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Attachment Disorders in Adopted Children: A Comparison of Parent Co-Therapy and Child Parent Relationship Therapy

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Various forms of attachment-based therapy have been researched subsequent to the failure of other methods such as holding therapy, mainly because of the insignificant results it produced. (Barth, Crea, John, Thoburn, & Quinton, 2005; Stams, Juffer, Van Ijzendoorn, & Hocksbergen, 2001). Child parent relationship therapy (CPRT) and parent co-therapy (PCT) have been proposed as alternative treatment methods in response to the lack of empirical significance of past interventions that have been offered. Both CPRT and PCT have been shown to be effective in improving parent-child relationships, but little research has examined these therapies in adopted children (Carnes-Holt & Bratton, 2014, Hart & Thomas, 2000). For this study, a between subjects experimental study to test the effectiveness of both PCT and CPRT for adopted children with attachment issues. The treatments' effectiveness will be measured by the Adult Attachment Interview and the Manchester Child Assessment Story Task. Scores from both tests will be compared and analyzed upon completion of the study. If significant improvements are observed in this study, more modern forms of treatment can be implemented that produce positive outcomes for adopted children suffering from attachment issues.

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In 2010, over two million children were reported to be living in the United States (U.S Census Bureau, 2014). Since 2008, international adoption has increased by 44.46% (Child Welfare Gateway, 2011). During the 1800's, adoption was originally designed to offer aid to impoverished or homeless children. By the 1900's, as more unwed mothers were forced to give away their babies, adoption became more popular among couples who could not conceive a baby for themselves (Yngvesson, 1997). Babies born out of wedlock were seen as the product of their mother's sinful behavior. Young, single mothers quickly became referred to as a filthy, lower class of women responsible for contributing to a town's hardships. Social critic Charles Murray, in a Wall Street Journal editorial, proposed that the increase in births among young, unmarried women was of economic concern to the federal government (Yngvesson, 1997). His idea was to end federal support for these women, forcing them to give their children up for adoption. Adoption, as society saw it in the 1950s, would not only rid a town of its problems but would offer mothers a way to be cleansed and forgiven of their sins (Yngvesson, 1997).

At first, many social workers and policy makers made it a point to hide the identities of babies who were put up for adoption. This allowed the birth mother to move on and continue her life without any obligation to her child (Yngvesson, 1997). By law, any evidence of the birth mother having any relation to her baby became non-existent. The government thought in order to fully form these new families, evidence of any pre-existing lineage must be legally destroyed (Yngvesson, 1997). One example was the creation of new birth certificates, in which the baby was said to belong strictly to their adoptive parents. This way of thinking not only influenced society then, but has become the basis for closed adoption today.

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In 1976, the view of adoption shifted from the ideology of the birth mother having no relationship with her child to the concept of open adoption. Open adoption was first proposed by social workers; Annette Baran and Reuben Pannor as well as psychiatrist, Arthur Sorosky (Yngvesson, 1997). Open adoption shifted the view of traditional adoption to include the birth mother in both the lives of the adoptive family and her baby. This new method of adoption enabled couples to adopt a new baby while also allowing the birth mother to stay in contact with her child when she herself did not have the means to support her baby (Yngvesson, 1997). Many in favor of open adoption believe the birth mother has just as much a right to her child as the adoptive parents. Open adoption soon gained many critics as well as supporters and still remains a controversial topic. Since the proposal of open adoption, many other researchers have submitted their own opinions and research concerning adoption and its effect on children.

In 2007, researchers Feldman, Weller, Zagoory-Sharon, and Levine found that biologically, the release of oxytocin during birth plays a significant role in stimulating maternal bonding behaviors in new mothers. Some of these bonding behaviors include increased fondling, protection, and affection of the baby. Almost immediately, the mother has increased attachment-related emotions and thoughts (Feldman et al., 2007). When children are placed in adoptive families, this strong attachment bond diminishes with their birth mothers and it becomes harder for children to form new attachment bonds with their adopted parents.

