-case synthesis technique. Lastly, to promote the rigor of the study, an internal and external auditor reviewed the analysis process and findings, participants provided feedback on a synthesis of their interview, and I engaged in a reflexivity and bracketing process to control personal biases and assumptions throughout the study.

CHAPTER 4: RESULTS

The purpose of the study was to explore adoptive parents' experiences and perceptions of using filial play therapy post-adoption with their child to address their parent-child relationships. Using a mixed methods multiple case study design, adoptive parents were able to describe their family, the adoption, and their unique experiences using filial play therapy. The following section will provide a brief overview of each family as well as specific demographic information relating to each child and their adoption. Results from the parent Relationship Scales Questionnaire will also be discussed. Next, the parent-child playtime observation data and crosscheck methods will be explained, as well as perceived child attachment styles. Lastly, descriptions will also be given of main themes from participant's adoption experience, filial play therapy experience, and timing and suggestions for receiving services.

Participants

In this section, I will briefly describe each parent participant and their adopted child(ren), including demographic and adoption information. It is important to note that although it was not intended, our sample ended up being transracial special needs adoptions. At the end of this section, Table 1 will be included depicting the demographic and adoption information for each parent and their child(ren). Lastly, I will present the results for the parent Relationship Scales Questionnaire (Table 2).

Sarah and William. Sarah is a Caucasian female in her late forties. She is married and has some graduate school education. Sarah and her husband adopted William about four years ago when he was 2 weeks old. William's adoption is considered a semi-open domestic adoption. Sarah has two other children who are adopted and one that is in the process of being adopted and

lives in the home. Sarah also has five other biologically related children. Although Sarah has a total of nine children, only five are currently living in the home.

William was born 15 weeks early and with multiple complications. Sarah was notified about William immediately following his birth and jumped on the opportunity to adopt and raise him despite his health complications. He remained in the hospital with severe health concerns, with Sarah by his side until she brought him home. Sarah later discovered that William had multiple health probelms, one of which was a visual impairment.

Williams visual impairment impacts the way he interacts with his surroundings. Because of this, William is not able to play like other children, and Sarah has had to adjust filial play therapy skills to meet Williams needs. For example, rather than a parent's typical child-directed stance, Sarah provides William with a description of the toys in the room and asks William questions to ensure he knows he has options to play with. William's visual impairment affects his behaviors. For instance, William use to frequently hit Sarah when the two of them were together in public settings. However, Sarah later discovered through therapy that William's defiance was actually a manifestation of anxiety. William would act out when he felt anxious in public because he could not see who or what was occurring around him.

Sarah also shared with me her observation that William was extremely friendly with adults and interacted with them easily, but he was not so successful interacting with his peers. According to Sarah, this too is related to his visual impairment because he was not able to clearly see what his peers were doing and was thus reluctant to interact with them. Sarah reported that William experienced many outbursts of screaming and crying prior to engaging with her in filial play therapy. Sarah had tried many different behavioral aids and therapies, but none of them seemed to work until she discovered filial play therapy.

After receiving filial play therapy training and using it with William, Sarah and William experienced significant positive results. First, William was able to learn how to play. Sarah reported that through exploration, child-directed play, and empathetic listening, William was able to engage with his toys in a way that he had never been able to do before filial play therapy. Furthermore, Sarah was able to recognize William's needs (specifically when he needed special one-on-one time), and William was also able to have a sense of control that he had not experienced before. According to Sarah, this was very meaningful for William, because he is naturally controlling, yet his visual impairment hindered him from having control in his life. Lastly, Sarah was able to learn that there is a reason behind every behavior in children, which enabled her to emotionally relate to and console her other children as well.

Tracey, Melody, and Lucy. A choice was made to include both of Tracey's children in the study in order to see how their experience was different or similar to other families where only one child was adopted. Tracey is a married Caucasian female in her early fifties who had a graduate school education. Her only children are her 11 year-old daughters, Melody and Lucy. Lucy was adopted at 1 year of age and Melody was adopted at age 5 years. Both adoptions were considered closed and international. The family enjoys playing family games or participating in activities outdoors.

Since Melody was adopted at age 5, she was still developing her language skills at the time of the interview. Tracey stated that when Melody came to the U.S., she could not speak English, which impacted her ability to communicate with others and express her needs to Tracey. Melody also had a physical impairment that sometimes restricted her to a wheelchair. Sarah reported that Melody engaged well with others and made friends easily. Although her physical impairment sometimes prevented her from physically engaging with her friends. Melody had a

positive experience in foster homes before she was adopted and even developed some self-soothing skills that aided in her mental health. Tracey reported that one of the first goals for Melody after the adoption was to direct Melody to be soothed by Tracey rather than by herself in order to build a secure parent-child bond.

Lucy was adopted internationally at birth. She has been reluctant to do things without her parents or sister, which makes it difficult for her to engage in activities on her own. It is also much harder for Lucy to make friends and engage with others. After Melody's adoption, it was difficult for Lucy and she began to react in problematic ways. Tracey reported that it was difficult for Lucy to have to suddenly share her parents' attention when she was the only child for five years. Lucy's tantrums would consist of a complete loss of emotional control, including screaming, hitting, and an inability to listen to Tracey. Lucy's behavior served as a catalyst for Tracey to seek out filial play therapy.

Tracey described how she immediately created a special playroom in their home for filial play therapy, which the family called "the clubhouse." Through filial play therapy, Tracey began to notice a decrease in the frequency of Lucy's tantrums. In fact, Tracey reported that Lucy would even ask Tracey for some time in the clubhouse when she was getting upset. Melody also benefited from filial play therapy even though she did not exhibit adverse behaviors. According to Tracey, Melody was able to develop her language skills through play and became able to communicate her emotional needs. She eventually was able to seek out Tracey for soothing rather than relying on herself.

Jasmine and Kate. Jasmine is a married Caucasian female in her mid-thirties with a college education. Her daughter, Kate, is 8 years old and was adopted when she was 6 months old. Kate's adoption was an open domestic adoption, but Jasmine reported that she has had no

contact with her birth mother to date. Jasmine was born with fetal-alcohol syndrome and mild drug dependency due to her birth mother's substance use. Jasmine has another child who is older and biologically related living in the home. According to Jasmine, Kate has multiple possible health problems that contribute to her behaviors; however only ADHD, Anxiety, and Depression have been officially diagnosed. These diagnoses have severely impacted both Kate's and Jasmine's ability to sleep in the past.

Jasmine's daughter, Kate, is energetic and athletic and enjoys playing outside. Jasmine reported that she and Kate usually play structured games. Kate tends to portray Jasmine as "bossy" when participating in imaginary play together. Kate generally demonstrates unpredictable behaviors. Jasmine reported that Kate's emotions can change rapidly, which is likely related to her anxiety. Kate would exhibit tantrums where she would throw herself to the ground and scream and cry. Jasmine also described Kate as "a difficult baby" who had to be held at all times and was not easily consoled. In fact, Jasmine stated that Kate preferred Jasmine's husband rather than her for a long period of time. This was distressing to Jasmine, because in addition to losing sleep and dealing with an emotionally unstable baby, Jasmine was feeling rejected as Kate's mother.

After about 2 years, the family moved, and Kate's behaviors seemed to get worse. At this point, Jasmine sought a filial play therapist. She described how filial play therapy helped to change Kate's perspective of Jasmine by showing her that Jasmine could be fun and was looking out for her best interests. Jasmine reported that Kate was able to see how much she was loved and they began to have more positive interactions. Filial play therapy allowed Kate to attach to Jasmine over time. Although progress with Kate was difficult for Jasmine to see at first due to

sleep deprivation and emotional exhaustion, she reported looking back on that time and attributing their success to filial play therapy.

Table 1. Demographic information for study participants and their children.

Demographic Information for Participant's Children

	William	Lucy	Melody	Kate
How long ago was child adopted?	4.5 years	10 years	5 years	8 years
How old was child when adoption began; finalized?	1.5 weeks; 2 weeks	0; 1 year	5 years; 5 years	0; 6 months
Domestic or International adoption?	domestic	international	international	domestic
Open or Closed adoption?	semi-open	closed	closed	open but no contact
Biologically related to you?	no	no	no	no
Age of adopted child?	4	11	11	8
Gender of adopted child?	Male	Female	Female	Female
Ethnicity of adopted child?	Hispanic or Latino	Asian or Pacific Islander	Asian or Pacific Islander	Black or African American
Child living with you?	yes	yes	yes	yes
Number of other adopted children living with you?	2 and 1 not yet finalized	1 (Melody)	1 (Lucy)	0
Number of other non-adopted children lviving with you?	2	0	0	1

Parent Relationship Style

Each attachment score was derived from averaging specific questions. Secure attachment used questions 3, reverse 9, 10, 15, and reverse 28. Anxious attachment used 1, 5, 12, and 24. Disorganized attachment used reverse 6, 8, 16, and 25, and avoidant attachment used items 2, 6, 19, 22, 26. Scores for attachment styles revealed that Sarah scored highest for anxious attachment (3.75), closely followed by secure (3.2), avoidant (3.4) styles. Sarah's lowest score was a disorganized attachment (1.25). Tracey scored highest for secure attachment (3.8), closely followed by avoidant (3.6), anxious (2.0), and disorganized (2.0) styles. Jasmine also scored highest for secure attachment (3.4), followed by avoidant (3.2), disorganized (2.75), and anxious (1.75) styles. All three participants reported that they tended to go to their spouses first with their problems, with Tracey also indicating going to her close girl friends, but they thought about

other relationships as well, such as close friends, when filling out the relationship scales questionnaire.

Table 2. Relationship scale questionnaire results.

