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What is This?
Child–Parent Relationship Therapy for Adoptive Families

Kara Carnes-Holt

Abstract
Adopted children may present with a wide range of disruptive behaviors making it difficult to implement holistic therapeutic interventions. The number of primary caregivers, disrupted placements, and repeated traumatic events contribute to the overall mental health of the adoptee and greater number of occurrences increases the risk of maladjustment. Adoptive parents are faced with the challenge of developing a relationship and helping the child experience that relationships can be safe and trusting. Child–parent relationship therapy (CPRT) is a structured, time-limited approach that trains caregivers to be an active participant as a therapeutic change agent in their child’s life. CPRT therapy offers an empowering treatment modality for families striving to feel connected and secure.

Keywords
adoptive families, foster care, child–parent relationship therapy, attachment

The substantial research on child–parent relationship therapy (CPRT) to support its effects with a variety of presenting issues and populations, indicates that it is a viable treatment modality for adoptive families (Bratton, Landreth, & Lin, 2010; Bratton, Ray, Rhine, & Jones, 2005; L. Guerney, 2003; Landreth & Bratton, 2006; VanFleet, 2003, 2006). Barth et al. (2005) argued that “it is the parent-child relationship that is the central reason that adoptive parents come to therapy. Evidence-based interventions that address parent-child relationships and the parents’ expectations about them also deserve testing with adoptive families” (p. 264). Because attachment disruptions indicate the presence of a relationship-based problem, CPRT’s focus on the parent–child relationship makes it an appropriate therapeutic treatment modality for helping adoptive families respond to the challenge of establishing and maintaining a secure relationship.

Current Status and Perceptions of Adoption
Adoption is a familiar occurrence in society; “almost two-thirds of Americans have personal experience with adoption through their own family or close friends” (Department of Family Social Science, University of Minnesota, 2009). It is estimated that there are 1.5 million adopted children in the United States, over 2% of all U.S. children (Evan B. Donaldson Adoption Institute, 2007). Annually, approximately 127,000 adoptions occur in the United States: 15% intercountry, 39% through publicly funded agencies, and 46% through private adoptions (Child Welfare Information Gateway, 2004b). Infant adoptions are overwhelmingly the majority of international adoptions, and stepparent adoptions are the most common form of adoption in the United States (Evan B. Donaldson Adoption Institute, 2007).

The majority of Americans have a positive view of adoption, and 4 of the 10 adult Americans have considered adoption for their families. However, fears related to the return of the birth parents, adoption expenses, and the overall health and behavior of the child paralyze the potential development of adoptive families. Increased public awareness and effective mental health services are essential in uniting adults and children as safe, loving, and permanent families.

A growing concern is the number of children in the U.S. foster care system available for adoption. Foster care adoptions represent only 15% of adoptions in the United States. Most adoptive families do so because of infertility and are primarily interested in adopting an infant; only 2% of children available in the foster care system are infants. Ninety percent of children adopted through foster care are 5 years old or older (Evan B. Donaldson Adoption Institute, 2007). International adoption serves as a viable option for many couples wishing to adopt a younger child. Statistics for 2009 indicated that over 12,000 children were adopted to the United States via intercountry adoption (Child Welfare Information Gateway, 2009).
Potential maladjustment risks related to international adoptions are present. The majority of these children are adopted from orphanages with a high ratio of children to caregivers. Medical histories, prenatal care, and early living conditions are typically not available to the adoptive parents. Gribble (2007) acknowledged that adoptive parents may have difficulty providing care based on emotional rather than chronological age due to the Western values of promoting early independence. This can be particularly challenging for parents adopting young children, who were not expecting intense emotional and behavioral struggles.

**Therapeutic Needs of Adoptive Families**

The parent-child relationship is the initial and essential medium for creating safety and love. The interaction between parent and child is the child’s primary introduction to the world of relationships (James, 1994; Purvis, Cross, & Sunshine, 2007; Ryan & Wilson, 1995; Ryan & Bratton, 2008; Siegel & Hartzell, 2004; VanFleet & Sniscak, 2003). Feelings of safety, acceptance, and love are directly impacted by unique experiences that occur within relationships (Axline, 1974; Landreth, 2002). The length of contact between biological parent and child can range from a few minutes to years of formative interactions. An infant’s introductory relationships begin the framework for future interactions with others; however, an infant’s initial relationships are often not conducive to facilitating a felt sense of safety and security.

Children who have experienced adoption often present with unique challenges connected to disrupted relationships with primary caregivers. The term disrupted adoptions is used to describe the termination of the adoption process after the child is moved into the adoptive home but before the adoption is finalized. The disruption rate in the United States is between 10% and 25% (Child Welfare Information Gateway, 2004a). Adopted children may present with a wide range of disruptive behaviors making it difficult to implement holistic therapeutic interventions. Juffer and Van Ijzendoorn (2005) conducted a meta-analysis on behavioral problems reported with international adoptees, domestically adopted children, and nonadopted children. The authors of this meta-analysis reported that adopted children demonstrated more internalizing and externalizing behavioral problems than nonadopted children.