Age at adoption can also be a variable in a child's ability to build strong relationships. Late-adoption refers to children placed after being a year old as compared to early adoption when the child is adopted as an infant (Pace, Zavattini, & D' Alessio, 2012). Feeney et al. (2007) found that forming a secure attachment with parents is harder for late-adopted children. Chances of demonstrating disorganized attachment and having trouble displaying emotional understanding often increases in later adopted children (Barone & Lionette, 2011). Researchers suggest that these risks decrease if children are adopted at an earlier age (Hart & Thomas, 2000; Howe, 2001). As children get older, those who were adopted early are more likely to report feeling loved and that they are a significant part of the family (Howe, 2001). Early-adopted children are more likely to remain in close contact with their adoptive mothers later in adulthood.

The rise of interest in attachment first began in the 1930's and 40's when attention was brought to children living in institutions (Barth, Crea, John, Thoburn, & Quinton, 2005). Attachment can be classified as secure, avoidant, ambivalent, and disorganized. Secure attachment exists when there is a strong bond between the child and his or her parents in which they become emotionally attuned to one another (Howe, 2006). Children are better able to self-regulate emotions and develop control of their behavior. When a child is unable to acquire this sense of security, he or she can become emotionally detached from their adoptive parents (Howe, 2006). Children begin to have a sense of insignificance, abandonment, and guilt when they feel insecurely attached. As a result, they may display anger, sadness, loneliness, or despair (Hughes, 1999). They may also lack empathy for others with little remorse for their actions, and they may have trouble choosing promising relationships with others their age.

According to Hughes (1999), adoption is considered to be successful once a secure attachment has been established gradually over time between the adopted child and the adoptive parents. Generally, adopted children are suspected of suffering from some form of maltreatment or neglect (O'Connor & Zeanah, 2003; Wimmer, Vonk, & Bordnick, 2009). Children adopted later are especially more likely to have past histories of abandonment or abuse (Howe, 2001).Typically, children who are adopted find it hard to form strong bonds with their adoptive families (Feeney et al., 2007; Hart & Thomas, 2000). As a result, adopted or previously fostered children are at a higher risk of developing an attachment disorder (Barone & Lionette, 2011; Carenes-Holt & Bratton, 2014; Feeney, Passmore, & Peterson, 2007; Howe, 2001; Hughes, 1999; Palacios & Brodzinsky, 2010).

Avoidance, ambivalence, and disorganization are all forms of insecure attachment. Unlike children who display signs of a secure attachment, avoidant children find it hard to accept and cope with attachment-based feelings. They often show signs of anxiousness, distress, or aggression when presented with a situation where attachment-related issues arise. This behavior is usually a result of having been abused or maltreated before placement in a new foster or adoptive home (Howe, 2006). Children whose parents also display feelings of anxiety or rejection when faced with emotional issues can also influence avoidant behavior (Howe, 2006). The main objective of therapy is to get these children to recognize, identify and begin acknowledging the different emotions they feel when avoidant behaviors present themselves. According to Howe (2006), working through emotions, allows children to establish a closer relationship with parents that can eventually lead to the formation of a secure attachment.

Ambivalent children are fearful of being ignored or abandoned by their caregivers. As a result, they over emphasize their need for attention through exaggeration of their feelings (Howe, 2006). Ambivalent children become preoccupied with the emotional availability of others to them and can enter relationships needing to feel in control of that relationship. There is an increase in dependency of others and ambivalent children often display feelings of anger or helplessness when their needs are not met (Howe, 2006). Treatment for this type of attachment style includes having them reflect on their thoughts and feelings

of rejection or abandonment. Howe (2006) states the goal is to refocus them into recognizing the consequences of their behavior and find new ways to cope with how they are feeling.