RSQ Data			
	Score	Who were you thinking most about?	Who do you go to first with your problems?
Sarah	Secure=3.2 Anxious= 3.75 Disorganized= 1.25 Avoidant = 3.4	all relationships	spouse
Tracey	Secure= 3.8 Anxious= 2.0 Disorganized= 2.0 Avoidant = 3.6	spouse and close girl friends	spouse and close girl friends
Jasmine	Secure= 3.4 Anxious= 1.75 Disorganized= 2.75 Avoidant = 3.2	spouse and a friend	spouse

Parent-Child Playtime

Parent-child playtime segments were coded using the operational definitions for coaching and dismissing behaviors. Once all behaviors were coded, scores were added together and the emotion dismissing score was subtracted from the emotion coaching score to comprise a final emotion connection score. Using this calculation strategy implied that scores closer to zero indicated more dismissing behaviors than coaching behaviors. In other words, the higher the emotion connection score, the more emotion coaching behaviors were used. The participant's emotion connection scores were calculated as follows: Sarah = 24, Tracey = 25, and Jasmine = 25. Emotion coaching to emotion dismissing ratios are also provided: Sarah ≈ 6:1 (actual = 29:5), Tracey ≈ 9:1 (actual = 28:3), and Jasmine ≈ 3:1 (actual = 36:11). It is important to note however, that these scores were likely impacted by the activity that each dyad participated in.

For example, Jasmine and Kate's activity was fast paced, therefore there were more behaviors overall and a higher probably for more dismissing behaviors. Thus, the emotion connection scores are dependent on the context of the interaction and should only be considered a part of their parent-child relationship.

Observations. To better understand these scores, playtime observations were recorded in the post-interview notes immediately following each interview. Observations about the choses playtime activity and perceived parenting role were made. These observation notes also included tasks that the family performed, their mood, or how they seemed to engage with one another.

Sarah and William. Sarah and William engaged in free play in William's room. Various toys were spread out on the floor, most of which were noisy or light-up toys. Although Sarah prompted William often, their playtime appeared more like a "free play" where William was free to choose which toy he wanted to play with. This may suggest that Sarah typically attempts child-directed play, possibly because she found this skill helpful for William. It is possible then, that Sarah tends to take a more filial-like role as a parent and typically gives William the space to explore and engage in play on his own terms despite limitations brought on by his visual impairment. For their playtime, I made the following observations:

> William played a lot with noisy toys and would frequently hold them up towards the laptop and mother, William frequently would throw toys to ground to hear the noise. Half way through play time he stood up and walked over to his bike, then engaged with Sarah using his building blocks at the end. Sarah sat in front of him about two to three feet away and would ask questions and attempt to hand him toys, but William would decline them and play to himself. At the end, the two played with blocks together. William tried speaking to me frequently and asked Sarah lots of questions.

These observations indicated that much of the playtime was spent with Sarah trying to redirect William to reengage in play, which Sarah attributed to his visual impairment. Sarah

explained that it could be difficult for William to fully engage in play when he was unable to see all of his toys or how others were attempting to interact with him through visual cues. Therefore, rather than the playtime being more child-directed, Sarah had to frequently ask and answer questions to allow William to fully experience his playtime.

Tracey, Melody, and Lucy. Tracey and her two daughters, Lucy and Melody, participated in a game of Uno together during their playtime. They were located at their kitchen table sitting across from each other. Choosing a game of Uno for their playtime may suggest that Tracey prefers more structured play and prefers not to use child-directed play. This is likely because Lucy and Melody have "outgrown special playtimes", as Tracey reported. Therefore, her decision to use a structured game may not be because she did not find child-directed play helpful, but rather that her children have developed past it. Observation notes for Tracey, Melody, and Lucy are as follows:

> Tracey, Melody, and Lucy quickly began playing a game of Uno (Tracey described that Melody and Lucy had outgrown the typical child-directed playtime and now they typically engaged in family style games). Melody and Lucy appeared nervous and apprehensive at first, but after about 5 minutes they were smiling and did not look at the camera again. Melody and Lucy did not speak much throughout the playtime unless answering a question from Tracey. Lucy appeared happy and enthusiastic about the game, while Melody appeared more calm and apathetic. Tracey did not demonstrate the use of many filial skills although she would occasionally describe that card they were playing, remind them of a rule, and reinforced the time limit after I gave them a one-minute warning about their playtime.

These observation notes suggest that the family participated in more guided rule-based games together, which could contribute to Lucy and Melody's quiet demeanor as they were trying to follow rules rather than participate in their own self-guided pretend play. On the other hand, Lucy and Melody's engagement in the game could suggest that the family participated in family games so frequently that it has become routine. Observations about Tracey may also

indicate that she desires for Melody and Lucy to be engaged with her, which is why she frequently asked questions and reminded them of the rules of the game.

Jasmine and Kate. Jasmine and Kate also participated in a family style game called "Spot It" where they had to quickly identify different images on a card and match that image to one on their own card until one player runs out of cards. Jasmine and Kate were also located at the kitchen table facing each other. Jasmine disclosed at the beginning of their playtime that she prefers using structured games because when Kate is given full control, she says things that Jasmine finds disrespectful, such as calling Jasmine "bossy". This may suggest that Jasmine prefers directing Kate's playtime as much as possible to prevent her from saying things that may feel offensive to Jasmine. In an effort to manage some of these negative feelings, it is possible that Jasmine chooses to take less of a child-directive role in her parenting and may choose not to adhere to some of the filial play therapy skills. Specific observations were taken after this playtime:

> Throughout the parent-child playtime, Jasmine was laughing and periodically described what Kate was doing. Jasmine also asked Kate questions throughout the play to engage her in the game. Numerous times, Jasmine would laugh and touch Kate's hand. Kate appeared happy and was even making funny faces occasionally. Kate did not seem too nervous, although Jasmine said she had been nervous towards the beginning of their playtime.

It seemed as though Jasmine and Kate had a positive interaction during their playtime. Although the game was not child-directed, Kate did not appear to have trouble engaging in the game, and the two appeared to enjoy each other's presence. Jasmine also displayed affection towards Kate throughout their playtime, possibly suggesting feelings of connectedness.

Question 1 Crosscheck. Playtime data was further crosschecked using question 1 of the semi-structures interview. This question asked participants to clarify how much the playtime actually represented their typical playtime together. Responses to this question allowed me to

gain a broader understanding of the emotion connection scores. Participants indicated how their typical playtime differed from the observed playtime.

Sarah and William. Sarah initially revealed that William was typically more imaginative during play, often pretending to go through a drive-thru or riding his bike to a concert. She also reported that William was typically more controlling during playtime, stating, “he likes to be in charge.” Lastly, Sarah discussed how she has had to readjust their playtime to accommodate William’s visual impairments. Sarah described her experience learning how to get William engaged in play therapy,

> So while 3 years old is the youngest that [play therapist] accepts children, she was a little leery about accepting him because of the visual impairment. So some things we had to work out to make it work because we can’t just let him into a room and expect him to know what toys are there. So it couldn’t be just free for all, like “William, what do you want to do?” because he didn’t know what was there.

According to Sarah, William’s visual impairment required her to point out toys, ask questions, and use many descriptive words. So, while their observed playtime contained these behaviors, their typical playtime may consist of even more instruction.

Tracey, Melody, and Lucy. Tracey reported that Melody and Lucy were usually more interactive than they appeared to be during the observed playtime, and that they may have been slightly nervous about being watched on the laptop. Additionally, Melody and Lucy were typically more imaginative during play, specifically with their father. Tracey reported,

> I tend to not do much imaginative play with the kids… [spouse] will do more than I do. He’s really good at it. He’s the one that would literally get down on the floor and play Barbie dolls with them.

Lastly, Tracey stated that the girls “play together more than with us as a family.” As Melody and Lucy have gotten older, they tend to do solitary activities together such as write

stories, do crafts, or read. Tracey also reported that when they do play as a family, they enjoy being outside.

Jasmine and Kate. Jasmine reported that similar to the observed playtime, she typically played with Kate during the day because Kate, "is calmer in the morning," and less impulsive. Additionally, Jasmine typically avoided using child-directed play because of the way Kate behaved during play,

> With free play, like with Barbies or something like that, that doesn't always go as smoothly. That's more… I don't even know how to explain it. It's almost like she wants to point out with the Barbies that I'm a controlling person… And she'll think it's funny with the dolls to kind of have disrespectful responses that she knows she wouldn't get away with.

It appears that Jasmine and Kate were participating in more child-directed play, which was fairly represented in the typical playtime. However, when Kate is more directive in their play, then more controlling behaviors and commentary might be evidenced.

Child Attachment Style

Question 2 of the semi-structured interview addressed the possible attachment style of each child. This question lists four attachment types in terms of child behaviors and asks the parent to rate their child according to how accurately the description portrays them. This was not an official assessment, but rather a guide to better understand each child's attachment relationship according to their parent.

William. Sarah reported that William is usually very friendly with adults, although had some trouble engaging with his peers. However, according to Sarah, William's behaviors were greatly influenced by his visual impairment,

> So he doesn't know what [his peers] doing, so he doesn't know how to join them. It's hard to find out where they are or what they're doing. So among his peers, he tends to stick to himself. But if there are adults around, he's going to try to engage with them.

Sarah reported that of the four attachment descriptions, William best fits the disorganized attachment style. Although he "separates fine" and connects with Sarah easily, William can be "very explosive" and goes "very quickly from 0 to 10." Sarah rated William a 5 on the scale for disorganized attachment.

Melody. Tracey reported that Melody was able to get emotionally close to her, engaged well with others, and although Melody sometimes has to be more independent due to a physical impairment, she typically "wants to be with people" and "makes friends fairly easy." Tracey also reported that Melody was getting better at communicating her emotions as she learned more English,

> We had the sign with faces on it… and we would have her point to those, "which of these are you feeling now?", but now she knows enough language that she can tell us. You know, "I didn't like this so I'm sad" or "I'm mad because of this". She's pretty good at saying "I'm mad".