Children who have experienced frequent changes in caregivers, recurring neglect, and abuse can experience difficulty feeling safe in relationships with others (Forbes & Post, 2006; James, 1994; Purvis & Cross, 2005; Purvis, Cross, & Sunshine, 2007; Sweeney, 2003; VanFleet & Sniscak, 2003). Adoptive parents are faced with the challenge of developing a relationship and helping the child experience that relationships can be safe and trusting. Confusion, frustration, and heartache become part of the adoptive parents’ daily lives when it appears that their child continues to reject them, sabotaging the relationship (Ginsberg, 1989; Purvis et al., 2007; V. Ryan, 2007; VanFleet, 2003). Adoptive parents often resort to blaming either self or the child, and familial relationships can quickly deteriorate.

Mental health professionals have the responsibility to educate potential adoptive parents and provide therapeutic resources for parents and children. Purvis and Cross (2005) conducted a survey and reported that only 7% of adoptive families felt they were “absolutely prepared” for the aftermath of institutional care and its effects on their child. It is often difficult for outsiders to possess a realistic view of the daily stresses a parent can face when raising an adopted child with demanding emotional needs. Supportive and comprehensive family services make a fundamental contribution to ensuring secure placement of adopted children.

**Attachment and Trauma Concerns Associated With Adopted Children**

Attachment is the “reciprocal, enduring, emotional, and physical affiliation between child and a caregiver” (James, 1994, p. 2). Healthy attachment enhances one’s ability to feel safe and secure and to self-regulate. The primary caregiver’s ability to meet the basic needs of an infant in a genuinely nurturing and consistent manner is basic to the formation of secure attachment. Hughes (1999) referred to the ability of parents to help their child establish a secure attachment as facilitating the “psychological birth” of their child. This attachment process is intrinsically connected to the holistic development of the child.

As an infant enters early childhood, the testing of boundaries and the initial process of individuation occurs (Hughes, 1999; Purvis et al., 2007). A child with healthy attachment has the ability to explore limits with the confidence that caregivers are present to keep the child safe and secure. Stress and anxiety increase for children when their environments are unpredictable and chaotic, because they wonder what will happen next (Perry, 1994). Children who have previously experienced inconsistent care, neglect, and abuse perceive that, in order to be safe, they must control their own environment (Hughes, 1999). The child’s need to master premature independence disrupts the natural developmental process. This control may manifest itself through behaviors such as extreme tantrums, aggression, indiscriminate affection, and isolation from others. These are the survival skills the child has developed as a way to maintain personal safety and control.

Adoption, regardless of age, is a traumatic event due to the break in attachment from the primary caregivers. Attachment and trauma are often integrative factors, particularly in the lives of adopted children. Repeated traumatic events, such as any form of abuse, as well as losses associated with the primary caregivers, significantly disrupt the attachment process. In addition, how the child makes meaning of these events must be taken into account. A child who lacked attentive and protective parenting is continually searching for a way to achieve a felt sense of safety, commonly manifesting in hypervigilance (Perry, 1994). Increased fear, sensory processing issues, difficulty self-regulating, disorder of memory, and short-term
memory loss are some of the consequences present in the lives of children who have experienced attachment breaks and trauma (Forbes & Post, 2006; Hughes, 1999; James, 1994; Purvis et al., 2007; Siegel & Hartzell, 2004). An understanding of the interrelationship between trauma and attachment is essential in both parenting and providing mental health services to the adopted child.

**CPRT**

CPRT is filial therapy model grounded in the philosophy and principles of child-centered play therapy (CCPT). The underlying philosophy of CCPT is that play is the child’s language and toys are the child’s words (Landreth, 2002). Children may not have the capacity to verbalize feelings because of their developmental level or as a result of traumatic experiences. The child-centered therapist recognizes this dynamic and understands that children use toys as a way to say what cannot be verbalized (Landreth, 2002). Allowing children to play in most of the ways, they would like opens the window of opportunity to experience control. Allowing the child to remain in the lead of the play within certain limits is central to the change process, because it promotes the freedom for the exploration of one’s self-concept as it relates to the ideal self.

Filial therapy developed by Bernard and Louise Guerny is a relationship-focused mental health intervention that provides an opportunity for the parent and child to engage in a child-centered play environment that promotes feelings of safety, acceptance, and love (Ginsberg, 1989; B. Guerney 1969; Landreth, 2002; Landreth & Bratton, 2006; Van Fleet, 1994). This approach is typically used for children from ages 3 to 10 and their primary caregiver. The Guernys’ premise for this approach was that children’s problems are often due to the lack of parental knowledge and skill, and parents have more emotional significance in the child’s life than anyone else (B. Guerney, 1969; L. Guerney, 2000; Guerney & Guerney, 1989). Therefore, directly involving parents in the therapeutic process with their children became the rationale for the development of filial therapy. Until this point, parents were blamed for the child’s struggles; the goal of filial therapy is to align the parent and therapist for the benefit of the child.