Disorganized children are usually those who live in environments where their caregivers abuse, threaten, frighten or completely neglect them when they are in need of support (Howe, 2006). In an effort to experience parental care and attention, children with disorganized attachment try different strategies to increase their caregiver's availability to them. Children become disorganized when attempts to form a secure attachment with their adoptive parents fail (Howe, 2006). Hughes (1999) proposed that children learn to be self-reliant and may become manipulative of parents. They may try charming their adoptive parents or using screaming and violence as forms of intimidation. Children with disorganized attachment are also selective in how they approach certain people (O'Connor & Zeanah, 2003). They can refuse to approach a caregiver when feeling distressed or they can approach the caregiver with fear or hesitation. Children that seem to display abnormal or insecure attachment are described as those who have not established attunement with their birth mothers. They often lack the type of bonding or nurturing that would typically stimulate positive emotions in the brain (Hughes, 1999). Similarly, adopted children who are insecurely attached often push their adoptive parents away because they do not recognize or understand parents' efforts to form trust and a loving environment. Howe (2006) suggests that treatment include helping children feel safe. Children should be able to recognize, accept, and cope with their thoughts and emotions psychologically and physically.

Insecurity and attachment issues of adopted children can carry into adulthood. Feeney et al. (2007) found that there was a higher rate of insecurity reported by adults who were adopted than by adults who were not adopted. In addition, participants who were adopted as infants and were reunited with their birth parents presented themselves as insecurely attached. These adults displayed high anxiety and developed a continued avoidance of their birth mothers over time (Feeney et al., 2007). Insecurity in attachment also foretold the likelihood for adult participants to predict future negative reports and perceptions of relationships. If adult adoptees had reported having recent hardships or breakups in their prior relationships, they were more likely to display signs of avoidance or anxiety in new relationships.

Most attachment-based interventions mainly focus on parent and child interactions. Therapists are interested in facilitating the ability of the parent to become someone the child can see as trustworthy and eventually build a secure attachment with (O'Connor & Zeanah, 2003). In most cases, although the source of attachment insecurity is not necessarily the adoptive parents, children may still find it hard to form a secure attachment. Weak mother-child attachments have been studied since the mid 1900's, during the same time, services directed towards helping families after adoption were starting to increase (Wimmer et al., 2009). Whether intervention is needed or not, it is important that parents are psychologically open to working with their children. Parents must help them identify their current issues and redirect their thoughts and feelings into eventually becoming securely attached. A main component of intervention is for parents to be educated on what is considered normal and abnormal child development. Howe (2006) and Hughes (1999) proposed parents must be informed of the possible reasons for their child's behavior and what behavior can be expected based on their child's attachment style. Knowing how to be supportive in helping the child cope with and change their attachment issues is also important.

Attachment Theory was first proposed by John Bowlby and Mary Ainsworth and refers to normal and abnormal psychological development**.** They proposed that the bond formed between parents and children at a young age predict future attachment behaviors in future relationships (Hughes, 2006). Yet, despite the lack of empirical support for attachment theory, Barth et al. (2005) found that adoptive parents continue to be concerned over the lack of a secure attachment between themselves and their children. Parents desperate for a treatment plan look to attachment theory interventions hoping to find a quick solution. However, these interventions may not always work and O'Connor and Zeanah (2003) emphasize that studies that compare both attachment-based and alternative interventions are very limited. Although many psychologists and foster or adoptive parents have found attachment theory helpful, there is little scientific or empirical evidence supporting attachment theory or its significant long-term outcomes for the adopted child (Barth et al., 2005; Wimmer et al., 2009).

One attachment-based intervention is holding theory, which is designed as a way to help treat children with severe attachment difficulties. Holding therapy typically takes place in a secure and supportive environment that helps the child engage with the therapist while working through their attachment issues (Hughes, 2006). Treatment includes increased touching and eye contact of the child by the therapist or the adoptive parents in order to establish a secure base within the child. Those in support of holding theory see it as a better way for a child to address their problems than only talking about them. Holding theory is believed to mimic the type of bonding experienced between a mother and her baby (O'Connor & Zeanah, 2003). Supporters also argue that the presence of adoptive parents in therapy helps the child to receive emotional support and feel safe. Parents' participation in therapy may help the therapist to see the progress being made between the parents and the child (Hughes, 2006). Still, despite the many therapists who practice this type of intervention and find justification in

attachment theory, there actually seems to be no scientific basis for this intervention (Barth et al., 2005; O'Connor & Zeanah, 2003).

