CREATING FAMILIES: PARENT PSYCHOEDUCATION AND THE EXPERIENCE OF PARENTS ADOPTING CHILDREN WITH A DISRUPTED ATTACHMENT

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by
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ABSTRACT

Difficult social conditions, including family violence, poverty, and substance abuse/dependence, contribute to increasing numbers of children who are not newborns and who need a permanent home. Parents who accept children with disrupted attachment into their families need to know about evidence-based ways that they can learn to help those children feel part of their new family and to develop lasting bonds of attachment to one another. Parent psychoeducation and its accompanying filial therapy skills for use by adoptive families were the focus of this qualitative study, which sought to understand the lived experiences of parents of adopted children who have turned to this method to help their child. The study looked at how the parents came to their decision to adopt, how they realized that they needed help with their child, their experiences learning how to do special play time with their child, the meaning they attributed to being their child’s therapist, and what types of learning they experienced.

The five families who participated in the study were varied in terms of family composition, adoption circumstances of the child, and racial/ethnic diversity. Two of the families were married couples, one was a same sex couple, one a single parent, and one a grandmother. Two of the children were adopted as infants from Guatemala, two of the children came from the United States foster care system, and the final child was at risk for going into the system were it not for her grandmother’s willingness to provide kinship care. All of the children had experienced disruption from a primary attachment relationship prior to being adopted.
Five major themes in the findings were identified in the responses from the eight adults: 1) the desire to be a parent but not necessarily through childbirth; 2) the decision to seek help through learning new skills in parenting due to escalating concern they did not have the skills to help the child; 3) the ease in learning filial skills with the help of the skilled parent psychoeducation process; 4) a systematic positive change in behaviors and emotions of all members of the parent-child dyad or triad; and 5) the citing of different forms of learning throughout the process.

Implications for future research include seeking a broader range of family demographics of adoptive parents who practice parent psychoeducation with their adopted children, focusing on long term adjustment of families, and comparing parent psychoeducation/filial therapy with other therapeutic models used with adoptive families. Suggestions for practice include increasing the numbers of therapists trained in parent psychoeducation, attachment, and trauma; and expanding the parent psychoeducation process to include detailed information about the meaning of child responses in therapy, changes in child behavior due to increased feelings of safety and security, and the applicability of the filial skills outside of the special play time.
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DEDICATION

In honor of Dr. Bernard and Dr. Louise Guerney
for your foresight and vision in establishing filial therapy
as a way to create strong and loving families

In loving memory of
my parents, Jack and Flora Bergh,
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Chapter One: INTRODUCTION

Chapter One identifies the subject of the study and reviews the background information that explains my interest in understanding the contribution of adult education to parenting practice. I offer a rationale for why the research should be done, and why it is important in today's changing world for families. I review some of the ethical issues in the education of parents. Lastly, I outline the research questions that guided the study.

An Intriguing Aspect of Adult Life

Parenthood is a status that many adults desire. Other adults found parenthood to be more of an unwanted inconvenience. Some adults were unsure what they thought about parenthood, wanting more information about what to do to be a “good enough” parent (Winnicott, 1965). As a social worker whose primary interest has been children and families, I had often wondered what makes the difference between that “good enough” parent and the adult who just cannot seem to make the connection with the child.

Discovering the Research Question

I have always had a lively interest in why people do what they do. In my first job as a social worker with a county children and youth agency, I witnessed multiple episodes of family breakdown and their outcomes. I worked with families who opened their homes to children who no longer had a home, and I saw how some couples could forge a lasting connection with the most difficult children and how others would give up at the first episode of challenging behavior. During this time, I was selected as a member of a group of county caseworkers to receive training in
teaching positive parenting skills to foster and adoptive parents through a grant in the College of Health and Human Development at the Pennsylvania State University. I was able to see that learning positive parenting skills helped the parents who participated feel more confident in their abilities.

After five years as a county caseworker, I moved into hospital social work, working with families who had seriously ill newborns and witnessing the impact of health problems on the connection between parents and children. I received my MSW during that time, focusing on parental adjustment to a newborn with life-threatening medical issues. I became a parent myself, getting a new perspective on just how challenging raising a child to be a healthy member of adult society can be.

In 1996 I began to work as a children’s therapist, again seeing a range of interest from parents in what they were willing to invest in their child’s recovery. I remembered learning about filial therapy in my undergraduate program at Penn State in the 1970s. I learned how Bernard and Louise Guerney had found that teaching parents to do filial therapy, parent-provided therapeutic play sessions with their children at home, resulted in improved parent-child relationships and lessened behavior or emotional difficulties in the children (VanFleet, 2006). I learned how to teach parents how to use play therapeutically with their child, and I found that not only did the child get better, the parents believed their parenting skills had improved. In the majority of cases, once children were discharged home with their parents they did not return to the formal mental health system. I reviewed research into the experiences of parents who had learned therapeutic play and learned that nearly all of the research focused on biological parents and their children. I
remembered my early experiences with adoption, and I realized that the positive parenting skills taught to parents back in the 1970s were based on the work of the Guerneys, pioneers in the methods of filial therapy. I sought advanced training from a well-established and world-renowned trainer of filial therapy, Rise VanFleet, who had been trained and supervised by the Guerneys. With her encouragement I began to think about the use of filial therapy with adoptive parents. I thought about some of the children who come through the child welfare system currently, and their histories of abuse, neglect, and trauma. I wondered about the experiences of adoptive families who were taught the techniques of filial therapy through parent psychoeducation. I decided that I wanted to conduct a study that would explore the lived experiences of parents who learned filial therapy and who adopted a child who came from a background of disrupted attachment and little reason to trust any adult.

Statement of the Problem

Deteriorating social conditions, including family violence, poverty, and substance abuse/dependence, had contributed to increasing numbers of children who needed a permanent home. These children were also likely to suffer from severe trauma and were at risk for disrupted attachment (Webb, 2003). Children with attachment disorders could display extremely challenging behaviors, including exploiting, manipulating, controlling, and bossiness toward others; destructive behavior toward themselves, property, or others; inappropriate sexual conduct; and inability to match emotions with events (Cain, 2006, pp. 95-96).
If those behaviors are not effectively treated, they pose grave dangers to society as the child grows older. Potential dangers include failure to form relationships with others and likelihood of criminal activity (Cain, 2006). It is important to identify ways to educate adoptive parents so that they can develop secure bonds with their adopted child, have an understanding of how the child’s history influenced present behaviors, and increase their own strategies for parenting a troubled child.

Children today experience events far more complex and with more risk for long-term harm than they did even thirty years ago:

A great many of the families of traumatized and vulnerable children are struggling with inadequate resources in areas such as housing, employment, income, education and educational opportunity, and access to health care. These challenges are historically complex and are associated with the long-term effects of inequalities arising from race, class, and gender (Sprinson & Berrick, 2010, p. 10).

Sprinson and Berrick (2010) described other elements that could disrupt a child’s critical early relationships with parents and other caregivers, such as poor prenatal care, exposure to substances in utero, premature birth, and domestic violence. Research into parents’ own attachment histories was showing how those could greatly influence the development of parental attachments with their own children (p. 17).

Family disruption continued to impact American families (Sprinson & Berrick, 2010; Webb, 2003). During Federal Fiscal Year 2011, a nationally
estimated 676,569 children were found to be victims of maltreatment (US Department of Health and Human Services, 2012, p. 20). Of these children, 78.5% were victims of neglect, 17.6% were physically abused, 9.1% were sexually abused, and 10.3% were victims of other types of maltreatment (USDHHS, p. 21). Once the court removed children, parents were given a specific time period to demonstrate capability for reunification. If capability was not demonstrated, parental rights were terminated and the child became available for adoption. For these children, their attachment to their parent was jeopardized by the nature and intensity of maltreatment, and a concurrent risk of further disrupted attachment came with removal from parents and placement in foster or pre-adoptive care. Attachment disorders affected not only the families involved, but could negatively affect the broader society as well.

Parents who adopted children coming from circumstances like those described often sought practical information on managing the behaviors associated with attachment disruption and repeated trauma (VanFleet & Guerney, 2003). Their need for specific parenting education to help them care for the child and maintain a stable home increased, since many parents were not prepared for the challenges presented by children who were unable to trust adults to properly care for them. Parents found that children who were securely attached tended to be responsive to their parenting strategies, which created a feeling of competence for them. In contrast, when parents decide to adopt an older child coming from the foster care system, they are likely to receive a child with insecure attachment who views the world as a dangerous place, and who believes that in order to be safe, he
must control his own environment, making him less responsive to parenting attempts (Wilson, 2001). When a child with insecure attachment is placed in an adoptive home, this worldview creates the behaviors that challenge the adoptive parents’ previously successful strategies (Sprinson & Berrick, 2010).