Melody was able to do things independently and also engage with other people without too much trouble. Tracey rated Melody a 5 on the scale for secure attachment style.

Lucy. Tracey reported that Lucy does not like being separated from her and will often ask to do things with her parents or sister close by. Tracey stated that Lucy, "does not like to be alone… and it's a lot harder for her to make friends." Lucy also has a more difficult time expressing her emotions than Melody does. Tracey rated Lucy a 4 for avoidant attachment and a 4 for anxious attachment.

Kate. Jasmine reported that Kate's behaviors are unpredictable, which made it difficult to rate each description:

> It just depends on how much attention she's had that day with what she can handle. Yeah I mean it's hard because our typical is constant change… So yeah there's no consistencies. Her moods and frustration levels, I mean you never know what you'll get.

Jasmine also reported that Kate has trouble getting close to others and "puts walls up to guard herself". Kate sometimes has a difficult time interacting with Jasmine and other people in the evening when she is more energetic. Jasmine also reported that Kate was typically not easily consoled when upset. Jasmine rated Kate a 5 on the scale for disorganized attachment.

Adoption Experience

When considering the main themes within cases for participants' adoption experiences and comparing them between cases, specific similarities and differences arose. Theme words were considered similar if at least two of the three participants reported similar experiences. All other themes were considered different.

Similarities.

Adverse Behaviors. When asked to describe how their child behaved before receiving filial play therapy, all three participants reported their child displayed adverse behaviors. These behaviors were essentially considered by the participants to be emotional reactions and were typically described as "outbursts" or "tantrums". Sarah described these reactions for William:

> When he is really struggling there were days when it would be pretty much 24/7 that he would be on the floor screaming, yelling. He was very self-injurious for a long time. He would bang his head on the floor.

For Tracey, emotional reactions mostly occurred for Lucy after Melody was adopted. Tracey described how Lucy immediately bonded with Melody, however after having to readjust her position in the family after Melody was adopted, "it just became too much emotion for her to process as a 6-year old child". According to Tracey, these conflicting feelings (loving her new sister while disliking the change) became difficult for her to handle, which resulted in emotional reactivity towards Tracey and Melody at times. Tracey reported that Lucy had displayed tantrums as well, often to the extent that prevented them from going out in public as a family:

> I mean it was completely out of control. Like outright, full-out tantrums. Full-out I mean the eyes would glaze over. When you talk about or hear about children completely breaking down emotionally, that's what she was experiencing… So we went through a real tumultuous 6-9 months. We would not even go out. We would not go to a social event because the emotions were so uncontrolled.

Likewise, Jasmine described how Kate exhibited outbursts at a very young age after her adoption:

> She oh gosh she was still crawling; it was right before she walked at 9 months that I saw her throw herself to the ground for the first time, and that's younger than any kid I've seen for a tantrum, so I knew I was in trouble then. But she would cry on the ground. She threw things. Crying, screaming.

Emotional Distance. Both Tracey and Jasmine described incidents of emotional distance from their child. Tracey reported that Melody had adapted "self-soothing habits" as she lived in a child welfare institute before the adoption took place. According to Tracey, this made it difficult for Melody to emotionally connect with her at first, and they had to "pull her out of the self-soothing and pull her into being soothed with Mom and Dad." Similarly, Jasmine reported that Kate "wouldn't really respond to toys or being consoled." In fact, Kate wanted to be held for the first 6 months and would still show signs of restlessness. In both families, most efforts to comfort their child were unsuccessful, leaving both Tracey and Jasmine feeling defeated, frustrated, and discouraged at times.

Previous Failed Attempts. Similarities existed in Sarah and Tracey's attempts to address some of the negative behaviors they were experiencing. For both participants, these attempts did not seem to work and led them to seek filial play therapy services. Sarah describes this frustrating time in their journey:

> We went to an occupational therapist… we tried everything. Like bringing in pillows, but he didn't want the pillows; he wanted that feeling of hitting his head on the floor. We tried everything. External hugs to give him that pressure, but no, that didn't work. And that was another reason that we went to filial.

After noticing Lucy using imaginary play to process some of her negative emotions, Tracey decided to seek out therapy services as well. However, this also did not seem to work in the same way that filial play therapy worked:

> And we had actually tried some other family therapists but nothing worked out well like it did with [filial play therapist]… They just didn't have the skills; they didn't use [filial play therapist's] play therapy skills.

Differences. There were two main differences noted in participant's post-adoption experiences. First, Melody's experience was unique because of her language barrier. Tracey noted that much of Melody's behaviors and emotional distance was possibly due to an inability to understand English right away. In fact, most of Melody's behaviors started to subside as she developed more English language facility. Melody's language barrier was a significant part of their family adjustment, as the whole family had to learn how to communicate in a meaningful way with Melody.

The second difference discussed by one participant was parental preference of the child. Jasmine described how after the adoption, Kate attached well to Jasmine's husband rather than her. This was the only time that a participant reported their child preferring one parent over the other before play therapy. Jasmine reported that Kate distinctly preferred to interact with her husband, which was distressing to Jasmine:

> There was a big chunk of time where she preferred [spouse] over me, and that was frustrating. You know cause he went to work all day, but okay, 'I'm all ya got, kid'. So that was hard for her. And by the time [spouse] got home, I was really flustered and sad that I couldn't console my kid. You know frustrated and all. Just really stressed out. And very little sleep, very little sleep. Not a winning combination.

Filial Play Therapy Experience

The second half of the interview focused on parents' experiences with filial play therapy. Each parent described her experience learning filial play therapy skills, as well as how filial play

therapy has helped their child's behaviors and their parent-child relationship. Similarities and differences were also noted among the participants in their description of the process and impact of the therapy.

Similarities.

Challenges Learning Filial Play Therapy. Both Sarah and Jasmine reported experiencing some challenges learning filial play therapy skills. Sarah stated, "there was a little bit of fear going in thinking, somebody's going to be watching me and how I play and what does that mean?" Sarah's fear subsided after a few sessions of practicing filial play therapy skills and getting to know the play therapist. Likewise, Jasmine reported that it took her a while to connect with the therapist, because she felt overwhelmed and even "scrutinized" at times as she was learning the skills. However, once Jasmine was able to relate to the therapist on a personal level and see some progress from engaging in filial play therapy, she began to feel better. Jasmine also described how understanding the goals of each filial play therapy skill was also helpful for her:

> But it took us awhile to kind of connect because I kind of do better if you explain the end goal; it was a lot of "just do this today", "just do this at home this week", "come back". Okay where are we going here? So I feel like there was some of that and I was also sleep deprived. I mean I read, I learn, I do a lot of that, so if I had been my normal self, I would have read more about it and learned for myself… I think once I saw more with where [filial play therapist] was headed and you know seeing a little bit of progress kind of helped too.

Emotional Connection. Sarah and Tracey described how filial play therapy helped them emotionally connect with their children. Sarah described how filial play therapy helped her understand where some of William's behaviors were stemming from and that, "it has helped [her] to recognize when he needs one-on-one attention, and a way to do that [in a way that] he enjoys and that can give him what he needs." For Sarah, such insights were meaningful, because

as she began to understand what William needed, she was able to meet those needs, which then strengthened their parent-child bond.

Tracey also described how filial play therapy gave her and Melody, "ways to communicate," and Lucy a way to express her emotions safely. Tracey attributes filial play therapy with providing skills to Melody that allowed her to develop more emotional language and then use that language to express herself to Tracey so that Tracey could address her emotional needs,

> Now she knows enough language that she can tell us. You know, "I didn't like this so I'm sad" or "I'm mad because of this." She's pretty good at saying, "I'm mad." Okay so let's figure out why you're mad and see if we can get rid of those feelings.

Decrease Adverse Behaviors. Tracey reported that Lucy's adverse behaviors started to decrease after about six months of using filial play therapy. In fact, Lucy was experiencing so much progress that she was even able to identify when she needed to have a special filial playtime:

> And then after that, maybe once a month for the next 6 months we used. Because she didn't really need it, but when she would feel herself feeling that way, then she would start asking for it. And you were like, 'okay she's got enough control of what's going on with her emotions and understanding', and that was the big deal, trying to help her understand what she was feeling and being able to express it in a positive way.

Jasmine also reported that she and Kate were less frustrated with each other and helped Kate to connect with Jasmine rather than react to her out of frustration:

> I think she was finally able to connect with me and we could play and have fun. I think she was young, and we had so many straining interactions, just all the emotions on both sides. I don't think she knew that I could be fun, that I wanted to kind of interact with her. I think she was able to just see a different side of me and start thinking of me as a caregiver that did have her best interest in mind… it was always this power struggle and trying to - I mean she wouldn't let me dress her, she wouldn't let me do anything without a fight. So seeing that I could be fun and that I cared about her in that way to have fun with her kind of changed her perspective.

Through filial play therapy, Kate and Jasmine's interactions began to be more positive, rather than strained and conflicting.

Differences.

Sarah. Due to William's visual impairment, it was difficult for him to engage in child-directed play right away. Sarah reported one unique experience they had through filial play therapy,

> I know filial is not for visually impaired kids but I think it's helped him learn to play. I think it helped him learn to imagine… So I think part of it for me was realizing he is a normal kid.

Sarah believed that play is something that does not come as naturally for William, however William was able to develop play through filial playtimes with Sarah. Sarah also described how filial play therapy helped give William an appropriate sense of control**:**

> It has helped me to recognize when he needs one-on-one attention. And a way to do that that he enjoys and that can give him what he needs… And now I have something to do in that one-on-one time with him and where he feels in control. And also it helped us to see his need for control and to give him a controlled place where he can have control.