Researchers who disagree with holding therapy propose that it can be intrusive or traumatic on children (O'Connor & Zeanah, 2003). In fact, O'Connor and Zeanah (2003) have found that holding therapy may instead be detrimental to the child. Such outcomes are unlike the principals of attachment theory and are therefore seen as controversial. Children are often held for long periods at a time and can have their space intruded on by unwanted physical contact. Other forms of contact such as tickling or poking can also be seen as annoying (Barth et al., 2005). Children who are hesitant or fearful of caregivers become forced to make contact with parents or therapists in ways that are against what they may perceive as comfortable. Another issue that critics note is the therapists' and adoptive parents' concerns about the child's tendency to violate the physical boundaries of others (O'Connor & Zeanah, 2003). Critics of holding therapy state that children are, in a sense, being forced to build a secure bond with the therapist who is essentially a stranger. If that is the case, holding therapy does little to help improve insecure attachment. In terms of the worst possible scenario, O'Connor and Zeanah (2003) have reviewed six reports of children who have suffered death during holding therapy. All six accounts were a result of extreme sadistic methods from parents or therapists attempting to accomplish therapy. Nevertheless, it is good to know that other attachment-based interventions do exist, having more promising and less fatal outcomes.

Another form of attachment-based interventions include parent training and family support. This type of therapy intervention targets parents who feel like they have failed in establishing a secure attachment between their adopted children (O'Connor & Zeanah, 2003). O'Connor and Zeanah (2003) have suggested treatment interventions similar to Hughes (1999) which include support groups, respite services, or in-home help. The establishment of parental support groups particularly offers global networking to other parents concerned for their children's development and special needs. These support groups offer a way of broadly communicating that may not be available in other types of support groups (O'Connor & Zeanah, 2003). Respite and in-home groups, in comparison, offer direct support within the adoptive family's home and allow for the easing of stress among the parents.

Studies on attachment by Barone and Lionetti (2011) and Hughes (1999) suggest children who have a harder time feeling secure with their adoptive parents are most likely those who have been institutionalized. Children may have also developed negative Internal Working Models of caregivers. Past experiences become references for new relationships causing adopted children to feel fearful or hesitant when placed in a permanent home if they had been treated badly. In conjunction with these findings, research conducted by Feeney et al. (2007) suggests negative early life experiences even have the potential to affect adult relationships as well. Adoptees' working models are prone to become highly sensitive to relationships when they perceive the relationship as threatening or having challenges.

Researchers in previous studies have also tested parent behavior and cognition towards attachment and how it affects attachment in their children. For example, Barone and Lionetti (2011) examined parents' mental representations of attachment in relation to their child's adjustment within the family. They found that specifically for adoptive mothers, there was a significant relationship between her mental representation of attachment and their child's attachment patterns. Their study also revealed an interesting finding on parents' own security regarding attachment. In families where at least one parent was securely attached, children seemed to form secure connections with their parents better than children who were placed in families where both parents showed insecurity (Barone & Lionetti, 2011). Similar work by O'Connor and Zeanah (2003) help support Barone and Lionetti's (2011) finding. Parents can potentially offer protection against insecure attachment if they display a secure attachment themselves.

Similarly, research conducted by Pace et al. (2012) provided evidence that adoptive mothers who had a secure state of mind were able to influence an "earned secure" attachment in their children after eight months. The researchers suggest that an adoptive mother with a secure state of mind might be more prone to demonstrate behaviors that would lead to a more secure attachment in the child. Pace et al. (2012) also found that adoptive mothers who often discussed her childhood and past experiences in a disorganized fashion had children who showed the same disorganization.

Remarkably, a study by Feeney et al. (2007) showed that attachment insecurity was based on more than just whether the adults in their study were adopted as a child. Both the experimental and control groups of their study showed to have more similarities than differences concerning attachment. Therefore Feeney et al.'s (2007) results emphasize the effects of caring and responsiveness in adoptive parents to influence a positive attachment style in their child. The process of adoption alone does not necessarily play a role in the type of attachment style a child might acquire (Pace et al., 2012). Attachment style can be influenced by how sensitive the mother is and how secure her state of mind is at the time of adoption and throughout child care (Feeney et al., 2007). Even if adopted children have a secure attachment with their adopted parents, there is still potential for their attachment styles to change depending on significant events that cause them to feel a sense of abandonment or loss (Hart & Thomas, 2000). Hughes (1999) explains that parents should implement the type of affective skills

needed in order to provide the child with the right attention.