Filial therapy continues to grow in popularity, and adaptations are implemented for a variety of populations. The hope for children is that they will increase the ability to express feelings, enhance self-esteem and self-responsibility, and reduce problematic behaviors (B. Guerney, 1969; L. Guerney, 2003; Landreth & Bratton, 2006; Van Fleet, 1994, 1998, 2000). Filial therapy aims to help parents understand and accept their child, gain insight into self, change perception of their child, increase general understanding of child development, and improve parenting skills. The literature often indicates the effectiveness of filial therapy with adoptive families. The authors of various case analyses reported that family filial play therapy was helpful in strengthening relationships and increasing parenting strategies such as increases in their ability to therapeutically respond to behavioral difficulties (Ginsberg, 1989; S. Ryan & Madsen, 2007; V. Ryan, 2007; VanFleet, 2003, 2006).

After years of experience with children in the playroom, Landreth had a growing belief that parents could be helpful to their children if they gained the same attitude and skills reflecting the environment provided for children in CCPT sessions (Landreth, 2002; Landreth & Bratton, 2006; Watts & Broaddus, 2002). CPRT is a 10-session filial therapy model utilizing a published treatment manual that outlines a group format, weaving together didactic information and group process (Landreth & Bratton, 2006). The model is designed for an average of six to eight caregivers meeting together in 2- to 3-hr groups for 10 sessions.

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

**Evidence-Based Research Outcomes for CPRT**

Outcome research with various populations contributes to the belief that CPRT is a well-researched and effective treatment modality. Continued execution of outcome research is needed to maintain and enhance the credibility of filial therapy. Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analysis of 93 outcome-controlled research studies examining the efficacy of play therapy. Meta-analytic results on the effectiveness of CPRT indicated an overall large treatment effect size (ES) for CPRT (ES = 1.25).

A separate analysis within this study was conducted specifically for filial therapy, which resulted in a large treatment effect (ES = 1.05). These results indicate that filial therapy provided by parents, mentors, or teachers is effective at decreasing parental stress, reducing children’s disruptive behavior, and enhancing parental empathy. Carnes-Holt (2010) investigated
the effects of CPRT with caregivers of adopted children in the only controlled outcome study to date to examine humanistic play therapy procedures and found statistically significant results in favor of CPRT.

**Rationale and Possible Adaptations of CPRT With Adoptive Families**

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

CPRT empowers parents to be therapeutic caregivers to their children. “Sensitive understanding of the child occurs to the extent that the parent is able to put aside personal experiences and expectations and appreciate the personhood of the child, as well as the child’s activities, experiences, feelings and thoughts” (Landreth & Bratton, 2006, p. 81). James (1994) listed several necessary attributes of therapeutic parenting, such as understanding the child’s need to process and integrate past experiences; recognizing, acknowledging, and witnessing the child’s pain, and having enough self-awareness to seek personal support and therapy (p. 60). Parents learn the skills in CPRT to use the child’s language of play to facilitate a healing environment (Landreth, 2002; Landreth & Bratton, 2006).

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

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

The developmental sequence that characterizes a secure attachment contrasts significantly with that of a child who experiences chronic neglect, abuse, and placement with multiple caregivers. Often the maltreated child does not discover that he is special; does not learn the joy and interest that is elicited from experiences of shared affect with his mother; and does not feel affirmed, identified, or important (Hughes, 1999, p. 548).

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

The group dynamic of CPRT has the potential to create a supportive atmosphere for adoptive parents. Parents of adopted children often feel depleted and hopeless and experience a lack of support. They may not feel that their needs are met in traditional mental health services. The group experience can help normalize many struggles of raising adopted children while also validating the intense emotions of the parents. Parenting adoptive children requires the ability to relate to the child with affection and empathy, deal with frequent rejection from the child without taking it personally, and regulate intense personal emotions (Hughes, 1999). Parents can integrate the new skills taught in CPRT only after they are able to process their feelings, emotions, and cognitions connected to parenting the child (Landreth & Bratton, 2006). In addition, connections made among parents in CPRT training sessions often extend to support outside of the weekly sessions, such as respite care and a supportive voice during stressful times throughout the week.

The group dimension of the CPRT training model may enhance the benefits of filial therapy with adoptive families.