Tracey. Unlike Sarah and Jasmine, Tracey reported that she was able to engage in filial play therapy training fairly quickly. Tracey even described how they created their own special playroom at their home that they used quite frequently. Another unique element that Tracy experienced with filial play therapy was Melody's ability to learn and use the English language. Tracey was able to use emotional termonology through play to teach Melody helpful language for her emotions. Tracey described superficially how filial play therapy has helped Melody in emotional language acquisition,

> But really having the doll reflect back like, "Oh you can see that she looks sad" or "Oh she looks really happy" or "Oh she looks like she's frustrated with this, like she wants something." Being able to use that play therapy and reflect back to them changed the whole language and communication.

Jasmine. The main difference that Jasmine pointed out in her interview was how Kate developed an attachment with her through their playtime. Since Kate was more attached to Jasmine's husband, it was encouraging for her to see Kate begin to connect with her as well. Jasmine reported, "[filial] really did help our relationship that she could kind of transfer her attachment onto me also, so that was good". Jasmines described how filial play therapy helped to change Kate's "perspective" and begin to view Jasmine in more of a positive light so that emotional connections could be made.

Timing and Suggestions

Participants were asked about when they received filial play therapy training after the adoption, and the suggestions they might have for the adoptive or filial play therapy population.

Similarities. All three parents reported that more filial play therapy services are needed especially for adoptive families. Each participant described their difficult experience finding play therapy services, and that in most cases; connections were the only route to such services. Tracey even wondered, "if [she] was not a teacher and was not familiar with all these kind of things already, how successful would [she] have been finding a play therapist?"

Furthermore, for trained filial play therapist already practicing, Tracey and Jasmine suggested that they be more knowledgeable about the adoptive population. For example, Tracey described a negative experience she had with a therapist who used a book that appeared "anti-adoption" and spoke with language that was slightly offensive (e.g. "gave up" for adoption rather than "placed" for adoption). Tracey stated that more filial play therapists should be knowledgeable about appropriate language to use with adoptive families. Similarly, Jasmine suggested that more therapists be aware of other mental health resources to provide adoptive families with. Jasmine frequently talked about the "many layers" in Kate's adoption experience,

and coupled with Jasmine's lack of sleep, it was difficult for her to navigate the many resources available to them at the time. Jasmine states:

> Someone working especially with adoptive families it would be useful for them to have information. … And maybe have a list of resources for the area that you are I think would've been helpful too because I think we caught on late to some of the other things going on that may have been affected by adoption.

Differences. First, all three parents received filial play therapy training at different points after the adoption: Sarah received it 3.5 years after, Jasmine received it 3 months after Melody was adopted, and Jasmine received it 2 years and three months post-adoption. The biggest difference in this question however, was the timing in which each participant suggested adoptive parents *should* receive filial play therapy training. Interestingly, all three participants suggested different time periods to receive filial play therapy training. Sarah suggested that parents get trained in filial play therapy post-adoption when they actually find that they need it. Sarah states, "if we had known about it earlier, maybe we would've pursued it earlier, but I don't think it would've clicked until we needed it". She believes filial play therapy worked so well for them because they knew they needed something different and they were highly motivated to use the skills they were being taught.

Sarah also mentioned that during preparation for adoption, most parents are given heaps of information, tips, and guidelines, so learning one more skill might feel too overwhelming. Tracey, on the other hand believed that pre-adoption training *would* actually be the best time to learn filial play therapy:

> So going through that process [of pre-adoption training], I might have felt a little resentful, like ugh. But as soon as you need that skill, you had it. So now talking to parents who are going through the process, I would probably recommend that they get the play therapy training before the adoption – at least for an older child. I would recommend it – especially if they're dealing with an international adoption because you have that language barrier.

For Tracey, there is value in having the filial play therapy skills ready when you did need them. So although learning filial play therapy before an adoption might feel overwhelming, Tracey believes that parents would benefit from having those skills at their disposal as soon as they are needed. Lastly, Jasmine recommends parents receive filial play therapy training post-adoption, but before there are too many problems in the family. A large part of Jasmine's story was feeling exhausted from years of sleep deprivation. Jasmine described how a lack of sleep really affected her ability to engage in filial play therapy and see progress right away. Because of this experience, Jasmine believed that "early intervention would've been good". Essentially, she states that it would be best to receive filial play therapy training post-adoption when you need it, but not too long after feeling tired and defeated by all of the difficulties.

Conclusion

This chapter provided a brief overview of the demographic and adoption information for the families of Sarah, Tracey, and Jasmine. Results for the parent Relationship Scales Questionnaire were also discussed. It appeared that the parent-child playtime observation data closely represented each family's typical interactions, as confirmed by the crosscheck question offered in the interview. Additionally, each parent's perception of her child's attachment style was provided in the form of a 5-point Likert-style rating scale. Lastly, main themes from participant's adoption experience, filial play therapy experience, and timing and suggestions for receiving services revealed that although adverse behaviors and emotional distance occurred post-adoption, participants experienced positive outcomes from using filial play therapy with their adopted child and believed that more adoptive families should be offered this service.

CHAPTER 5: DISCUSSION

This study sought to answer the question, what is the adoptive parent perspective on using filial play therapy as part of their family adjustment? The purpose of this mixed-methods multiple case study was to explore adoptive parents' experience and perceptions of using filial play therapy after their adoption. The purpose of the current chapter is to discuss the findings of the study by exploring some of the main ideas that derived from the cross-case synthesis of the interviews. Analytic generalizations will be made based on these ideas that could be applied to other similar populations. In an effort to evaluate the clinical implications of the results, existing literature will be used to discuss the complexity of participant's adoption experiences, as well as the outcomes they expressed through their use of filial play therapy. Lastly, limitations of the study will be discussed as well as future directions for research.

Interpreting the Findings

Making generalizations from case study research can be challenging due to its naturally small sample size (Yin, 2013). However, it is suggested to develop analytic generalizations, which is "the extraction of a more abstract level of ideas from a set of case study findings − ideas that nevertheless can pertain to newer situations other than the case(s) in the original case study" (Yin, 2013, p. 325). When interpreting findings to form an analytic generalization, theory and existing literature should be used as a guide (Yin, 2013). In this section, attachment theory and existing research will be used to evaluate the study's results. Findings will be divided into two main categories: complexity of experiences and filial play therapy outcomes.

Complexity of Experiences. There appeared to be a complexity in each participant's story. As discussed in the previous chapter, each family's story was layered with different components, all intertwining to create a very unique experience. Layers such as age of the child,

family structure, circumstances of adoption, and diagnoses all played a role in the adoption and filial play therapy experience for each family. Given this complexity, it is important to understand the systemic interaction between individual needs and relational needs for the parent and child as it related to each experience.

Individual Needs. There were individual needs within each family that contributed to their adoption and filial play therapy experience. For example, William's visual impairment played into his ability to play with toys, Melody's development of language impacted her ability to communicate her needs, and Kate's anxiety affected her ability to sleep. These factors required specific individualized solutions as well. In order to simply play with toys, William needed Sarah to point out which toys were in the room. For Melody to communicate her needs, Tracey had to create a way for her to communicate through feelings charts and pretend play. And for Kate to get enough sleep, Jasmine had to find ways for her to release her anxiety outdoors. Each of these individual factors contributed to the wellbeing of each child, while simultaneously impacting how each child interacted with their parent.

Relational Needs. It seemed as though the individual experience of each child was so impactful that it affected the interactions within the family. As mentioned in the previous literature, adoptive parents and their children may both be experiencing a clash of competing needs; the parent needs the child to engage, to reassure their need to be valued as a parent (Weistra & Luke, 2017), while the child is pulling away because of their own psychological difficulties (Brabender & Fallon, 2013). So while the child might be experiencing an individualized problem, their parent is also having individual experiences that impact how they are able to connect and communicate. For example, Kate's anxiety was preventing her from getting enough sleep, which prevented Jasmine from sleeping as well, and then made it difficult

for Kate and Jasmine to interact in a positive way and connect emotionally. Jasmine described this experience in this way:

> There was a big chunk of time where she preferred [husband] over me, and that was frustrating… by the time he got home, I was really flustered and sad that I couldn't console my kid. You know frustrated and all. Just really stressed out. And very little sleep, very little sleep. Not a winning combination.

It appears that the post-adoption experience is not limited to individual needs, but rather it transcends into relational needs as well. Ultimately, there is a complex system of individual and relational factors involved in forming these experiences, and influencing the parent-child relationship for adoptive families.

Attachment Styles. When comparing the results from the RSQ, playtime observation, and child attachment style, there appears to be a systemic interaction occurring between parent attachment style behaviors and those of their child as well. For example, participants who scored highest for an insecure attachment style also rated their child highest for an insecure attachment style. In fact, Tracey scored highest in secure attachment (3.8) and avoidant (3.6), and she rated Melody as a 5 for secure attachment, and Lucy as a 4 for anxious-avoidant. Although many factors interplay to determine one's attachment style, one explanation in the literature is the concept of intergenerational attachment.

Intergenerational attachment is based on the idea that one's attachment style can be passed down to subsequent generations based on the caregiver's internal working model of relationships (Obegi, Morrison, & Shaver, 2004). A few studies have been done to test this idea, and have found that the parent-child attachment relationship is correlated with the primary caregiver's adult attachment style (Main, Kaplan, & Cassidy, 1986; Obegi, Morrison, & Shaver, 2004; van IJzendoorn, 1995). Therefore, it is possible that the attachment style of parents can influence the way they interact with their child, thus influencing their child's attachment style.

Although more information is needed to determine how much of the participants' attachment style is impacting that of their child's, the concept of intergenerational attachment is one possibility given the similarities between the parent and child attachment behaviors discussed.