Despite the positive outcomes adoptive parents may present to their children, further investigation on parent training and family support interventions is needed. Similar to holding theory, parent training and family support interventions have their critics as well. Critics suggest that respite care can introduce increased insecurity in children. The presence of another temporary person within the household might cause the child to feel abandoned once their services to the family are no longer needed (O'Connor & Zeanah, 2003). Hence, the last attachment-based intervention takes more of a sociological approach.

Social-cognitive treatment interventions focus on investigating the possible social and cognitive problems seen in children with attachment disorders (O'Connor & Zeanah, 2003). Children suffering with attachment disorders have the potential to be rejected by peers and have a hard time understanding emotional behavior or expression in others. Therefore, social-cognitive treatment interventions become especially important in consideration of children's peer relationships. In their study, O'Connor and Zeanah (2003) acknowledge that more investigation on social-cognitive interventions is needed. Further research will help these interventions target specific social problems faced by adoptive children, and will also test certain hypotheses to determine whether attachment disorders can improve independently from treatments regarding the parent and child's relationship.

Perhaps just as controversial as the different interventions offered to treat attachment disorders are the mixed results in past studies of adopted and fostered children. Research both supports and opposes the outcomes of different attachment treatments. For example, Vonk and Bordnick (2009) found that children's scores from the Randolph Attachment Disorder Questionnaire (RADQ) and the Child and Adolescent Functional Assessment Scale (CAFAS) showed a significant decrease between pretest and posttest scores. Children scoring in the moderate range for RADQ had decreased to a subclinical score by posttest and children ranked as being markedly impaired for CAFAS had become only moderately affected by posttest. To come up with this conclusion, Wimmer et al. (2009) investigated the effectiveness of attachment therapy on 24 adopted children recruited from the Attachment Therapy for Adoptive Children with Special Needs program. All participants within the study were diagnosed with Reactive Attachment Disorder or RAD and suffered severe attachment issues regarding their relationships with their adoptive parents. Both the RADQ and CAFAS measured for attachment difficulties as reported by the mother and the child's daily functioning respectively. Such findings indicate that treatment can be effective in treating adopted children suffering from severe attachment issues. Successful treatment in Wimmer's et al. (2009) study contributes to the limited research done in the past on effective treatments concerning attachment.

Similarly, in an experimental study, van Londen, Juffer, and van IJzendoorn's (2007) results supported the hypothesis that adopted children were capable of developing a more secure attachment to their adopted mother. They were particularly interested in both infant-mother attachment in relation to mental (MDI) and psychomotor development (PDI) in adopted children. Despite being adopted, children's scores for both mental and psychomotor development were similar to scores representing a normative sample. The only significant difference found was in attachment: adopted children were more likely to be classified with disorganized attachment when compared to non-adoptees. In addition to van Londen et al.'s (2007) results, the adopted children in this study did not present a lag in mental or psychomotor development and there was no significant difference between the ages at which adoption occurred. However, insecure children, especially those with disorganized attachment, were the only ones that were more likely to have lower MDI and PDI scores. Thus the children's overall results showed the child's ability to be resilient with these factors of adoption (van Londen et al., 2007). As suggested by Pace et al. (2012) attachment style is not necessarily stable and the effects of adoption can be changed over time with intervention.

Although there are studies that support effective treatments of attachment disorders, there are also studies that oppose them. Studies reviewed by Barth et al. (2005) show little evidence of psychological problems resulting from adoption. Past studies also point to stability of attachment behavior despite evidence of slight improvement after placement in an adoptive family (O'Connor & Zeanah, 2003; Palacios & Brodzinsky, 2010). For example, Stams, Juffer, Van Ijzendoorn, and Hocksbergen (2001) indicate that over a short-term period, intervention techniques did have an effect on adopted children in their study but did not have any significant enduring effects. By the time the children in their study had reached seven years of age, they found that intervention only had slight positive effects on ego-resiliency and ego-control in adopted females. Internalizing behavior, found in both sexes, were also marginally improved. Stams et al., (2001) suggest that further research on the effects of intervention is needed.