Filial therapy, developed by Drs. Bernard and Louise Guerney at the Pennsylvania State University in the 1960s, is a form of parent education that was a “theoretically integrative and evidence based approach that combines play therapy and family therapy.... The therapist trains and supervises parents as they conduct specialized child-centered play sessions with their own children” (Van Fleet, 2006, p. 149). Early evidence suggested that parent-provided filial therapy could be equally effective, if not more so, than therapy from a mental health professional (Bratton, Ray, Rhine, & Jones, 2005, p. 386). However, research was scant about how adoptive parents who practiced filial therapy with their adopted children learned the necessary skills and perceived their subsequent experiences.

Many modifications in filial therapy process and settings had been made with no reduction in its effectiveness (Van Fleet & Guerney, 2003, p. 2). New research was needed to determine whether the lived experiences of adoptive parents practicing filial therapy were similar to the experiences of biological parents and children, which consistently reflected an improved relationship between parent and child and a decrease in child behavior problems (Van Fleet, Ryan, & Smith, 2005).
Critiques of Parent Education

Although the idea of parent psychoeducation was most often presented as respecting the parents’ strengths, building and enhancing parental skills, and ultimately transferring the intervention with the child to the parents alone, several potential ethical issues required careful consideration and thoughtful analysis. As the twentieth century proceeded, several ethical critiques of parent education arose, including parent education 1) as a form of social control, 2) as a tool for assimilation into the mainstream those who appear “different” from the dominant social group, 3) as elevating the so-called experts in the rearing of children, and 4) as a concomitant devaluing and dismissal of women’s experiential knowledge (Dr. Esther Prins, personal communication, 6/13/13).

Parent education as a form of social control

Income eligibility requirements for many federal programs designed to assist families raised the issue of equity or social justice. Particularly since the 1960s the Federal government has supported, at varying levels, a number of programs designed to alleviate the cycle of poverty and related issues such as substance abuse and family violence that both influence and result from living with inadequate resources. Fundamental ethical issues must be considered in the design and implementation of these programs (Sigel, 1983).

Social control is defined as the enforcement of conformity by the dominant sector of society upon its members, either by law or by social pressure (Random House Dictionary, 2014). Inherent in many poverty programs was a value judgment of what was good, desirable, or healthy. There was an assumption that human
behavior was modifiable through appropriate actions on the part of practitioners working with families. Another assumption concerned ineffective behaviors being products of an individual’s experience, and the avenue to correct those ineffective behaviors being remediation through new experiences that changed the outcome of those previous negative experiences (Sigel, 1983, p 8). All professionals carried their own views about the appropriateness of interventions, which subtly or openly influenced their actions in carrying out program interventions. Thoughtful consideration of issues of social control in the design and implementation of parent education as part of intervention programming was strongly recommended by Sigel (1983), Schwartz (2002), and Sprinson and Berrick (2010).

Several additional dilemmas have been identified in the literature. Although parent educators recognize the importance of informed consent and freedom of choice in ethical practice, subtle issues such as manipulation of parental goals, excessive pressure to alter behavior, and pressure by the practitioner for information were not recognized as problematic. Coercion of any type raises ethical questions (Sigel, 1983, p. 11). Parents may not be consulted in program design or in the planning of treatment goals, which is in opposition to one of the basic assumptions of adult education: To “appreciate and take into consideration the prior knowledge and experience of [adult] learners” (Merriam, Caffarella, & Baumgartner, 2007, p. 27).

**Parent education as a tool for assimilation of differences**

Assimilation is the process of integration into the dominant culture. In assimilation, disparate groups fuse together so that people could not distinguish one
group from another by cultural practices or characteristics (DuBois & Miley, 2008). Issues of assimilation could be implicit or explicit in the design of parent education programs. Parent education as practiced in the poverty programs was considered interventionist as “there was a direct intrusion into how families are organized” (Sigel, 1983, p. 10). Certain assumptions made about family organization or operation disallowed pertinent information about the differences in families. Many intervention programs focused on the deficits and issues of the parents, particularly the mother. Minimal efforts were made to address systemic issues of racism and economics that contributed to the perpetuation of the problem. The question was raised whether members of a democratic society had control over their destiny, and a mutual relationship of shared responsibility was recommended (Sigel, 1983, p. 2).

**Parent education as elevating the role of the expert**

Discussion of the role of expert in parent education is apparent throughout the literature. An overview of expert advice to parents during the years 1900-1985 stated that experts may identify different child rearing goals in the context of the times, but whatever the goal that was considered the most critical, the experts warned that parents would encounter difficulty reaching the goal without their help (Wrigley, 1989, p. 74). Experts over the last hundred years and their particular philosophies were discussed in the book *Raising America* (Hulbert, 2003). In the late 1800s, L. Emmett Holt and G. Stanley Hall began to explore the fledgling field of child development and to offer advice to parents. Nearly one hundred years ago Frank offered his opinion that the ineptness of American mothers in rearing children was due to their ignorance of how to utilize expert advice (Schlossman,
1983, p. 23). The numbers of parenting experts rose. The scope of their influence expanded widely, with the introduction of widespread print media, the television, and later the Internet.

A parent browsed the Internet or the bookshelves of a local bookstore and chose a book without knowing much about the author, raising another ethical issue concerning the elevation of the expert. Sigel (1983) raised questions about what the experts revealed to the parent about their training and philosophical orientation and also questioned whether the parents had the ability to interpret and understand what they were told. Practitioners erred when they failed to disclose the limits of their knowledge, and were encouraged to examine their own personal and professional ethics before intervening in the lives of others with hidden agendas and exaggerated research claims. As the practitioner develops a relationship with the parent, one of the first steps is establishing the legal and professional parameters of the service to be provided, with the welfare of the family system being the first priority (McGuire & McGuire, 2001, p. 35).

**Parent Education as dismissing women’s experiential knowledge**

The advent of the expert ushered in the decline of women’s experiential knowledge as worthy of consideration in caring for children. As the 19th century moved toward its end, the increasing availability of education for women, coupled with a declining need for household production and overall declining fertility rate, gave women the opportunity to gather outside the home to discuss common concerns (Hulbert, 2003, p. 35). However, at the same time, interest in science was increasing, and the scientific perspective on child rearing claimed that a need for
exact measures and discipline were needed that had theretofore been lacking (Hulbert, 2003, p. 28). Such measures were believed to create an even more intense relationship between a mother and her child.

As child development became an established field of study, doctors were able to specialize in pediatrics, the medical care of children. Other professions adopted child development as their emphasis, increasing the numbers of those purporting to be knowledgeable about the development of the child. As discussed in the previous section, mothers had numerous sources of information to consider, without knowing the qualifications of those offering the information. Programs to help parents operated from many different theoretical perspectives. For the most part, parents were uninformed about the value of each perspective and the alternatives they might consider (Sigel, 1983, p. 12).

Sigel (1983) identified an implicit sexism in models of parent education with the assumption that mothers should stay home and raise their children. Sixty years prior, Frank was explicit with his statement that American mothers were fundamentally inept at raising their children (Schlossman, 1983). The prevailing view held that a mother could not raise emotionally healthy children without some form of expert assistance (Wrigley, 1989). As women have struggled to have their voices heard over the past 100 years, it was understandable how the prevailing philosophies toward their work as mothers coupled with the oppressions of the times had influenced the field of parent education.
An a priori ethical issue

The combination of complex societal factors and deteriorating social conditions created immense pressure on the families who lacked the resources and support to adequately parent their children. Sigel (1983) discussed the minimal effort made by most intervention programs to deal with the fundamental issues created by poverty, racism, and sexism. Those programs focused instead on parental insufficiency, particularly that of the mother, and failed to resolve the underlying problems with which families contended.

Confronted daily with issues of limited resources and discrimination, those parents struggled with raising their children, since the job of parent and holding the family together became increasingly difficult to maintain. Circumstances faced by parents overwhelmed by adversity rendered them less amenable to sources of information and support about parenting, as the family spiraled toward dissolution. American families were noted as the most fragile in the Western world, with twenty percent of marriages and cohabitations broken up after five years (Cherlin, 2009). Family dissolution as the result of a combination of complex factors and deteriorating conditions had increased the numbers of children coming into the foster care and adoption system who had experienced trauma and disrupted attachment (VanFleet & Sniscak, 2003).

The adoptive parents may not have personally experienced such circumstances, and consequently were unaware of the array of persons and circumstances bearing influence on the adopted child. Adults who adopted children with disrupted attachment often sought specialized parenting education to help
them successfully integrate these children into their homes. It was incumbent on those who offered that specialized parenting education to be aware of the multifaceted situations children with disrupted attachment encountered, including children’s experience prior to being removed from the family of origin, and the impact those experiences had on current and future behaviors of children with disrupted attachment.