Furthermore, insecure attachment behaviors disclosed in this study may have evolved over time. In other words, attachment styles are not considered an indefinite relational style, but rather a fluid pattern that can change over time (Cassidy & Shaver, 2016). Of course, literature also suggests that it is not so fluid that it will change in a short amount of time, but actually takes many interactions to change one's internal working model and attachment relationships (Cassidy & Shaver, 2016; Ringel, 2004). So although the parents in this study primarily reported insecure attachment styles, it is highly possible that these styles have changed in intensity overtime because of the positive interactions that they have consistently experienced through filial play therapy. Based on the reports from these parents, their children have started the process of moving towards a secure attachment relationship.

Outside Variables. Evidence from the study implies that there may be variables outside of the adoption itself contributing to the behaviors of each child. Similarities in the interview suggest that some adoptive parents may experience adverse behaviors or emotional distance in their child post-adoption. Some studies have found that children who are adopted older and internationally are at a higher risk for behavioral problems (Gagnon-Oosterwaal et al., 2012). However, the results from the current study found that Melody, the only child who was adopted internationally and at an older age, was also the only one who *did not* exhibit adverse behaviors. This may tell us that other variables are at play in the behaviors of adopted children, such as other diagnoses inhibiting a child's ability to manage their emotions (e.g. Kate's diagnosis of anxiety or William's visual impairment).

Furthermore, these behaviors may not be directly related to adoption, but rather a natural tendency for young children in general (Campbell, 1995; Poulou, 2015). Although some studies have found that adoptees experience adverse behaviors and mental health problems, the effect size is usually small (Juffer and Van IJzendoorn, 2005) and other studies have found no difference between groups of adopted adults and their non-adopted peers (Collishaw, Maughan, & Pickles 1998; Rushton, Grant, Feast, & Simmonds, 2013). This suggests that adoption alone may not determine adverse behaviors in children, however other factors such as anxiety or a lack of sleep may be better predictors (Reid, Hong, & Wade, 2009), such as with William and Kate.

Clinical Implications. Given the many layers contributing to adverse behaviors, there is a potential danger in comparing children who are adopted to other non-adopted children. Clearly, adoptive families are dealing with issues and circumstances that are very unique, and deserve to be treated as individual experiences so as not to generalize. However, it may also be detrimental to look at these individual experiences and assume that it's only an adoptive family problem. As clinicians we need to be able to do *both* to capture the whole story. In other words, we should not treat these families as different, we should not treat them all as the same, but instead we should treat them as *both*.

When considering the complexity of the adoptive family experience, it is imperative for clinicians to give attention to various factors contributing to family distress. Both individual and relational needs should be addressed that are impacting family interactions. Ultimately the systemic dynamics at play here suggest a need for more relational style therapies. Furthermore, both parent and child should be given the space to express their own unique experience since not every adoptive family is the same. When working with these families therefore, clinicians should

be sensitive to the uniqueness of each family and be careful not to make assumptions or generalizations without considering the entirety of the family's experience.

Filial Play Therapy Outcomes. Regardless of where adverse behaviors came from, participants reported positive outcomes from filial play therapy. More specifically, parents reported that filial play therapy helped them emotional connection as well as a decrease their child's adverse behaviors. According to the existing literature, this is most likely due to the effects of filial play therapy on the parent-child relationship (Carnes-Holt, & Bratton, 2014; Bratton et al., 2005). Filial play therapy is also likely successful because of its ability to address the complexity of one's experience, including past experiences and present diagnoses (Kinsworthy & Garza, 2010; Tew, Landreth, Joiner, & Solt, 2002; West, 2010)

Emotional Connection. The most predominate outcome discussion in each interview was the emotional connection that developed between parent and child. Participants described how using filial play therapy aided in their child's ability to communicate their emotions, regulate those emotions, and go to their parent with those emotions. Consistent with the literature (Cornett & Bratton, 2015; VanFleet & Sniscak, 2003), it appears that filial play therapy gave these children an outlet to express difficult emotions as well as skills to process those emotions with their caregiver.

It is important to point out that filial play therapy was not only beneficial for the children, but adoptive parents also reported better outcomes as a result. Take Jasmine for example stating, "It really did help our relationship that she could kind of transfer her attachment onto me also," or Tracey expressing her excitement in being able to provide emotional safety for her daughters. As the current study and previous research suggests, the effects of filial play therapy are bidirectional in its impact (Bratton et al., 2005; VanFleet & Sniscak, 2003). Thus, filial play

therapy could be a meaningful intervention for adoptive families seeking to improve their parent-child bond.

Decreasing Adverse Behaviors. In addition to improving emotional connection, parents in the study also reported less adverse child behaviors. William expressed less outbursts of anxiety after Sarah was able to "give him a controlled place where he can have control" and manage his anxiety. Likewise, Jasmine noticed Kate engaging in fewer tantrums as she began to view Jasmine as a caring and available caregiver. These parents attributed their success to the special playtimes that filial play therapy provided, where the parent could learn more about their child's needs while the child could explore how to express those needs, as well as problem solve to meet some needs themselves.

Within these families, filial play therapy seemed to provide a way for the children to work through some of the emotions fueling their adverse behaviors. Similar to other research findings (Ryan, 2004; VanFleet, 2005), the current study discovered that filial play therapy skills such as structuring and empathetic listening allowed the child to engage in more positive interactions with their caregivers. These positive interactions then replace negative behaviors that once invaded the parent-child relationship. Therefore, filial play therapy may be a helpful tool in decreasing difficult behaviors in other children as well.

Addressing the Complexities. An important finding in this study was the way in which filial play therapy addressed certain unique aspects of each family's experience. As stated earlier, each adoptive family seemed to have a complex experience that was related to both the adoption and typical developmental behaviors. Interestingly, filial play therapy was capable of addressing some of these complex factors. For example, even though typical filial play therapy calls for child-directed play, Sarah was able to tailor filial play therapy to meet the sensory needs

of William. The success that Sarah and William saw as a result suggests that filial play therapy not only tends to the parent-child relationship, but it also aids in difficulties related to disability or impairment.

Similarly, Tracey discussed how filial play therapy helped address Melody's language barrier. As a young girl from a different country, Melody struggled to communicate with Tracey and her sister at first, causing relationship stress and emotional instability. However, Tracey reported that the skills they used through filial play therapy (i.e. empathetic listening), Melody was able to improve her emotional language and express some of her needs effectively. It is important to note, however that future research should be done on the effects of filial play therapy for other children who are internationally adopted or have a disability since little literature is available to help explain these experiences.

Clinical Implications. Given the positive experiences these parents had with filial play therapy, the field of Marriage and Family Therapy could benefit greatly from increasing the amount of therapists trained in filial play therapy. When asked the open ended question, "Is there anything else that you think is important for me to know in this interview?" all three participants made a point to discuss the lack of filial play therapy services available to them. Each participant recommended better access to such services as well as more filial play therapy trained therapists in general. Therefore, it may be beneficial for the Marriage and Family Therapy field to invest in more filial play therapy training for its professions so that more adoptive families can be treated.

Moreover, professions who do work with adoptive families may need better training in how to interact with this population. During the interview, two participants reported a difficulty when they began their filial play therapy training. One participant stated that's he felt like she

was “being watched” and the other felt “scrutinized.” Interestingly, both reported having very positive experiences after they got to know their therapists. This suggests that family therapists could do more to make parents feel comfortable at the beginning of training in order to build rapport sooner.

More attention may also need to be on the use of filial play therapy with children who are internationally adopted. One participant reported how filial play therapy was especially helpful for her daughter because it gave them a way to communicate feelings and interact with one another when there was a difficult language barrier after the international adoption. This experience suggests that filial play therapy could be used as a helpful tool in teaching communication skills to both child and parent when language is a barrier.

Limitations of the Study

Although there were strengths within the design of the study, such as evaluation procedures and diversity in participant families, there were also some limitations that need to be addressed. First, the parent-child playtime may not have completely reflected an actual interaction between parent and child, because they knew they were being watched. We attempted to address this limitation by crosschecking during Question 1 and using observer notes, however there may be reliability concerns within the observational tasks due to participant reporting bias or observer bias.

Another limitation was the evaluation for parent and child attachment. When scoring adult attachment in the RSQ, only four or five questions were used to score each attachment style. Although its reliability coefficient is high (.81 - .84), it is of course difficult to make an assumption about one’s attachment style using only five questions, thus the RSQ was only used for supplemental data in understanding the dynamics of each family rather than analyzed as part

of the research question. Furthermore, the child attachment questions asked during the interview were not direct questions from an official attachment assessment. Instead, they were derived from the concepts of attachment theory. This too can make it difficult to conclude the attachment style of each child since these questions were not officially assessed for reliability.

Lastly, there were no inter-rater reliability procedures in place during analysis. Since I was the only one who conducted all of the interviews and analyzed all of the data (except for transcriptions), it is possible that some pieces of data were overlooked or skewed due to personal bias. Although the inclusion of internal and external auditors helps address some of these concerns, the current study would benefit from more researchers evaluating the data.

Areas of Future Research

First and foremost, more research with adoptive families is needed. In order to better understand their needs and the services that are helpful to these families, more research should be done that address the many layers of the adoption experience for these families so that further steps can be made to better support them. More specifically, it may be helpful to conduct more observational studies that look at adoptive parent-child interactions in the context of parent-child relationship quality. For example, it may be interesting to see if adoptive parents who use more filial skills report more secure attachment relationships with their child.

Another possible direction for research is to study the impact of filial play therapy on other children with disabilities. Sarah reported that filial play therapy helped William "learn to play," a skill that was difficult for him due to his visual impairment. It may be interesting then to investigate if filial play therapy has helped other children with disabilities. If so, did these parents have to readjust their play therapy training to meet their child's needs like Sarah did?