The mixed results of these studies led researchers to believe that more studies concerning treatment of attachment should be conducted for empirical and psychological reasons (Stams et al., 2001). Despite studies that support the idea that attachment-based interventions do have some effect, the long term effects of such treatments could not be predicted. If an intervention is to be implemented with adopted children and their adoptive families, that intervention must be conducted over a longer period of time than what has been done in past research to amount to any significant changes.

Unfortunately, many reports of attachment theory and their success with interventions are based heavily on self-reports and case studies. Barth et al. (2005) propose that both families and therapists need to look for therapy treatments that move away from attachment theory and more towards intervention treatments that have shown significant changes. Some of the alternative treatments suggested by Barth et al. (2005) include conduct-behavior therapy and treatments geared towards foster and adoptive parent understanding. Still, other suggestions include sensory integration and caring for the child with an exaggerated attunement for their needs. Other interventions geared towards helping the child feel safe and lower their defenses in order to establish a secure relationship are also needed (Howe, 2006). In order to treat children with significant attachment issues, Hughes (1999) suggests traditional therapy would not be as effective as therapy that is both designed for and includes the child and their adoptive parents in treatment. Treatment should focus on confronting and dealing with the child's past problems of neglect, abuse, maltreatment, or instability in moving from foster home to foster home (Hughes, 1999). With any form of treatment, parents and therapists must take care in displaying positive emotions such as empathy and understanding towards the child's attempt to change.

Through the process of a three year case study, Hart and Thomas (2000) proposed a new model of alternative therapy called Parent Co-Therapy or PCT. Compared to other forms of treatment, this model of therapy is designed to minimize socialization and contact between adopted children and their therapists. The goal of PCT is for children to create a stronger sense of security and safety with their adoptive parents. Therapists, instead, act as mediators by working directly through the adoptive parents to treat the child (Hart & Thomas, 2000). Adoptive parents, in Hart and Thomas's (2000) study, worked with lead therapists in creating an effective treatment plan that would help with each child's special needs. To do this, adopted parents took over the roles of both therapist and caregiver. The three children involved in Hart and Thomas's (2000) case study were biologically related siblings who had histories of abuse, neglect, and multiple placements among foster parents. In addition, all three children were adopted after 12 months of age and suffered from severe developmental and psycho-social issues (Hart & Thomas, 2000). Each child was individually evaluated and effective interventions specific to each child were implemented. As a result, Hart and Thomas (2000) found that PCT significantly improved each child's behavior. The more severe behaviors exhibited in each child seemed to nearly disappear after three years of PCT whereas behaviors that were less extreme still required additional work. Hart and Thomas (2000) suggest that any children with similar past histories will also benefit from PCT and other less intrusive forms of treatment. Despite the proposal for further research, PCT provides psychologists with a positive new treatment option that has the possibility of implementation on adopted children who have severe issues related to attachment. Without these interventions, the constant social interactions among new people and strangers would most likely continue to cause stress upon the relationship trying to be established.

Another less intrusive treatment option proposed, is child parent relationship therapy or CPRT. Child parent relationship therapy is an empirically based intervention for children displaying problems in behavior, emotions, and social situations (Carnes-Holt & Bratton, 2014). Similar to PCT, CPRT is designed for children and parents trying to establish a more secure attachment relationship, but is usually a treatment option offered in the form of a small parental support group. Therapists continue to take on the traditional roles of therapy as they teach parents and offer supervision of the progress being made. Carnes-Holt and Bratton's (2014) research showed that upon completion of CRPT, the children's overall problems had decreased significantly while parental empathy had significantly increased from pre to post testing. With regard to behavior, CPRT had shown to significantly reduce behavior problems in adopted children.