**Brief Overview of Theoretical Framework**

Three theoretical perspectives guided my study. Two were found in the theories of adult education: experiential learning theory and situated cognition or learning theory. The third, relational theory, was drawn from both feminist theory and social work practice.

Adoptive parents need practical information and guidance on managing the behaviors associated with attachment disruption and repeated trauma. The work of the parent who practiced filial therapy with the child reflects experiential learning theory as well as situated cognition. Relational theory explores the human need for affiliation and relationships with others, and demonstrates its contribution to human well-being.

Experiential learning in education “depends on the quality of the experience which is had” (Dewey, 1938/1998, p. 16). The quality of the current experience depends on whether it could be successfully carried over into future experiences. (Dewey, 1938/1998) emphasized the need for continuity in learning experiences, as preparing for experiential learning in education required a plan, “framed with reference to what is to be done and how it is to be done” (p. 16). Carrying out the
parent psychoeducation in the practice of filial therapy is according to a plan of what is to be learned, how it is to be learned, how it will be practiced, and how it will be continued in the future.

The actual practice of filial therapy corresponds with the premises of situated learning, first articulated in the field of adult learning by Lave and Wenger (1991). Clancey (1995) described situated learning as “the study of how human knowledge develops in the course of activity, and especially how people create and interpret descriptions of what they are doing” (p. 49). The knowledge was a “product of the activity, context, or culture in which it is used” (Caffarella & Merriam, 2000, p. 59). Parents learned the skills of filial therapy through practicing them with the child, under the supervision of the therapist.

Relational theory places emphasis on the two-way interactive connection between two or more persons, showing how they could repair past hurts and rebuild new relationships in positive ways. Relational theory explains the importance of “[creating] a deeper, more meaningful sense of connection... [where] mutuality, reciprocity, and intersubjectivity [have] the potential to enhance clients’ capacity to cope under adverse circumstances and to promote adaptation under normative ones” (Freedberg, 2009, p. 30). Parental practice of filial therapy with a child who prior to adoption lived in adverse circumstances corresponds with the tenets of relational theory.

**Rationale for Study**

Current societal and contextual factors of poverty, dismissal of childhood as unimportant, crime and violence, and parental mental health and addiction
problems are a short list of the most formidable barriers to a healthy attachment between parent and child (Webb, 2003). Parent psychoeducation merits further study as a tool to recreate healthy attachments, and adults who seek parenthood must be able to draw upon the most effective forms of adult education. The rationale for this study stemmed from my desire to uncover effective ways to assist parents in learning skills to address an adoptive child’s perplexing behavior. As an instructor of play therapy, I was also interested in helping therapists and parent educators find evidence-supported ways of helping parents with their children.

Children grow into adults. When children have been damaged by life events beyond their control, their risk of being unable to reach healthy adulthood escalates. With every failed placement, the risk increases. A meta-analysis of problems reported by adoptees showed more internalizing and externalizing problems than were common with non-adopted children (Juffer & Van Ijzenhoorn, 2005). A qualitative study of early recollections of children with severely disrupted attachment found that the children felt abandoned and alone, describing unmet emotional needs as well as feelings of fear and sadness (Tobin, Wardi-Zonna, & Yezzi-Shareef, 2007). Mental health therapists and parent educators must find ways to effectively help adoptive parents heal the pain of a disrupted attachment and raise their child to healthy adulthood.

Filial therapy, due to its grounding in the parent-child relationship and its success with biological parents and children, merits study of its efficacy with adoptive parents and children. Filial therapy addresses two central components of positive parenting: the relationship between the parent and child, and skills for
parents that can be used outside of the therapy session. Carnes-Holt (2010) and VanFleet & Sniscak (2003) have suggested that parents who practice filial therapy with their adopted children gave those children the opportunity to become healthy adults. Children who did not have a secure attachment to a caregiver are at high risk for interpersonal problems throughout childhood and into adulthood, where they risk repeating the cycle with their own children (Lieberman & Van Horn, 2008).

Currently there is only one other research study with this population, a quantitative analysis of 62 adoptive parents who learned to use filial therapy with their children (Carnes-Holt, 2010). This qualitative study, which sought a rich, contextual account of the lived experiences of parents who adopted a child and were trained through parent psychoeducation, added a new dimension to the existing work. Carnes-Holt (2010, p. 80) recommended a qualitative study be conducted to provide greater insight and understanding of the Child Parent Relationship Therapy (CPRT) [filial] process and experience with adopted families.

**The Teaching and Learning Aspects of Parent Psychoeducation**

The actual sequence of parent psychoeducation and filial therapy is divided into three phases of teaching and learning: early, middle, and closing (Appendix A). In the early phase, parents share their concerns about their adopted child and describe the behaviors that they are seeing. The parent psychoeducator draws from her knowledge of child development, attachment, and cognitive growth to validate the parents’ concerns, and begins the process of teaching the parents about filial therapy, previewing the steps and learning that will occur. The parents then come with their child to a session where the therapist demonstrates the filial skills in play
with the child while the parents are in the playroom with them, observing the therapist in action.

At the beginning of the middle phase, the parent psychoeducator teaches the parents about the four skills of filial therapy, as she rehearses each step with each of the parents. She has the parents recall the skill from the session observed with their child, helping them put each skill into the context of the play session. The parent psychoeducator often gives parents a booklet or worksheets about the skills for them to review between training sessions. After a “mock” session where the parent psychoeducator plays the role of the child with the parents, the parents bring the child for several more sessions where they each play with the child, practicing their newly learned skills in the actual situation of a play session. The parents each discuss the session at its conclusion with the parent psychoeducator, which helps consolidate their learning. When the parents are comfortable with their skills and have had the opportunity to discuss the themes of the play with the parent psychoeducator, they stop bringing the child to the office and begin filial sessions at home. The parents’ learning and skill develops through situated learning, and they continue to meet with the parent psychoeducator to review the sessions and receive additional supervision and training.

In the closing phase, the parent psychoeducator and the parents discuss the use of the filial skills outside of the session, and additional parenting techniques using one or more of the skills are taught to and practiced by the parents. As the parents gain skills and confidence, plans are made for them to be discharged from the services of the parent psychoeducator. Through situated practice, focused
supervision, and integration of parental concerns into the filial skills, the parents leave with skills that will serve them throughout their adopted child’s childhood as well as allow them to help any future adopted or biological child.

**Purpose of the Study and Research Questions**

The purpose of this phenomenological study was to describe the lived experiences of parents who adopted children with attachment difficulties and who used parent psychoeducation from a therapist trained in providing filial therapy. Specifically, this study highlighted how adults chose to be adoptive parents, how they selected parent psychoeducation/filial therapy, and their experiences providing therapeutic play at home. The study sought participants from various points in the parent psychoeducation cycle: those who were still in the training/supervision stage, others who were actively providing sessions at the present time, and others who had completed the process with their child and were no longer providing sessions.

The study examined the lived experience of the participants, by addressing these particular questions:

1. What life experiences shaped the context for the parent’s decision to adopt?

2. How did the parents describe their experiences with their adoptive child after placement? What factors did they identify as influencing their seeking help in managing their child’s behaviors?

3. How did the parents describe their experiences with parent psychoeducation?
a. What meaning did the parents derive from being their child’s therapist?

4. What types of learning were reflected in the experiences parents described?

**Research Method**

This study examined the lived experience of parents who were currently practicing filial therapy with their adopted children, as well as parents who had completed filial therapy sessions. Two to three interviews were completed with each participant, revolving around the following areas: 1) the parent’s life history pertaining to the decision to become an adoptive parent; 2) the adoptive parent’s contemporary experience with the filial therapy process; and 3) the adoptive parent’s reflection on the meaning of the experience to the relationship with their adopted child (Seidman, 2006). The inclusion of these three different focus areas was consistent with the idea of Dewey’s continuity of experience (1938/1998).

Qualitative research methods seek to understand the lived experience of a group of persons, seeking understanding through the perspective of the person(s) being studied. Qualitative research offers a richer, more nuanced comprehension of the matter under study, by direct observation and assessment of the topic (Babbie, 2007). Although measures can be applied to assess the success of parent psychoeducation in terms of specific criteria related to the care of children with disrupted attachment, qualitative research adds another dimension to our understanding, that of the actual lived experience of the parent who learned to provide therapeutic play sessions with an adopted child. Qualitative research
allows us to learn the “heart” of the matter, the parent’s experience in creating a positive bond of attachment with a child who previously knew only a broken one.