Furthermore, what can be done to improve the generalizability of filial play therapy training to all populations in order to address impairments like William's?

Lastly, future studies could look at the role of diagnoses in child behavior and family adjustment after adoption. In line with the experiences of William and Kate, certain diagnoses may be contributing to unique experiences after adoption for both the parent and the child. It would be helpful, therefore, to look at what some of the common diagnoses are that adoptive families experience, as well as which diagnoses seem to make the most impact on their family. Addressing these research questions may help to guide our understanding of the adoptive family experience in order to provide them with the services they need for family health.

Conclusion

Certain themes across cases suggest a phenomenon exists between positive parent-child relationships and filial play therapy for adoptive families. Adoptive parents seem to have complex experiences that involve an interaction between individual and relational needs. This then impacts the quality of the parent-child attachment relationship. However, as adoptive parents use filial play therapy to address these needs, they begin to see improvements in their emotional connection as well a decrease in their child's adverse behaviors. In order to better understand these experiences and generalize to other adoptive and non-adoptive families, it is important for future research to address some of the complexities listed in this study. Furthermore, more clinicians should address these complexities in their work and make filial play therapy more accessible to adoptive families.

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APPENDIX A: IRB APPROVAL FORM

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
4N-64 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · **www.ecu.edu/ORIC/irb**

Notification of Initial Approval: Expedited

From:	Social/Behavioral IRB
To:	Georgeanna Chizk
CC:	Andrew Brimhall Georgeanna Chizk
Date:	1/16/2018
Re:	UMCIRB 17-002729 Filial Play Therapy with Adoptive Families

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) is for the period of 1/15/2018 to 1/14/2019. The research study is eligible for review under expedited category #6, 7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The Investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Name	Description
Demograhic questionnaire.docx	Surveys and Questionnaires
email and FB script	Recruitment Documents/Scripts
Interview Questions.docx	Interview/Focus Group Scripts/Questions
parental permission for child and adult consent	Consent Forms
RSQ.pdf	Surveys and Questionnaires
Thesis Proposal Chizk 11.13.17.docx	Study Protocol or Grant Application
Verbal Assent Script.docx	Consent Forms

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX B: E-MAIL SCRIPT

Address Line: Primary investigator will send out a group email with all addresses in the 'BCC:' line.

Subject Line: Research Participation Invitation: To Adoptive Parents with Filial Play Therapy Training

Email Message Body:

The following research study has been approved by the East Carolina University Institutional Review Board (IRB).

Are you an adoptive parent who has received a minimum of 8 to 10 week Filial Therapy training (for example, the Guerney model as taught by Rise VanFleet) and used it within the past 5 years? Is your child between the ages of 3 and 12? If so, we need your help with our research study. Filial play therapy has been shown to help improve the parent-child relationship, and may be used as a helpful tool for adoptive families. While adoption is a wonderful and joyous time for the family, some families may experience difficulty adjusting after the adoption and will turn to filial play therapy for support. We acknowledge that each adoptive family has their own unique story to tell, and are interested in understanding adoptive families' experiences using filial play therapy with their child. Participation in this research study will require one meeting time via teleconferencing software that will last between one and two hours. During this interview we will ask you and your child to participate in a three to five minute playtime followed by a parent interview. Your responses will only be used for research purposes and will be confidential.

If you are interested in participating please email Georgeanna Chizk with your contact information (including your phone number) at robertsg16@students.ecu.edu.

APPENDIX C: FACEBOOK SCRIPT

The following script Was posted on Rise VanFleet's Filial Therapy Facebook page:

Are you an adoptive parent who has received a minimum of 8 to 10 week Filial Therapy training (for example, the Guerney model as taught by Rise VanFleet) and used it within the past 5 years? Is your child between the ages of 3 and 12? If so, we need your help with our research study. Filial play therapy has been shown to help improve the parent-child relationship, and may be used as a helpful tool for adoptive families. While adoption is a wonderful and joyous time for the family, some families may experience difficulty adjusting after the adoption and will turn to filial play therapy for support. We acknowledge that each adoptive family has their own unique story to tell, and are interested in understanding adoptive families' experiences using filial play therapy with their child. Participation in this research study will require one meeting time via teleconferencing software that will last between one and two hours. During this interview we will ask you and your child to participate in a three to five minute discussion followed by a parent interview. Your responses will only be used for research purposes and will be confidential. If you are interested in participating please email Georgeanna Chizk with your contact information (including your phone number) at robertsg16@students.ecu.edu.

APPENDIX D: FIELD JOURNAL

P-I indicate "Post Interview" notes

12/16/17—After reflecting on my thesis proposal meeting and reviewing the feedback from my committee, I have realized three things about this research project that are shaping the way I view adoptive families and their service needs. First, adoptive families have their own culture that will require me to do more research on how to speak with and refer to these families. Second, not all adoptive family research is reliable. This will require me to be more intentional about my research and writing in this thesis. And third, committee members have pointed out that they believe adoptive families would (and have) greatly benefit from filial therapy, which has inspired me to continue with this research beyond this thesis. If this research project indicates that families have a meaningful experience using filial, then I would love to include filial in my future work with this population. One assumption that I found myself having is that adoptive families generally experience difficulty adjusting, and they all benefit from filial… But is this actually a true assumption?

1/23/18—I have submitted my IRB proposal and while waiting for approval I have been thinking about my hopes for this study. I hope that adoptive families will be able to find their voice in research and feel like the world can gain a more accurate perspective on what its like to be an adoptive parent. I also hope that in light of the findings, we may see that filial therapy can be a useful tool in family adjustment, although I wonder if the results of this study will be that straightforward (this may only be a small step in that direction after all)

2/2/18—Now that I have begun recruitment, I am realizing how difficult it really is to find and contact adoptive families within this criterion. However, I have also noticed that there are lot of therapists and professionals who are very willing to help in this process, which is encouraging. I hope that I am taking an appropriate and respectful approach in recruitment even though I a am having to press many people for speedy responses in order to finish in time (if I expand on this project in the future I would rather to develop a relationship with one or two gatekeepers and slowly recruit).

2/8/18—I have received my first participant for the study! I had a few thoughts when I spoke with her on the phone during screening. First, she was so kind, although sounded a bit overwhelmed. I wonder if there was a better way of introducing the research and screening that would be more welcoming. I also wonder if it is appropriate to give a more detailed introduction of myself so that she could feel safe? Is it appropriate to develop a small relationship with participants during the study? I can imagine that their responses would be more authentic if there was rapport. This participant did say that there is a great need for more professionals that can deal with child trauma in adoption and was glad that I am doing this study.
A second thought I had was how paranoid I am to offend these families. After speaking with my committee member Bobbi, I realized that there is a whole culture within adoptive families that I know little about. I think moving forward I need so immerse myself in more exposure to this culture so that I can appropriately communicate with these families.
Some assumptions I'm having after speaking with P1: adoptive families are busy, overwhelmed, apprehensive about engaging in research, and have found great worth in filial—some of these assumptions may not be true!

P-I 2/15/18— P1 appeared very engaged and willing to share her experience and required minimal probing. P1 often spoke about the intersection between her child's disability and his adoption. It seemed as though C1's disabilities added a layer of difficulty to for him in the home and during play with peers. Since C1 has a visual impairment, P1 has had to adjust some of the filial skills to help C1 engage in play. As P1 spoke about her experience using filial play to help with C1's behaviors, she seemed appreciative (and even proud) of her ability to recognize C1's needs during play and better understand where some of his behaviors are coming from (anxiety). This in turn has allowed C1 to learn how to play despite his visual impairment *and* it has given him a much-needed sense of control when he feels he has none. Ultimately, it appears that this family has had a positive experience using filial as evidence by parental and child confidence, engagement in play, reports of closeness and trust between parent and child, and a decrease in negative behaviors that were once present in C1.

Observations of Parent-child play: C1 played a lot with noisy toys and would frequently hold them up towards the laptop and mother, C1 frequently would throw toys to ground to hear the noise, half way through play time he stood up and walked over to his bike, then engaged with mom using his building blocks at the end. Mother was sitting in front of him about two to three feet away and would ask questions and attempt to hand him toys, but C1 would decline them and play to himself, until the end when the two played with blocks together. C1 tried speaking to me frequently and asked mom lots of questions. C1 appeared easily engaged with me, but not so much mother until the end, very curious and interactive, preferred loud noises (due to visual impairment), mother appeared to give lots of instruction at first but gradually let C1 play on his own, mother used some filial skills (reflecting behaviors emotions).
Thoughts to note:

- Mother spoke a lot about how C1's disabilities interact with their play and ability to use filial.
- Child attachment part of the interview was a bit rocky, not sure if I actually measured it, may need to revise in future?
- The interview felt rushed, but also concise? Is this okay? Should I have asked more clarifying questions?
- I need to adjust video camera better and give more direction for the play time

One thing that really stood out to me was C1's opinion about when filial is offered. I assumed it would be better before adoption, but she actually said otherwise. This may very well be a bias for me that I hope to investigate more.

3/1/18—I have been extremely discouraged by the difficulty in recruiting families for this study. I have found myself wondering if this is due to my poor recruitment efforts, or if it is simply because this population is extremely difficult to reach. In either case, I am learning a lot about the importance of gatekeepers; most of my recruitment has been possible because of reaching out to therapists who are willing to email my flier to their former clients. I am currently trying to be aware of my attitude towards recruitment and how this might affect my communication with these families and gatekeepers. My hope is that I am able to stay patient and communicate respectfully despite my frustration.