The participants included in Carnes-Holts and Bratton's (2014) study were chosen out of a group of volunteers who demonstrated a need for an attachment intervention that would improve their child's behavior problems. Sixty-one adoptive parents were placed in either an experimental group that received CPRT or a wait-list control group. Results between pre and post tests were examined at the end of the study to see if there had been a reduction in children's behavior problems (Carnes-Holt & Bratton, 2014). Carnes-Holt and Bratton (2014) were also looking for a possible reduction in parental empathy. Those in the CPRT group participated in weekly two-hour sessions in which parents learned the proper CPRT skills needed to establish a secure-attachment with their children. These sessions lasted 10 weeks, during which parents were observed for 30 minutes in parent-child play and asked to record their play sessions at home to be reviewed for feedback (Carnes-Holt & Bratton, 2014). Both the Child Behavior Checklist-Parent version (CBCL) measuring children's behavior and the Measurement of Empathy in Adult-Child Interaction (MEACI) measuring parental empathy were used.

Although prior research generally supports the effectiveness of Child Parent Relationship Therapy, the effectiveness of CPRT in foster or adopted children is limited. Research by Carnes-Holt and Bratton (2014) supports that when CPRT is applied to adopted children, there are significant treatment effects on those involved. Similar effects were seen among the adopted children in Hart and Thomas's (2000) case study. There were significant improvements in both the children's behaviors and their attachments. However, despite these findings, little research outside of Hart and Thomas's (2000) case study has been conducted. The limitations of both PCT and

CPRT help support the claim that additional research in alternative treatments is greatly needed. Using an experimental design that incorporates similar methodologies of both interventions, this study will aim to compare the possibility of effective improvement of attachment in adopted children. It is hypothesized that children in both the CPRT and PCT groups will display an attachment to their adoptive parents that is significantly more secure than those in the control group, and when both CPRT and PCT groups are compared, adopted children in the PCT group will show significantly greater attachment outcomes.

PROPOSED METHOD

Participants

A stratified random sample of internationally adopted children will be chosen to participate in this experiment through VIDA, an adoption agency located in New York. There will be a total of 1,000 participants in this study: 400 to be placed in a parent co-therapy group, another 400 in a child parent relationship therapy group, and the last 200 to act as a control group. Children in this study will range in age from three to 10 years old.

Measures

A demographic survey will be distributed for adoptive parents to complete prior to treatment. The survey will consist of questions regarding age at adoption and current age of the child, race, gender, and socioeconomic status. Parents will also be asked to answer questions based on the child's mental and medical history given that this information is available to them. Adopted children presenting any form of serious mental or physical disabilities or having a severe history of abuse or neglect will be excluded from this study.

Adult Attachment Interview (Barone & Lionetti, 2011; Pace et al., 2012) will be administered before intervention. Adoptive parents will be asked to complete an hour long, 20 question interview that measures their state of mind in relation to attachment style. Parents' answers will be rated on 17 different ordinal scales each consisting of nine points (Barone & Lionetti, 2011; Pace et al., 2012). Results of adoptive parents' responses will place them into one of four attachment categories: Secure/Autonomous (B), Insecure/Dismissing (A), Insecure Preoccupied (C), and Disorganized (D).

The Manchester Child Assessment Story Task (Barone & Lionetti, 2011; Pace et al., 2012) will be administered after intervention. The adopted children will be asked to demonstrate a narrative story using dolls to represent their interpretation of their relationship with their adoptive parents. Presented with four main story themes, centered on attachment, children are rated based on their responses and categorized into different attachment descriptions. Ratings for attachment include Secure (F), Insecure Avoidant (Ds), Insecure Ambivalent (E), and Disorganized (U).

Procedure

A one-way between subjects experimental design will be conducted after participants give their consent and are randomly assigned into one of three groups: PCT only, CPRT only, and a wait-list control group. A comparison of the effectiveness of both parent co-therapy and child parent relationship therapy to improve the child's attachment with their adoptive parents will take place in this study. Before receiving any form of treatment, adoptive parents in all three groups will be asked to complete a demographic survey and the Adult Attachment Interview (AAI). Only children in the wait-list control group will complete the MCAST at this time (Barone & Lionetti, 2011; Pace et al., 2012).