Phenomenology provides the philosophical basis for all qualitative research. In addition, phenomenology is a branch of qualitative research, guiding studies that “described and interpreted the experience of people” (McMillen & Wergin, 2010, p. 90). Empirical phenomenological research sought to examine what an experience meant for persons who had the experience and who were able to give a rich accounting of it, allowing the researcher to derive a general meaning of the experience (Moustakas, 1994, p.13). As part of this I developed my understanding of the qualitative researcher as a tool of the research, seeking to make my biases, assumptions, and experience transparent. I conducted personal interviews with study participants, followed with study of the interview transcripts to code and identify themes within each participant’s discourse, as I sought to learn the meaning ascribed to the experience of parent psychoeducation and filial therapy, what made it what it was and its role in creating a family.

A Brief Summary of the Findings

Eight adults shared their lived experiences with adopting a child and learning the skills that allowed them to provide therapy for their child in their own home through parent psychoeducation. There were five major findings in the study.

1) The parents carefully and thoughtfully considered adoption as a reasonable means of creating a family.
2) The parents decided to seek education about increased parenting skills due to escalating concern that the child’s behaviors were not responding to the parents’ existing skills.

3) The parents described the teaching and learning of the parent psychoeducation process as one that facilitated their learning of the filial skills, depicting the skills as “readily learned.” The parents experienced deeply felt meaning in being able to provide therapy for their adopted child.

4) The parents noted a systemic positive change in the behaviors and emotions of all members of the parent-child dyad or triad.

5) The parents’ reflection on their experiences yielded information about the different types of learning that they had experienced.
Definitions

Disrupted Attachment: An experience that occurs when a child had an affectional bond with a parent broken by sudden death or another abrupt removal of the parent from the child’s life. Children who were unable to form a permanent bond with a caring adult were at risk for a number of adverse outcomes. It must be noted that not all disrupted attachments became the more serious attachment disorders.

Adoptive Parents: Adults who took the parental role through legal adoption as primary caregivers to a minor child.

Filial Therapy: A method of parent psychoeducation, developed and researched by Bernard and Louise Guerney and their associates at the Pennsylvania State University during a thirty-year span beginning in the 1960s. Parents learned and practiced skills to conduct play therapy sessions at home, with emphasis on modeling, role-play, and behavioral rehearsal (Guerney, 2003).

Parent Psychoeducation: The teaching-learning process of filial therapy, where the parents learned and practiced the therapeutic skills to do special play sessions with their child. Also refers to teaching parents how the child’s experiences can influence his/her behaviors, and how to incorporate that knowledge into the filial skills.

Parent-Child Relationship Therapy: A modification of the Guerneys’ method by researchers and practitioners at the University of North Texas. Research conducted on the method from the University of North Texas generally referred to it as parent-child relationship therapy.
Overview of the Dissertation

There are five chapters in this dissertation. This chapter introduces the research problem, ethical issues in parent education, rationale for the study, theoretical framework, and the proposed research method. Chapter Two reviews research related to parent education in the United States, identifies different methods of parent education, and introduces parent psychoeducation and training in the skills of filial play therapy as an approach to creating families where a child with disrupted attachment was adopted. Chapter Two also reviews three theoretical perspectives that provide insight into the practice of parent psychoeducation. Chapter Three articulates the purpose of the study and the specific research questions to be answered, identifies the participant sample, and discusses the appropriateness of a qualitative research approach and the suitability of phenomenology in learning the lived experiences of the adoptive parents in the study. Assumptions and biases influencing me as a researcher are identified, and the role of the researcher as an instrument of the research is explored. Ethical considerations and issues related to the quality of the study are discussed.

Chapter Four discusses the experience of the parents from the time they chose to adopt, through the placement of the child, to the completion of the parent psychoeducation and filial skills training and practice. The chapter concludes with the exploration of the meaning that parents assign to the experience. Chapter Five summarizes the findings, identifies possible direction for future research, and makes recommendations specific to adoption and the provision of parent psychoeducation.
Chapter Two: REVIEW OF THE LITERATURE AND THEORETICAL PERSPECTIVES

In this chapter, I review the literature regarding parent education and its development over the past hundred years. I describe some specific forms of parent education developed to assist families dealing with issues related to the care of their children.

Although forms of parent education have existed for several centuries, I focus on the literature relating to the development of parenting education from the early twentieth century, including a critical perspective on its goals and methods. I consider the influence of changing societal conditions over the last half-century in the development of parent education programs to address behavioral problems in children. Specific forms of parent education are described, and issues and shortcomings are identified. I discuss the need of parents who adopt children for parenting education specific to parental understanding and response to the children’s often complex emotional needs. I review the development of parent psychoeducation (filial therapy) and scholars’ ideas about its appropriateness for use with adoptive parents. Finally, I discuss three theoretical perspectives that provide insights into the practice of parent psychoeducation and that structure my analysis of findings.

Historical Perspectives on Parent Education

Early definitions of parent education included written materials designed to aid parents in effectively rearing children. Parent education also included group meetings of varying sizes where parents could participate in discussion and various
self-help activities (Schlossman, 1983). Formal written literature to assist parents was found in writings of the ancient Greeks (Schlossman, p. 8). The history of literature for parents in the United States goes back to the time of early colonization in the 1600s. Since that time, any discussion of child rearing and the considerations involved has varied with the prevailing social philosophies of the time.

More women gained access to formal education during the latter decades of the 19th century. In addition, women were less occupied with productive household labor, as manufacturing was shifting from homes to factories. The fertility rate was declining, and the combination of these three factors allowed women to expand their activities to address such concerns as voting rights and temperance, and socialization outside the home became more commonplace (Coontz, 2005; Hulbert, 2003). It was during this time that women began to form child study groups to discuss common concerns about raising children. By 1897 the National Congress of Mothers was formed (Schlossman, 1983, p. 8). At the end of the 19th century the scientific perspective on raising children “called for an exactitude and discipline that had been ... lacking” (Hulbert, 2003, p. 28). Eighty years ago, Gruenberg (1931), writing about child study groups for parents, stated that

the significance of parent education as a vital part of adult education lies not so much in our discovery that parents are people as in the recent general recognition of the fact that most people are parents. No plan of education for adults can be complete that does not take into account this important aspect of adult life and interest (p. 456).
Schlossman (1983) considered the first three decades of the 20th century (1900-1930) to be formative in American parent education. Prior to this, during the last decade of the 19th century, differing perspectives between private domestic responsibility and public activities for change were noted, and parents were more likely to rely on organized religion and maternal instinct than they were to turn to science and formal instruction for the raising of children. However, this changed as the 20th century continued, and recognition of the existence of both balance and tensions in the theory and practice of parent education in the pre-World War One era was necessary (Schlossman, 1983, p. 10).

One of the results of the tension in theory and practice was the appearance of those who sought to be regarded as experts in child development, an emergent field of study. Between 1911 and 1920 four key institutes to advance the study of the child were formed, and the actions of Lawrence K. Frank and the Laura Spelman Rockefeller Memorial (LSRM) Foundation shaped the enormously popular parent education movement of the immediate post-WWI era (Schlossman, 1983).

During the first twenty years of the twentieth century, the progressive movement in America spurred the development of educational programs for adults, with a belief that adult learners had abilities and experiences requiring a different approach than one developed for the education of children (Knowles, 1962). Multiple settings for the education of adults arose, and methods to effectively educate adults were developed, with parent education as one area of focus. Two main elements at this time contributed to the growing appeal of the parent education movement:
1. A belief that the family had lost its direction, and had failed to provide adolescents with guidelines for transitioning smoothly to adulthood. Indeed, the family was calling out for assistance.

2. The rapidly increasing confidence that the answer to the declining family life was a new scientific knowledge base, that would reestablish parental authority, if the parents would only conform to this approach (Schlossman, p. 32).

At this time in history, charitable foundations in the United States were striving to move from their former purely altruistic stance to one of integrating the prestigious new social sciences into their philosophy. Frank’s affiliation with LSRM resulted in his selection of parent education as an alternate way of helping children (Schlossman, 1983, p. 21).

During the same time period, the United States Children’s Bureau was established, with one of its targets the organization of a grassroots effort to save babies from sickness and death through better mothering. During this era, health issues and survival were critical for both mothers and children, since infection and lack of food safety practices compromised their health, and indeed, survival (Wrigley, 1989, pp. 48-50). By 1929 the Bureau estimated that its childrearing information had benefited half of U.S. babies (Bogenschneider, 2008, p. 148). The Bureau’s aim in parenting education during this period of history was instructing parents how to take care of their children. The focus was on improving the infant mortality rate as well as improving maternal health so that mothers would be physically able to care for their children (Bogenschneider, p. 147).
A counterpoint to the progressivism espoused by the Children’s Bureau came from Lawrence Frank, who believed that American mothers were fundamentally inept at child rearing because they did not know how to utilize the advice of experts (Schlossman, p. 23). Additional criticism of the progressive movement averred that its aim was to reform lower-class immigrant family life in a white Anglo-Saxon Protestant middle-class mold (Schlossman, p. 26).