APPENDIX E: DEMOGRAPHIC QUESTIONNAIRE

What is your gender?
- ☐ Female
- ☐ Male

What is your age? ________

What is your ethnicity?
- ☐ Caucasian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native American or American Indian
- ☐ Asian/ Pacific Islander
- ☐ Other

What is your marital status?
- ☐ Single, not married
- ☐ Married
- ☐ Living with partner
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Other, please specify: _________________

What is your family annual income?
- ☐ Under $29,999
- ☐ $30,000 – $49,999
- ☐ $50,000 – $74,999
- ☐ $75,000 - $99,999
- ☐ $100,000 - $149,999
- ☐ $150,000 - $199,999
- ☐ $200,000 or More

What is your highest year of schooling completed?
- ☐ Jr. High
- ☐ Vocational
- ☐ High School
- ☐ Some College
- ☐ College

Other, please specify: ___________________

How long ago was your child adopted? ________________________

How old was your child when you started the adoption process? _______________

How old was your child when the adoption was finalized? ________________
Is the adoption domestic or international?
____

Is it an open or closed adoption? _______________

Is your adopted child biologically related to you? If so, how?
____

Please describe your children:
Child 1:

How is this child related to you:
- ☐ Biologically
- ☐ Through adoption

Is this child currently living with you?
- ☐ Yes
- ☐ No

Age? ___________

Gender?
- ☐ Male
- ☐ Female

Ethnicity?
- ☐ Caucasian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native American or American Indian
- ☐ Asian/ Pacific Islander
- ☐ Other

Child 2:

How is this child related to you:
- ☐ Biologically
- ☐ Through adoption

Is this child currently living with you?
- ☐ Yes
- ☐ No

Age? ___________

Gender?
- ☐ Male
- ☐ Female

Ethnicity?
- ☐ Caucasian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native American or American Indian
- ☐ Asian/ Pacific Islander
- ☐ Other

Child 3:

How is this child related to you:

- ☐ Biologically
- ☐ Through adoption

Is this child currently living with you?

- ☐ Yes
- ☐ No

Age? ___________

Gender?

- ☐ Male
- ☐ Female

Ethnicity?

- ☐ Caucasian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native American or American Indian
- ☐ Asian/ Pacific Islander
- ☐ Other

Child 4:

How is this child related to you:

- ☐ Biologically
- ☐ Through adoption

Is this child currently living with you?

- ☐ Yes
- ☐ No

Age? ___________

Gender?

- ☐ Male
- ☐ Female

Ethnicity?

- ☐ Caucasian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native American or American Indian
- ☐ Asian/ Pacific Islander
- ☐ Other

Child 5:

How is this child related to you:

- ☐ Biologically
- ☐ Through adoption

Is this child currently living with you?

- ☐ Yes
- ☐ No

Age? ___________

Gender?

- ☐ Male
- ☐ Female

Ethnicity?

- ☐ Caucasian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native American or American Indian
- ☐ Asian/ Pacific Islander
- ☐ Other

If you have more than five children, please specify their information here:

APPENDIX F: RELATIONSHIP SCALES QUESTIONNAIRE

RSQ

Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about close relationships.

	Not at all like me		Somewhat like me		Very much like me
1. I find it difficult to depend on other people.	1	2	3	4	5
2. It is very important to me to feel independent.	1	2	3	4	5
3. I find it easy to get emotionally close to others.	1	2	3	4	5
4. I want to merge completely with another person.	1	2	3	4	5
5. I worry that I will be hurt if I allows myself to become too close to others.	1	2	3	4	5
6. I am comfortable without close emotional relationships.	1	2	3	4	5
7. I am not sure that I can always depend on others to be there when I need them.	1	2	3	4	5
8. I want to be completely emotionally intimate with others.	1	2	3	4	5
9. I worry about being alone.	1	2	3	4	5
10. I am comfortable depending on other people.	1	2	3	4	5
11. I often worry that romantic partners don't really love me.	1	2	3	4	5
12. I find it difficult to trust others completely.	1	2	3	4	5
13. I worry about others getting too close to me.	1	2	3	4	5
14. I want emotionally close relationships.	1	2	3	4	5
15. I am comfortable having other people depend on me.	1	2	3	4	5
16. I worry that others don't value me as much as I value them.	1	2	3	4	5
17. People are never there when you need them.	1	2	3	4	5
18. My desire to merge completely sometimes scares people away.	1	2	3	4	5
19. It is very important to me to feel self-sufficient.	1	2	3	4	5

	Not at all like me		Somewhat like me		Very much like me
20. I am nervous when anyone gets too close to me.	1	2	3	4	5
21. I often worry that romantic partners won't want to stay with me.	1	2	3	4	5
22. I prefer not to have other people depend on me.	1	2	3	4	5
23. I worry about being abandoned.	1	2	3	4	5
24. I am somewhat uncomfortable being close to others.	1	2	3	4	5
25. I find that others are reluctant to get as close as I would like.	1	2	3	4	5
26. I prefer not to depend on others.	1	2	3	4	5
27. I know that others will be there when I need them.	1	2	3	4	5
28. I worry about having others not accept me.	1	2	3	4	5
29. Romantic partners often want me to be closer than I feel comfortable being.	1	2	3	4	5
30. I find it relatively easy to get close to others.	1	2	3	4	5

APPENDIX G: OPPERATIONAL DEFINITIONS OF EMOTION COACHING AND EMOTION DISMISSING BEHAVIORS

COACHING BEHAVIORS	
Structuring	Any teaching or reflecting that aids in a broader emotional understanding of the experience
Sensitivity & Acceptance	Statement or gesture of empathy that endorse an emotion or behavior
Validation & Encouragement	Statement or gesture that aid in the engagement of the task by improving self-esteem
Enthusiasm & Interest	Expression of positivity or involvement that reassures the other of connection
Intimacy, Warmth, & Affection	Any expression, gesture, or statement that displays love and emotional safety
DISMISSING BEHAVIORS	
Derogation	Statement that detracts the other’s thoughts or feelings
Intrusiveness	Statement or gesture that invade in the others ability to engage with the task and connect with the other
Minimization & Discouragement	Statements that discount or invalidate the other’s thoughts or feelings
Detachment & Disinterest	Expression of negativity that reflect disengagement and prevent emotional connection

APPENDIX H: EXAMPLE TRANSCRIPT

RESEARCHER: What did those meltdowns typically look like? Like what was she doing?

PARENT: She oh gosh she was still crawling; it was right before she walked at 9 months that I saw her throw herself to the ground for the first time. Oh that's younger than any kid I've seen for a tantrum, so I knew I was in trouble then. But she would cry on the round. She threw things. Crying, screaming. Yeah.

RESEARCHER: Yeah. So going outside was the only thing that really helped.

PARENT: Yeah she liked to be outside. Of course, she was a runner, so I had to keep up with her. I was always looking for parks to have a fence all the way around, so I could just guard the exit. So shortly after we moved, that time when she was 2 was when we looked up a counselor and started play therapy and that lady also did the sandbox therapy with her too and did a lot with the figurines in there, so it was kind of mixed with the sand which was really good for a 2 and 3-year-old.

RESEARCHER: Yeah definitely.

PARENT: I think that brings us up to that time.

RESEARCHER: Yeah. So tell me a little bit about that play therapy training. **How was that for you?**
[Question 4: Please tell us about your filial play therapy experience]

PARENT: That was good. That was when we didn't have a lot of experience going to counselors in general. So that was really helpful. I remember it took a while to connect with the lady, she and I. We ended up becoming really quite different. We were there every week. But it took us awhile to kind of connect because I kind of do better if you explain the end goal; it was a lot of just do this today. Just do this at home this week. Come back. Okay where are we going here. So I feel like there was some of that and I was too sleep deprived. I mean I read, I learn, I do a lot of that, so if I had been my normal self, I would have read more about it and learned for myself.

RESEARCHER: You were stretched thin at that point.

PARENT: I think once I saw more with where (therapist's name) was headed and you know seeing a little bit of progress kind of helped too. And I think there was a day or two, I think we did finally connect when…. You know she would still be overseeing… She was in her final days at school, she had gone back to school. But she was still being overseen by her instructor, so she would video us and she told me one day the next week, "I was wondering why I kind of thought this in my head, and then when I rewatched the video I realized that you and I think a lot alike." I feel like if I were sitting there doing this with my child, you move and do and respond the same way. I was like oh, oh okay because I could never tell what she thought about me. So when she finally said, "Oh I see a lot of myself in you." I was like, "Oh that's why I feel like I'm being scrutinized." Because she was trying to figure that out. But the training was good; there were a

couple smaller rooms in her office, and they had one set up with the two way window or one-way window or whatever you call it and with the video in there so she could… I remember there was one exercise and it may have been an assessment at the very beginning, but it had a packet with like 10 different activities to do with your child with the supplies all in there, and I think (husband's name) each did that with (child's name). I think she was trying to assess our initial attachment going in and we would know how much progress we made as we went. And just learning and using simple things we could do at home. We were especially focusing on attachment at that point. (Child's name) was still so young. And it kind of spilled over into other aspects also, but we would do a lot of… you know (child's name) wasn't touchey-feeley at that point… Well I mean she wasn't really attached to us, so it was really games that let her see it was okay to touch and interact in that way a little closer than we normally do. (Child's name) responded really well to that, and I think that encouraged us to take what we were learning back to the office and do that more throughout the week, so that did help.

RESEARCHER: Good, good. So once you did take it home, did you notice a difference with (child's name) adjustment after doing play therapy?

PARENT: Did we notice a difference in her behavior?

RESEARCHER: Yeah, yeah. And her interactions with you guys.

PARENT: I didn't necessarily see it right away as soon as it happened, the progress. Within 2-3 years sleep-deprived and with a difficult child, put me in a difficult place, so I wasn't looking for progress I don't think. I thought, "We'll go. I don't know if this will do anything." You know you just kind of become a Debbie Downer.