Adoptive parents within the first group (N=400) will work directly with therapists in parent co-therapy. The goal of this experimental group will be for each individual adopted child to receive treatment interventions that are specific to their attachment problems or behaviors. Therapists will act as mediators between the adoptive parents and their children, allowing the parents to act in a therapeutic manner that helps to form secure attachments. Therapy will last for 10 weeks in which parents will have the opportunity to meet with the therapist for one hour each week to discuss current problems, concerns, or their children's progress in therapy. At the end of the 10-week intervention, the children will be asked to complete the MCAST.

In contrast, participants in the second group (N=400) will receive child parent relationship therapy. For the purpose of gathering a pre-intervention understanding of how parents interact with their children, adoptive parents will be asked to participate in a recorded 20 minute play session in addition to the AAI (Carnes-Holt & Bratton, 2014).Treatment and intervention will take place within the context of small parental support groups made up of eight pairs of parents. Parents and children will meet with the therapist once a week for two hours over a period of 10 weeks. Throughout treatment, parents will become familiar with and apply different CPRT skills in both the therapeutic and home settings. Parents will learn and be asked to engage in child centered play therapy with their adopted child for 30 minutes during sessions. They will also have the opportunity to record their play sessions at home to bring to therapy for discussion. Play therapy will attempt to formulate increased attunement and empathy within the parent-child relationship. Specific CPRT skills that will be addressed in each session will follow the guidelines specified by Landreth and Bratton (2006). Once all 10 weeks of CPRT is complete, the children will be asked to complete the MCAST.

Lastly, parents and children in the third group (N=200) will be informed of an alternative treatment option that targets issues with attachment. Participants in this group will act as a wait-list control group. Unlike the two intervention groups, the children in this group will be asked to complete the MCAST at the same time that their adoptive parents are taking the AAI and will take place before the PCT or CPRT groups receive any treatment. At the completion of the study, AAI and MCAST scores will be compared and analyzed within each of the three groups separately and then to each other. At that time, parents in the control group will be offered the necessary interventions that their adopted child needs.

CONCLUDING REMARKS

Significance

Many children who are adopted seem to present with certain attachment related issues or problems that can affect how they relate to their adopted parents or peers (Barone & Lionetti, 2011; Barth et al., 2005; Carnes-Holt & Bratton, 2014; Feeney et al., 2007; Hart & Thomas, 2000; Howe, 2001; Howe, 2006; Hughes, 1999; O'Connor & Zeanah, 2003; Pace et al., 2012; Palacios & Brodzinksy, 2010; Stams et al., 2001; van Londen et al., 2007; Wimmer et al., 2009; Yngvesson, 1997). Considerable research has been conducted; however, not all research has been successful in providing significant empirical evidence of treatment effects (Barth et al., 2005; Wimmer et al., 2009). In addition, most research has focused on children with past histories of neglect or abuse. It is important for further research to not only examine alternative methods of treatment and their effectiveness on adopted children, but to consider adopted children who may not have suffered any form of neglect or abuse and simply just have trouble forming a secure bond with their adoptive parents. The more research conducted on adoption and attachment issues, the more parents and researchers can understand how to offer treatment that is most likely to have significant and positive outcomes for children. If both PCT and CPRT show to have significant outcomes for adopted children with attachment disorders, therapists can begin to move away from attachment-based interventions and more towards alternative treatment options that work.

Limitations

Adoption is a very tedious and long procedure. The desired number of participants may be difficult to acquire given that parents may be at different stages in the adoption process. Finding enough adoptive families that have acquired a child in the last 12 months may produce a low number of participants that meet the requirements of the study. Second, because each child's presenting attachment problems are not the same, researchers may not be able to find significant effects of intervention in the PCT group given the limited amount of time allotted for therapy. Some children in the PCT group may present with attachment issues that may need more than two sessions a week over 10 weeks to work through. The children in the PCT group will each have their own individual therapist that will work with them and their adopted family. The difference among psychologists may also cause a variation in treatment and results in this group as well.

Similar to previous studies of attachment interventions, this study is limited to short-term interventions. To prevent a bias between the duration of treatment intervention for each group, the study is designed to follow the duration guidelines of CPRT. Although there may be a significant effect of both alternative interventions on adopted children with attachment related issues, the results of this study will not able to support their long-term effects. Further research that compares PCT and CPRT over a longer period of time is suggested with this proposal.

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