The burgeoning growth of scientific interest in child development brought with it an increase in expertise in child rearing, not necessarily of the parents themselves, but of an array of professionals to give advice to parents (Hulbert, 2003; Wrigley, 1989). It was during this time that the interest in parent education gave rise to a well-organized social movement that reached millions of parents. The professionals giving advice were largely male doctors, academicians, and psychiatrists. The majority of those caring for children at that time were mothers. Nevertheless, parent education received more sustained attention in the 1920s than it would again until the 1970s (Schlossman, p. 10).

As the century moved on, the complexities of American society increased. During the 1930s, the intellectual development of children began to attract attention. The scope of interest regarding children expanded to include emotional as well as physical well-being. Because the country was in the midst of a severe economic depression during this time, the federal government initiated programs to serve disadvantaged children, introducing the concept of education into child management. A different approach was used for middle-class children in nursery school programs. The focus for these children was on their emotional development,
with a lesser concern for their intellectual growth (Wrigley, 1989, pp. 59-60).

However, the 1930s did mark the beginning of a later burst of interest in children’s intellectual development (Wrigley, p. 64).

Parenting education via expert proclamation again ascended after World War Two, with the beginning of the baby boom years in 1946 contributing to rapid growth in the advice market. The advent of television provided another tool for dissemination of advice about raising children and the ability to reach a wider market than ever before. Dr. Benjamin Spock became a household word. Child development became established as part of the curriculum in many universities, and families and children became subjects of a variety of research projects and dissertations.

The social upheaval of the 1960s led to changes in the provision of preschool services. The tone of expertise was shifting from keeping children alive to maintaining their health both physically and emotionally, as pediatricians began to offer advice on child behaviors. First at Rutgers University and then at the Pennsylvania State University, Drs. Bernard and Louise Guerney began to develop parent psychoeducation, a way to teach parents how to have therapeutic play sessions with their children, working in the child’s language, the language of play (Ginott, 1960). In the 1960s this was considered a radical idea, met with suspicion by many of the experts of the time, since it introduced an educational model and involved a family member becoming a therapist for another family member (Guerney, 2003, p. 1).
The need for parenting education rose again during the 1970s, due to the baby boom generation, the largest ever born, growing up and becoming parents. A wide range of social change buffeted families, with multiple factors contributing to the post-modern family’s embattled spirit. Following the social tumult of 1960s and 1970s the American family became more diverse, vulnerable, and volatile than ever before, and more outspoken about the public dilemmas of raising children (Hulbert, 2003, p. 295). Another shift came with parents being reminded to consult their own good sense to find workable solutions (Wrigley, 1989, p. 66). During the period 1984 – 1994, a trio of female non-experts wrote a series of books, all beginning with the words “What to Expect…”, aimed at what they called “Everyparent” (Hulbert, 2003, p. 360). The first book, What to Expect when You’re Expecting (Murkoff, Eisenberg, & Hathaway, 1984), was reportedly read by 93% of pregnant women seeking advice (p. 361).

By the 1990s through the beginning of the 21st century, one hundred years after the experts began their attempt to enlighten and educate parents, their predictions about parenting education and practice had not been borne out. The contribution of the Internet and technology could not be foreseen at the beginning of the 20th century. America as a country was unimaginably different, but current concerns about how to raise children still echoed the issues that had inspired the movement in parent education in the first place. Science’s quest to prove the early formative influence of parents on children’s long-term development had turned out to be far more complicated, and less definitive, than ever acknowledged by the experts (Hulbert, 2003, pp. 361 – 362). The changes in the American family
required personalized and practical information to help parents draw upon their own strengths to develop effective ways of raising children. Professionals in the field began to recognize that giving all parents the same advice was similar to giving all patients the same dose of medicine (Goddard and Dennis, 2004). Different circumstances of individual parents required customized education and intervention following a careful and discerning assessment of family circumstances.

**An Evolving View of Parent Education into the 21st Century**

During the 1990s, due to increased awareness by family researchers and practitioners of the issues expressed by parents, interest arose for developing parent education programs according to the kind of difficulty being experienced: 1) education to help those who wanted to be ‘good enough’ parents; 2) education for parents who had children with behavioral problems; and 3) education for parents who were struggling with their own problems and low self-image (Smith, 1997, p. 113). Schwartz (2002) questioned the levying of all blame to ‘dysfunctional families’ for damage to children, and urged family and parent educators to be unbiased when working with families. Family and parent educators were encouraged to seek parents’ own expertise as the building blocks for parent education, and to work with parents with the understanding that they did possess strengths and talents that could be incorporated into helping their children.

A subsequent review of the literature of the early 21st century found numerous categories of parent education, reflecting a variety of circumstances ranging from prior to birth throughout the childrearing years. I reviewed literature reviewed that corresponded with the issues faced by present-day families as
discussed in the previous section of this dissertation. Settings for parent education included the home, the school, and the clinic, using groups and individualized instruction by either a parenting educator or a therapist. Populations featured in the literature included parent education for the following situations: providing therapeutic foster care (Schwartz, 2002), adopting a child (Barth, Crea, John, Thoburn, & Quinton, 2005), following divorce or separation (Pollet & Lombreglia, 2008), parenting a child with behavioral difficulties (Hagen, Ogden, & Bjornebekk, 2011), and parenting a preschooler (Conner & Fraser, 2011). Literature on preventive programs included premarital parent education (Amato & Maynard, 2007) and parent education for parents of young children (Conner & Fraser, 2011). The review included methods for designing and improving parent education programs (Briesmeister & Schaefer, 2007).

In addition to the information about specific populations and issues affecting families and children, several authors described the scarcity of information about the effectiveness of parent education programs (Hagen et al., 2011; Baker, Arnold, & Meagher, 2010; Schwartz, 2002). Other authors investigated issues that prevented parents from participating in parenting programs (Baker, Arnold, & Meagher, 2010; Scott & Dadds, 2009; Johnson, Harrison, Burnett, & Emerson, 2003).

**Some Specific Forms of Parenting Education**

The literature review revealed several broad categories used in conceptualizing the various forms of parent education. Some of the earliest emphases in helping parents learn to be parents to their children included the parent as the child’s teacher, or manager of the child’s behavior. Accompanying the
increase in mental health counseling during the latter part of the 20th century, were models of parent education that placed the therapist or parent educator in an expert role, one who taught the parent how to build a relationship with the child or who worked with the parent to strengthen their parenting skills (Briesmeister & Schaefer, 2007). Each of these emphases is discussed in greater detail later in this section of the chapter.

Using formats that incorporated education about parenting and child relationship skills were demonstrating positive results (Briesmeister & Schaefer, 2007). Parents learned ways to increase cooperation within the family, which resulted in mutual respect, acceptance, and good will among family members. Children learned to control their feelings and actions, and parents learned to increase their feelings of competence. Parent educators and therapists coached parents in learning and applying their knowledge to the process of changing their children’s dysfunctional behaviors (Briesmeister & Schaefer, 2007).

**Parent as teacher and manager of child behavior**

A review of studies of methods that taught parents how to manage their child’s behavior revealed that programs that provided multiple levels of intervention offered to a range of parents, from anyone interested to those whose additional sources of family distress compromised existing parent-child difficulties. A public health approach for managing behavior was developed at the University of Queensland, educating parents in skills of self-regulation for both themselves and their children, and focusing on enhancing parental knowledge, skills, and confidence to prevent severe behavioral problems in the children (Sanders, 2007).
A similar program based on enhancement of parental skills was developed to form positive child behavior (Ducharme, 2007). Parents learned to use praise and warmth after each compliant response from the child. Beginning with ‘low probability’ requests that were unlikely to provoke a defiant response from the child, parents were coached to gradually introduce more challenging requests to help the child learn to tolerate difficult situations that were previously met with defiance and acting out. Skills were transferred to the parents, and the intervention was situated in natural contexts for the child, with parents able to employ the skills in multiple settings.

The filial psychoeducation approach expands the Ducharme method by teaching parents a positive three-step process to stop unwanted behavior (VanFleet, 2000). The three steps include 1) stating the limit against the unwanted behavior to the child; 2) repeating the limit with a clear consequence attached; and 3) implementing the consequence if the behavior persists. The parents were taught the skill during practice settings under the supervision of the therapist, and then use the skill when needed during therapeutic play sessions at home. The parents learn that the skill can be used outside the play session and with other children in the home when needed. There were consistencies between the methods of Sanders (2007) and Ducharme (2007) and the overall filial process, including teaching parents behavior management skills that work in multiple settings, and producing a more positive relationship between the parent and the child.