It is reasonable to assume that the consistent implementation of CPRT has long-term effects for the health of the child and overall family unit. Research studies focusing on the effects of adoption identify several key factors in the long-term mental health of the adoptee. According to their study of the mental health of adolescents who were adopted as infants, Benson, Sharma, and Roelkepartain (1994) identified six factors as essential to the well-being of adopted adolescents, including “a strong emotional attachment of child to parent and parent to child and the use of positive approaches to the issues unique to adoptive families” (p. 3). In addition, McCormick and Kennedy (1994) identified key factors between parent–child attachments and the self-esteem of adolescents. Their research indicates that those adolescents who classified their parent–child attachment as secure rated their parents as encouraging and accepting. Encouragement and acceptance are vital elements in filial therapy (B. Guerney, 1969; Landreth & Bratton, 2006; Van Fleet, 1994). Smith (2001) reported that the adoption status is not the main risk factor contributing to behavioral and emotional difficulties in youth “but rather the feelings of parent toward child, whether positive or negative, that lead to feelings of being desirable or undesirable” (p. 497). The
limited research available on the mental health of adults who were adopted at a young age identified similar key factors for secure attachment, including unconditional acceptance, open expression of thoughts and feelings, affectionate relationships, and quality of parental bonding (Baldwin & Kay, 2003; Feeney, Passmore, & Peterson, 2007). It seems apparent, therefore, that the philosophy and interventions promoted in CPRT training support the potential long-term emotional health of adopted individuals.

Possible Adaptations of CPRT With Adoptive Families

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

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

Generally, it is important that the group leaders take into account the unique needs of the population present in the CPRT group. Material in each session should be adapted to fit the context of the group and should be applicable to the unique needs of parents. For example, in Session 1, the leader assigns parents the task of noticing one physical characteristic of the child they have not seen before. Adopted children often have to master the fear that they are unlovable, that the adoptive parents may send them back, or that they will always feel different than others (Kottman, 1997, p. 351). Therefore, an adaptation of this assignment could be to find a physical characteristic or positive behavior that the adopted child has in common with the parents. For example, the child and the parent laugh at the same jokes, or they both have a freckle on their right hand. This provides an opportunity to find a new connection in the relationship between parent and child.

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

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

Choice giving is introduced in Session 6. During this session, the therapist should explore specific needs of each child. It may be recommended that some parents use only basic, positive, and empowering choice-giving skills for a while before progressing to choice giving as a method of discipline. It is essential that the leader repeatedly reiterate that empathy and patience are the key factors in experiencing success with choice giving. It is common that children will initially make poor choices, exhibit increased opposition, or display angry outbursts. The use of advanced choice giving provides the parents the empathy for the child’s choices without rejecting the child and perpetuating the insecure attachment. In addition, the concept of close proximity instead of time-out as a consequence for misbehavior should be discussed (Forbes & Post, 2006; Hughes, 1999; Purvis et al., 2007). The concept of choice giving, close proximity, and the developmental needs of the child should be woven into the discussion for several sessions.

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

By telling stories about the child’s life before he or she came to live with the adoptive family, stories about the family’s life before he or she came to live with the adoptive family, and stories about how the parents decided to adopt the child and the process of adoption can build a shared history that will make claiming occur more smoothly (Kottman, 1997, p. 348).

In addition, trauma creates a fragmented and disordered memory (Forbes & Post, 2006; James, 1994; Purvis et al.,
Feedback From Adoptive Parents Who Have Participated in CPRT

The following are excerpts from feedback that adoptive parents have shared with the author regarding their experience of completing CPRT (Carnes-Holt, 2010). A mother with several adopted children who attended the CPRT training with her husband wrote the following as the training was approaching the end:

_This Is Just Not 10 Weeks It’s A Lifestyle_: thanks for saving our family. I’m a better mom and my spouse is a better dad. I’m so completely grateful . . . I’m incredulous that you and (co-leader) would donate your time and effort. When I screw up I no longer wallow in it. I pick myself up and get back on track.

Because of early trauma, frequent caregivers, and attachment breaks the majority of adoptive parents quickly connected to the philosophy of the strengthening the parent–child relationship as one of the vehicles for behavioral changes. An adoptive parent shared the following:

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

Themes that parents often shared were that “no one can really understand what we are going through unless they have adopted themselves” and “it feels so freeing and healing to know that other families are struggling with the same issues as I am with their adopted child.” In response to the question “what was most helpful about the training?” parents reported “the information was most valuable, but I also enjoyed hearing others experiences and giving voice to my own.” “Face to face contact with other parents who are struggling like we are/did was so helpful . . . so to be able to hear the stories, success and struggles, of other families was so encouraging.

Parents raising both biological and adoptive children reported that as a result of the training:

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

Another parent shared:

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

Another parent raising both biological and adopted children shared with the CPRT leader shared this account of an interaction with her 2-year-old adopted daughter:

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

Conclusion

Children deserve the experience of belonging to a family that prizes and nurtures their unique abilities and gifts they have
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