RESEARCHER: Yeah of course.

PARENT: So I don't think I saw it at first, but I kind of attributed any progress we had to just, "Well she's getting older and has more language skills, you know there's going to be less frustration and I think looking back now I can see. Oh some of that, we would have not gotten that far if we had not worked with play therapy and attachment therapy at that young age. We wouldn't have gotten to where we were at age 4 if we had not done that, so…. I hope that answers your question, I'm sorry.

RESEARCHER: No of course. That's perfect. What kind things did you notice looking back? What specific behaviors did you notice that filial might have helped with?

PARENT: I think she was finally able to connect with me and we could play and have fun. I think she was young, we had so many straining interactions. Just all the emotions on both sides. I don't think she knew that I could be fun, that I wanted to kind of interact with her. I think she was able to just see a different side of me and start thinking of me as a caregiver that did have her best interest in mind. Or start to anyway, still getting there.

APPENDIX I: CONDENSED TRANSCRIPT

P1 Condensed Transcript

Q1) Please tell us about how it was for you doing the parent-child playtime?
Q1a) In what ways, if any, was this representative of your interactions at home?

Playtime
1. Adjust play
2. More imaginative
3. More control

P1 reported that the playtime was representative of their typical play and that she has had to tailor their play to address certain obstacles brought on by C1's disability, such as using more questions and directive language. P1 also reported that C1's play is usually "very imaginative" and C1 "likes to be in charge", which has come out with the use of filial at home.

P1-- So while 3 years old, is the youngest that she [their therapist] accepts children, she was a little leery about accepting him because of the visual impairment. So some things we had to work out to make it work because ***we can't just let him into a room and expect him to know what toys are there. So it couldn't be just free for all,*** *"(child's name), what do you want to do?" because* ***he didn't know what was there.***

Q2) How does your child typically engage with other people?

P1 reported that C1 is typically very interactive with other people, especially adults. However C1 is less interactive with other children because he "doesn't know how to join them" in play.

P1— So he likes new adults; he likes um..... Because of the visual impairment, he's a little socially awkward, ***but he's very quick to jump in and talk to somebody****. So if he hears a voice, we could be at McDonald's and he's very quick to start talking to a voice around him.* ***Especially if it's an adult. He's not so great with peers****, but this is still the age where they all kind of do their own thing anyway... So he doesn't know what they're doing, so* ***he doesn't know how to join them.*** *It's hard to find out where they are or what they're doing.* ***So among his peers, he tends to stick to himself. But if there are adults around, he's going to try to engage them***

> **It is easy for him/her to get emotionally close to others and meet new people, he/she does not have much trouble being alone or away from you, but shows that he/she misses you when you return (secure)**
>
> P1 reported that it is easy for C1 to meet new people but not to emotionally engage with those people.
>
> *P1-- I'm gonna say in the middle, a 3. Because it's* ***easy for him to meet new people****, but* ***I don't think it's easy for him to get emotionally close to these people****.*
>
> P1 reported that C1 is able to adjust well when dropped off at school or left with some else.
>
> *P1-- Yes so he* ***separates just fine****.*

Attachment style
1. Engages well w/ Adults
2. Wants closness
3. Emotionally reactive

P1 reported that when P1 reengages with C1 after leaving him, he is able to interact with her just fine.

P1-- No he jumps right back into... yeah ***he's connected that way.***

It is difficult for him/her to get close to others or depend on/trust others, he/she has a hard time being alone away from you, but is reluctant to engage with you even after separation, seems very independent (avoidant)

P1-- So sometimes he has a difficult time getting close to others. Ummmm and the 5 was very much like (child's name) right? ***Okay so a 4.***

He/she desires to get close to others or you, but will spend time independently, does not open up or share feeling although expresses that he/she wants to (anxious)

P1 reported that C1's visual impairment plays a large role in this, because he has a difficult time knowing *how* to engage with others, but seems to want to.

P1—No I would say 2... ***It's not that he doesn't want to*** *[play with peers], it's just that* ***he has trouble with it.***

He/she appears upset most of the time and not easily consoled, shows extreme emotions such as anger or tearfulness, will open up about feelings some days, but other times will keep to himself, difficult to predict behavior (disorganized)

P1 reported a 5 for this questions, because C1 is "very explosive", however through filial, P1 was able to learn that these emotional reactions were due to anxiety from his visual impairment.

P1-- He ***goes very quickly from 0 to 10*** *in how he's going to react to something. And we* ***don't always know why the reaction is there****... in filial therapy, we recognized that so* ***many of his outbursts were due to anxiety*** *rather than anger or being upset with somebody.*

Please tell us about your adoption experience as it relates to family adjustment?

P1 reported that C1 was in very critical condition from premature birth and spent the first 3 months in the hospital, so P1 and husband were not able to interact much with him as a new born. P1 also reported that C1 had many difficult behaviors as he developed, which brought them to filial therapy.

P1-- When he's really struggling....There were days when it would be pretty much 24/7 that he would be ***on the floor screaming, yelling. He was very self-injurious for a long time****. He would* ***bang his head on the floor*** *and we went to an occupational therapist;* ***we tried everything****. Like bringing in pillows, but he didn't want the pillows; he wanted that feeling of hitting his head on*

Adoption Experience

1. Adverse behaviors
2. Many failed attempted solutions

the floor. ***We tried everything****. External hugs to give him that pressure, but no that didn't work. And that was another reason that we went to filial.*

Filial Experience

1. scary at first
2. Learn to play
3. gave control
4. Emotional attunement

Please tell us about your filial play therapy experience?

P1 reported feeling fearful at first about "being watched" while learning filial skills, but also reported it did not take long for them to engage in the process. P1 also reported that it was meaningful for her husband to be involved in the training as well.

P1-- there was a ***little bit of fear going in*** *thinking, "Somebody's gonna be watching me and how I play and what does that mean." ... So at first you were a little bit fearful, but as you got to know (therapist's name)* ***that kind of eased you and you were able to engage****... that helps too to help (husband's name)* ***see the importance of focused play*** *as opposed to "Hey (child's name), let's just go to the park and let you play while I'm on my phone. Which is also good that (child's name) is at the park* ***but to actually sit and play with Dad I think is important****.*

In what ways, if any, did filial therapy help your family post-adoption?

P1 reported that filial helped teach C1 how to play, since that had been difficult for him with his visual impairment. P1 also reported that it taught her how to cope with his disability.

P1-- I know filial is not for visually impaired kids but I think it's ***helped him learn to play****. I think it helped him learn to imagine... So I think part of it for me was* ***realizing he is a normal kid.***

How has filial play therapy been helpful for your relationship with your child?

P1 reported that filial has helped their relationship because it has taught her how to recognize some of C1's emotional needs, it has given C1 appropriate control, and it has helped teach her that "there is always a reason for [her] children's' behavior".

P1-- It has ***helped me to recognize when he needs one-on-one attention****. And a way to do that that he enjoys and that can give him what he needs... And now I have something to do in that one-on-one time with him and where he feels in control. And also it* ***helped us to see his need for control and to give him a controlled place where he can have control****... I guess if it helped in any way with the other kids, it's just the reminder that* ***there's always a reason under the behavior****; there's something else going on.*

At what point in your adoption process did you receive filial play therapy training?

P1 reported they started filial at 3.5 years and received training for about 6 months. Also that ending training was mutual between them and the therapist, and they have seen progress even after ending training.

Timing

1. 3.5 yrs. old / after adoption
2. recomonds post
3. More Filial Needed

P1-- And then we did that up till.... Probably around April of 2017! So about when he turned 4 I think is when we stopped. And I think ***it was very mutual between his counselor and us****, his therapist and us. She was saying, "Yeah I think you guys have got it." And we were saying,* ***"Yeah I think we've made good progress and that we can take it from here."***

What, if anything, would you change about this experience/timing?

P1 reported that receiving training when they did was the right time because they could absorb more of the information when they felt they actually needed it. P1 also reported that she wished more therapists were trained in working with child trauma *and* filial play therapy.

P1-- I think it was the right time because with a lot of things... If we had known about it earlier, maybe we would've pursued it earlier, but ***I don't think it would've clicked until we needed it****... And* ***there just aren't therapists that understand trauma****. That's the first problem. And the second problem is* ***for something so specific as filial therapy, there is so very few.***

Is there anything else you would like to add that would help us better understand your experience?

none

APPENDIX J: BETWEEN-CASE ANALYSIS CHART

	P1	P2	P3
Playtime	1. adjust play 2. more imaginative 3. more control	1. more interactive 2. more imaginative 3. more independent play	1. more energy in PM 2. more controlling in child-led play
Attachment Style	1. engage well with adults 2. wants closeness 3. emotionally reactive	1. C2 emotionally close 2. C2 engages with others 3. C3 emotionally dependent 4. C3 difficulty with social interaction 5. both emotionally expressive	1. inconsistent 2. friendly but guards self 3. emotionally reactive
Adoption Experience	1. adverse behaviors 2. many failed attempted solutions	1. C2 language barrier 2. C2 self-soothing/ distant 3. C3 adverse behaviors 4. previous services not helpful	1. not easily consoled 2. adverse behaviors 3. preferred father
Filial Play Experience	1. scary at first 2. learned to play 3. gave appropriate control 4. emotional attunement	1. P2 engaged right away 2. aided in communication 3. emotional expression 4. C3 less negative behaviors	1. difficult at first 2. changed C4's perspective 3. attached to mother 4. less adverse behaviors
Timing of Filial	1. 3.5 years after 2. recommends post 3. more filial needed	1. 3 months post C2 adoption 2. recommends pre 3. more trained professionals 4. better access	1. 2 years and 3 months post 2. recommends post but earlier intervention 3. more is needed 4. more information/resources from professionals