**The parent educator/therapist as the expert**

The literature also discusses programs for improving parent-child behavior
that keep the educator/therapist in position as the expert, in contrast to programs that respected the parents’ strengths, built and strengthened parental skills, and ultimately transferred the intervention to the parents alone. Parent-Child Interaction Therapy (PCIT), developed by Eyberg in the late 1960s, integrates traditional play therapy with behavioral principles of differentiation, and is an example of a program with the therapist in the expert role.

Designed to treat children between the ages of two and six, PCIT has two phases: one emphasizing the child-parent relationship and one concentrating on assisting the parent to develop a consistent and structured approach to discipline (Hershell & McNeil, 2007, p. 234). In both phases the therapist is “extremely active, directive, and assertive” (p. 234), observing the parent’s interaction with the child through a one-way mirror and coaching the parent through a device in the parent’s ear. Rather than working with the parent and child in their natural setting, the therapist has the parent bring the child to the therapist’s office. Although the therapist’s role is one of parent educator, the emphasis in PCIT differs from the emphasis of parent psychoeducation, which emphasizes the parent as partner and works directly with the parent. The goal of parent psychoeducation is the transfer of skills to the home with continuing supervision with the parent through the first months of their sessions with their child at home. PCIT requires special equipment and room arrangement, maintaining the therapist in the expert role without continued contact with the parent after the training has ended.

Hughes (2006) created dyadic developmental psychotherapy (DDP) as an outgrowth of his extensive clinical experience with children in placement in foster
or adoptive care, who had suffered childhood abuse and neglect and who frequently had disrupted or disorganized attachment to parent figures. In this approach the therapist does incorporate the foster or adoptive parent in treatment, working together to create a setting that builds trust and security between the parent and child, and ultimately allows the child to integrate past experiences, increase self-worth, and develop attachment security with the new parent. DDP maintains the role of therapist as expert, for despite the parent's involvement, the transfer of skills from therapist to parent that filial psychoeducation produces is not part of this method.

**Qualities of Effective Parent Education Models**

Schwartz (2002) included two priorities in developing parent education programs: 1) identifying with the parents the existing strengths and talents in their roles as parents; and 2) assisting and encouraging parents to use those strengths and talents in resolving the difficulties in family communication and relationships. “First-class” parenting education programs were described as “a collaborative effort that empowered parents in their child rearing as opposed to an expert approach that focuses on parenting deficits” (p. 253).

Writing about the family resilience perspective in treatment foster care, Schwartz (2002) offered the criticism that the majority of parent education programs failed to focus on the unique characteristics or situations experienced by the parent. Instead, programs that aimed to instruct parents were constructed toward some vague generic parent in a situation that had no relevance to the circumstances of the parents who sought help. Schwartz urged that parents in foster
care and adoptive situations be taught to develop skills that elicited the parents’ own expertise in caring for children, as appropriate given their own context and circumstances.

Scott and Dadds (2009, p. 1445) concurred with Schwartz in recommending that professionals consider parents’ thoughts and feelings as an essential component in treatment success. Clinicians and parent educators were to help parents think about their thoughts and feelings in a systematic fashion. The authors suggested incorporating elements of several different theoretical approaches: social learning theory, attachment theory, systems theory, cognitive factors and attribution theory, and motivational interviewing; and from there, understanding how to tailor the approach to meet the needs of individual families.

Looking at factors that influenced the success of parent education programs, a team of Norwegian researchers implemented a randomized experimental design to study the outcomes of a parent training program that taught behavior management for children with conduct problems one year after the conclusion of the program (Hagen et al., 2011). A foundational belief of the program was that parental action had a direct effect on child behavior. Negative parental actions over time resulted in ingrained negative responses, or coercive cycles of responding, where the child was reinforced for negative behavior. The coercive cycle was described as parental actions that lacked warmth, praise, or encouragement toward the child, with a child response of increased disruptive behavior (Hagen et al., 2011, p. 165). The training program taught parents to break coercive cycles of responding to child misconduct. Study findings for two parent families participating in the
training program indicated a reduction in observed negative behavior, an increase in children’s proactive behaviors and social competence outside the family, and a reported increase in feelings of family cohesiveness (Hagen et al., p. 174).

Filial therapy, or parent psychoeducation, developed by Drs. Bernard and Louise Guerney in the 1960s, is a form of parent education that is grounded in aspects of psychodynamic, humanistic, interpersonal, and behavioral theories. The hallmark of the approach is its return of the locus of control to the parent, with the redistribution of power from the therapist to the parent-child relationship. The therapist teaches the parent to work with the child at home using the same child centered skills that a trained therapist would use in the office. Parents are enlisted as allies in the process from their first contact with the filial therapist, and assessment and inclusion of the unique characteristics of the child and the parents is an important part of the approach. The method uses a sequence of parent psychoeducation, practice with the child in the therapist’s office, and ultimate transfer of sessions to the home, with the parents returning for supervisory sessions with the therapist (VanFleet, 2009, p. 163) until mutual agreement on discharge. Parents are able to continue the sessions for as long as needed, or return to them if needed again.

**Issues in Research about Parent Education Programs**

**Scarcity of Outcome Evaluations**

Research to determine the efficacy of parenting programs must examine both whether change occurs and how it occurs. Several issues were identified in follow up studies of parent education designed to resolve child behavior problems.
Although some studies followed a pre- and post- evaluation, outcome studies were few, and Schwartz (2002) noted a scarcity of studies evaluating actual methods of parent education.

Two reviews were cited that revealed only a small portion of parenting education programs reported outcomes after the immediate post-study period, with 38% in one study and 24% in another (Hagen et al., 2011, p. 166). Additional issues in conducting follow-up studies of child treatment included treatment non-compliance and attrition by parents. The scarcity of follow-up studies may be partly due to the difficulty in implementing and analyzing the results, and partly due to the lack of significance in effects, since studies with null findings tend to be published less frequently (Hagen et al., pp. 166-167).

**Low Levels of Enrollment and Attendance**

Low levels of enrollment and attendance in parent education programs were recognized as being problematic for both researchers and clinicians. Parent education programs studied included “manualized, short-term interventions that teach parents, often in a group format, how to build positive relationships with their children and learn consistent, appropriate responses to aggression and other discipline problems” (Bake et al., 2010, p. 126).

Two challenges to success in parenting education identified included 1) maintaining parent enrollment, and 2) the perception of parent education as unnecessary by groups of parents who could benefit, due to the preventive nature of the program. In addition, although many studies expressed concerns about enrollment and attendance, those concerns were rarely investigated (Baker et al.,
Studies addressing these issues in parent education prevention programs for young children were beginning to emerge in the first decade of the twenty-first century. However, the two separate constructs of enrollment and attendance were frequently blended into one measure that eliminated important distinctions between them.

One study of deterrents that prevented parents from participating in parent education programs offered by day care facilities reported a five-factor solution as the best representation of the data, including lack of confidence, lack of course relevance, personal problems, situational barriers, and time (Johnson, Harrison, Burnett, & Emerson, 2003, p. 414). The most important issue affecting participation was lack of childcare, and the next most important issue lack of enough knowledge about the program. Understanding and addressing the reasons parents do not participate are crucial in gaining their ultimate participation (Johnson et al, p. 421 - 423).

**Specific Concerns about Intervention for Children with Attachment Difficulties**

Additional issues of concern were identified in a review of the literature regarding intervention with children who experience attachment disruption. Both researchers and practitioners have found several theories of attachment intervention to possess serious flaws, including lack of an empirical base or a safety risk for the child. Those interventions include holding therapy, rebirthing therapy, and promotion of regression for reattachment. The rationale of recreating behaviors of infancy in children beyond that stage of life is flawed at best, and could have been experienced as humiliating and frightening by children who have already
had far too many of those experiences (Boris, N.W., Zeanah, C. H., & the Work Group on Quality Issues, 2003). Parent psychoeducation, in contrast, works in the present to establish healthy parent-child behaviors that repaired the damage of the past (Van Fleet & Guerney, 2003).

**Models of Specific Parenting Education Applicable to the Needs of Adoptive Children**

In reviewing literature relevant to the needs in educational programming for parents of adopted children, several cautions were noted. Therapists using a parent educator role needed to focus on helping families provide a stable base for secure attachment, and to avoid further harm to parents and children by refraining from using narrow definitions of attachment disorder (Zeanah, 2000, 1996; Werner-Wilson & Davenport, 2003).

Barth, Crea, John, Thoburn, and Quinton (2005) wrote from a psychological perspective about attachment theory and its use by practitioners working with foster and adoptive children and their parents. Practitioners were urged to understand how human attachment develops, and how it goes awry. This knowledge was important in understanding the dynamics of child placement, since the adopted parents’ concern about their individual parent-child relationship with their adopted child was the central reason for their seeking help. Practitioners were encouraged to focus on helping families build a secure basis for attachment, and to avoid seeing the new child through a lens of pathology (p. 259), since there was a tendency for practitioners and parents alike to focus on the diagnosis. Individualized parent education was recommended as part of the approach, and therapists were urged to consider a wider range of evidence-based interventions,
sensitively tailoring them to the needs of the particular family and child.

Recommended interventions addressed parent-child relationships and the parent’s expectations about the relationship. The specific process of filial therapy (see Appendix A) offers multiple opportunities to individualize the process and address expectations and relationships during the training, practice, and supervision components of the process.

Barth and associates (2005) offered the life course perspective as a way to positively view a child’s transition into foster care and adoption:

The effect of positive parenting may drastically alter the developmental trajectories of those children [who have likely experienced a radical and comprehensive change in environment]. ... Through the transition to a strong family setting, children have the opportunity to accumulate [experiences] with the potential to affect lifelong outcomes. It is critical that interventions target these windows of opportunity in a manner that is developmentally sensitive and appropriate to the context and culture of the family (p. 265).

Based on her extensive research, training, and practice experience with parent psychoeducation, VanFleet clearly articulates its appropriateness for use with the parents of adopted children with disrupted attachment. Parent psychoeducation provides parents with specific knowledge about the behaviors of a child with disrupted attachment. When parents practice the needed skills and grow confident in using them, they are able to make adaptations to the specific needs of their child. Additional strengths of the parent psychoeducation model include less
reliance on diagnostic labels, not viewing the child or parent as a “patient” with some inherent flaw, and not placing the therapist/parent educator in the position of expert (VanFleet, 2007, p. 4) throughout the parent psychoeducation process. At the time the parents seek out the filial therapist, they view the therapist as an expert and expect that s/he will perform in that way. They are often desperate for help and want to know that the filial therapist has the knowledge and expertise to help them deal with their child’s behaviors. A trained filial therapist, however, does not present as the sole source of knowledge, but is willing to listen to the parents and integrate their knowledge of the child and their concerns into the psychoeducation process. As the parents learn and practice the filial skills with their child, the therapist uses her expertise to create the conditions that move the locus of control to the parents.

**Parent Education in the Care of Adopted Children**

Currently in the United States, about 2% of the overall child population was adopted (USDHHS, 2012). Absolute numbers approached nearly 1.8 million, and did not include the children who were available for adoption but waiting for placement. In 2011, 105,000 children in the United States were waiting for adoption, with a mean age of 8.0 years. Achieving adoptions in a timely manner is a challenge for most states.

Parents of twenty-six percent of adopted children in 2007 reported “their child experienced moderate to severe consequences of any of 16 possible medical or psychological conditions” (Vandivere, Malm, & Radel, 2009, p. 5). These were the children who were likely to enter the mental health system, and whose parents
were likely to be seeking assistance and guidance, looking for learning experiences that taught them sound practice skills for helping the children (Vandivere, Malm, & Radel, 2009). Finding methods of effective, evidence-based treatment was imperative.

Early research concerning the efficacy of parent psychoeducation was done under the supervision of Drs. Bernard and Louise Guerney at the Pennsylvania State University from the 1960s through the 1990s. Since 1990, much of the research has been conducted under the auspices of the University of North Texas. A literature survey indicated 182 published articles and dissertations on filial therapy (Landreth, Schumann, Hilpl, Kale, Bratton & Homeyer, 2003). During the time period 1994 – 2010, 31 research studies involving filial therapy were identified (Baggerly, Ray, & Bratton, 2010). However, the research did not specify whether adoptive families were part of the population.

Research has found consistent outcomes of improved parent-child affective and empathic relationships in biological families, along with improved behaviors in the children (Sensue, 1981; Guerney & Stover, 1971; Andronico & Guerney, 1969). Filial therapy has demonstrated its effectiveness in different child-parent combinations, different settings, and different cultures and ethnicities. Modifications necessitated by the differences in children and families have not reduced the effectiveness of filial therapy (Van Fleet & Guerney, 2003).

Very few studies have concentrated on families created through adoption, particularly in cases of the adoption of children with disrupted attachment. Instances of parents who had adopted children were found throughout the research
literature. Existing studies had included adoptive families as part of a larger sample. A search of the literature revealed one study examining parent psychoeducation with adoptive families as the sole sample.

Carnes-Holt (2010) studied sixty-one adoptive parents throughout the process of training them in filial therapy. Thirty-two parents were in the experimental group and 29 in the wait-list control group. Using pre- and post-treatment performance on the Child Behavior Checklist – Parent Version (Achenbach & Rescorla, 2000) and the Parent Stress Index (Abidin, 1995), Carnes-Holt found a statistically significant decrease in overall behavior problems in the children (p. 63), and a statistically significant decrease in parent-child stress when compared to the control group (p. 65). Carnes-Holt noted that she had found no previously published outcome studies that focused on the use of parent psychoeducation with adoptive families. Given the numbers of children being adopted at ages past infancy in the United States, continued study of the outcomes of parent psychoeducation with this group is imperative.

**Theoretical Perspectives**

Three theoretical perspectives offer a foundation for the study and analysis of adoptive parents’ experience with parent psychoeducation: Dewey's (1938/1998) experiential learning theory, Lave’s and Wenger’s (1991) situated learning theory, and Freedberg’s (2009) feminist relational theory. A review of literature focusing on these theories suggested their applicability in understanding the processes of parent psychoeducation and the experience of parents who engage in it.
**Experiential Learning**

Experiential learning distinguishes the meaning making of our experiences from empirical theory, and the life experience of our days from the formal classroom. Much adult learning is located in everyday workplace tasks and interactions, home and family activity, community involvement and other places of nonformal or informal education (Fenwick, 2001, p. 243).

Dewey’s theories about education and learning focus on the work of the adult teacher and the young student in a school setting. The nature of freedom is reflected in the relationship between education and freedom of thought, movement, desire, and purpose. Rigid rules and procedures prohibit “the growth of individuals in the intellectual springs of freedom without which there is no assurance of genuine and continued normal growth” (Dewey, 1938/1998, p. 70). True intellectual growth requires the “reconsideration... and remaking of impulses and desires in the form in which they first show themselves” (Dewey, p. 74). Since children with disrupted attachment are beginning to trust the person who shares therapeutic time with them, their play behaviors during therapeutic play may reflect the circumstances of their early experiences. Dewey’s theories concerning genuine and continued growth are consistent with the framework and philosophy of parent psychoeducation with parents who adopt children with attachment difficulties. The combination of expressed parental warmth, empathy, acceptance, and therapeutic limit setting, skills learned and practiced under the supervision of the parent educator, allows the parent to create a setting for the child that contributes to intellectual and emotional growth for both the adult and the child.
Dewey (1938/1998) also theorized that “every experience affects for better or worse the attitudes which help decide the quality of further experiences, ... [and] every experience influences in some degree the objective conditions under which further experiences are had” (p. 29). Dewey urged educators to be attuned to the existing literal and figurative “surround” of the student, so that all can be incorporated into developing worthwhile learning experiences. The parent and the therapist, now functioning as an adult educator, meet to discuss the structure and form of parent-directed therapy. The therapist draws from that literal and figurative “surround” of the parent to identify what can be incorporated into parent psychoeducation.

The relationship between the concepts of situation and interaction are inseparable, since “an experience is always what it is because of a transaction taking place between an individual and what, at the time, constitutes his environment” (Dewey, 1938/1998, p. 41). The principle of continuity reflects the carrying over of learning from an earlier experience to later ones, because what the individual learns “in the way of knowledge and skill in one situation becomes an instrument of understanding and dealing effectively with the situations that follow” (p. 42). As the structure of parent psychoeducation moves from training to office practice, and lastly to home practice with supervised sessions with the parents back at the therapist’s office, the application of the concepts of situation, interaction, and continuity is observed, with adaptations being made as new learning occurs. Were the training to consist only of the two sessions in the beginning and parents left to figure out the rest by themselves, the effectiveness of parent psychoeducation
would diminish and disappear. Situating his theory in the interaction between teacher and child, Dewey (1938/1998) maintained that

The principle of interaction makes it clear that failure of adaptation of material to needs and capacities of individuals may cause an experience to be non-educative... it is a mistake to suppose that the mere acquisition of a certain amount of [knowledge] which ... may be useful in the future, has this effect, and it is a mistake to suppose that the acquisition of skills... will automatically constitute preparation for their right and effective use (Dewey, 1938/1998, pp. 47-48).

A similar process occurs as the parent psychoeducation works with the relationship between parent and child. A successful outcome depends on the adaptation of the filial skills to the needs and capacities of the parent-child relationship.

Experiential learning in education "depends on the quality of the experience which is had" (Dewey, 1938/1998, p. 16). The quality of the current experience depends on whether it can be successfully carried over into future experiences. Preparing for experiential learning in education requires a plan that identifies what is to be done, and how it is to be done. Preparing for experiential learning in parent psychoeducation requires a plan for learning the filial skills (what is to be done) and practice of the skills in the office with the child, beginning home sessions, and ultimate discharge from the therapist (how it is to be done).

Experiential learning theory assumes that certain experiences of cognition can be enhanced in ways that produce outcomes desired by the learners involved,
and situated cognition maintains that learning was rooted in the situation in which persons participated (Fenwick, 2000).

**Situated Learning**

The practice of parent psychoeducation and filial therapy corresponds with the premises of situated learning, first articulated in the field of adult learning by Lave and Wenger (1991). Situated learning considers the ways that learning develops as an activity proceeds, since the participants acquire and understand knowledge about what they were doing in the activity. Situated learning is further described as growing from the situation in which the learner participates and as the production of “person-in-activity”, always integrated with the individual’s identity and participation (Clancey, 1995).

The learning process cannot be separated from the situation in which it occurs. Placed within the actual experience, the learning process of parent psychoeducation in filial therapy is inseparable from the context in which the learning takes place, the premise of situated learning. The therapeutic techniques cannot be learned by reading a book or watching a live or video demonstration, but are practiced repeatedly in the real setting. The resulting knowledge is a “product of the activity, context, or culture in which it is used, [and] the activity in which knowledge is developed and deployed is not separable from or ancillary to learning and cognition... but is an integral part of what is learned” (Brown, Collins, & Duguid, 1989, p. 32).

The tenets of situated learning are played out in thoughtful, insightful practice, allowing the learner to utilize learning based on experience and prior
knowing (Caffarella & Merriam, 2000, p. 60). This is further expanded as “reflection-in-action,” which assists the learner in reshaping new learning as it was learned. The therapist/adult educator acknowledges that the parents have the experience and prior knowledge about children in general, but need to learn about the specific circumstances experienced by their adopted child prior to coming into their home. The therapist/adult educator weaves that information into the parent psychoeducation to teach the parents about the source of child behaviors as well as the methods for allowing the safe expression of those behaviors in therapeutic play. The therapist demonstrates the skills in therapy with the child while parents watch, teaching the parents the skills. The parents practice the skills and adapt them to the needs of the child, reshaping their learning to be specific to what the child needs. Parents come to recognize play as the child’s language, the way that children process their life experience (Bennett & Eberts, 2014, p. 12). Parents and their therapist/parent educator discuss specific behaviors of the adopted child and the impact of disrupted attachment on child development. The extent of this difficulty is communicated in Perry’s (2006) book, The Boy Who Was Raised as a Dog:

The challenge is that, in one moment, you will need to have expectations and provide experiences that are appropriate for a five-year-old… Ten minutes later, however, the expectations will have to match those for a younger child… He is, developmentally, a moving target. That is why parenting these children is such a frustrating experience. One moment you are doing the correct thing and the next you are out of sync (p. 223).
Research on situated cognition or learning was frequently done with workers in the workplace. Applications to computer learning (Clancey, 1995), occupational therapy for children (Copley, Roger, Hannay, & Graham, 2010), and training of novice nurses (Gillespie & Peterson, 2009) examined learning as it occurred when the student worker was practicing in the actual work setting.

Critiques of situated learning include a consideration of where the learning occurs, and questions how situated learning differs from learning in the classroom such as class learning and discussion (Merriam, Caffarella, & Baumgartner, 2007). When parents work individually with the filial therapist, the learning is situated in the practice of the techniques with the child. Necessary adaptations for particular child behavior are made as the parents and therapist work together.

The instructional setting impacts the learning, as “the question is... what kinds of complex social activities to arrange, for which aspects of participation, and in what sequence to use them” (Greeno, 1997, p. 10). The impracticality of abstract training in situated learning, and the importance of locating the training in some aspect of “real-life problem-solving” are central to the theory (Merriam et al., 2007, p. 180). The design of filial therapy contains training about activities, participation, and sequence, and the application of the method situates the learning in real-life problem solving between parent and child. A review of the literature about the application of situated learning theory shows its consistency and applicability to this study of filial therapy with adopted children.
Feminist Relational Theories

Theories of relationship as articulated by adult educators and feminist relational theorists are also applicable to this study of parent psychoeducation for adoptive parents of children with disrupted attachment. Elements “such as ‘trust, friendship, and support’ are necessary for effective reflective or rational discourse to occur, and receiving support, connecting with family, and developing trust are all ways in which relationships are evident in the ... learning process” (Taylor, 2000, p. 306). Several of the relationships that develop during the learning process of filial therapy for adoptive parents are the kinds of relationships described. Parents learn to trust in the filial process as well as in the therapist’s position as a helper. Trust develops between the parents and the child as the process evolves. Parents receive support from their therapist, from other parents who were involved in filial sessions with their own adopted children, and from extended family members who see the positive outcomes of the process.

In a study of developmental relationships in the lives of midcareer women, emotionally warm relationships were discovered to be more likely to promote instances of learning than did relationships that were practical and career oriented (Carter, 2000, p. xiii). The results of Carter’s and Taylor’s work further reinforce the humanistic theoretical underpinnings of feminist relational theory, emphasizing the development of genuine respect and acceptance for the strengthening of human relationships (Freedberg, 2009).

Freedberg (2009) argues that a determinant of healthy human development is whether the human has the ability to form connections through relationships.
Within this perspective, growth is seen as occurring within relationships instead of apart from them. The feminist relational approach emphasizes the nature and quality of connectedness to others. The development of the self is described as “[developing] in structure in the presence of a finely tuned shifting balance of connection and differentiation with significant others” (Freedberg, p. 22). The nature of the “special time” of filial therapy provides that finely tuned balance, and is noted for development of strong bonds of attachment between parents and children. Filial therapy takes the reciprocal influences of relationships into account and works to shift them to more adaptive positions. The family is given tools to alter past damaged relationships. The use of non-directive play sessions in filial therapy has been found to recreate parent-child interactions that resemble those that lead to healthy attachment in infancy (VanFleet, 2003, p. 286).

Relatedness with others was a necessary condition for physical survival (Freedberg, 2009, p. 18). Relationships that are characterized by mutuality, empathy, and affinity are ones where two or more individuals’ basis for relating to one another is an interest in each as a whole person, with concomitant awareness of the subjective experience of each. Showing that awareness of her children’s subjective experience, a mother described her play sessions with her adopted children as being “as important to my kids as oxygen” (Carnes-Holt, 2010, p. 76). The parents’ psychoeducation during the filial therapy process increases their awareness of their child’s prior experiences, and children, although lacking the cognitive sophistication to think about the parent’s experiences, still are likely to feel the difference in a relationship with a parent who is emotionally attuned to
them. Such an outcome is likely, since persons in a relational interchange must be capable of recognizing the subjective feelings, rights, and experiences of each other, in order to have a meaningful experience in one another’s presence (Freedberg, p. 26).

The common experience of parenthood, specifically applied to the experiences of parents who adopt children with a disrupted attachment, children who were likely to have had multiple adverse events beyond their capacity to cope, is a research area that is rich in detail and one that can yield insights into this difficult but vastly rewarding experience. The underlying theoretical framework of phenomenology, a research framework that emphasizes lived experience, enhanced with experiential, situated learning and relational theories to guide the study of parent psychoeducation, is a sound approach to this research proposal.

**Conclusion**

This review of literature provided a basis for a study of a specific educational approach, parent psychoeducation/filial therapy, for parents of adopted children with attachment difficulties. The literature emphasized parent education with the integration of both adult education and psychotherapeutic theories and values. Ethical issues affecting the delivery of parent education were explored. Numerous authors emphasized the importance of working with parents, and many encouraged accepting the expertise of the parents as well. Several sources located in the psychological literature were more attuned to a therapeutic perspective than an educational one, but continued to emphasize the importance of assisting the parents to learn usable, practical skills to help their children. From the perspective of adult
education theory, a limitation of several of the articles from the psychological literature base was the dependence on the therapist as the primary change agent.

This section ended with a discussion of experiential learning theory (Dewey, 1938/1998), situated learning theory (Lave & Wenger, 1991), and feminist relational theory (Freedberg, 2009), three theories that support the understanding of parent psychoeducation with adoptive families. The common experience of parenthood, specifically applied to the experiences of parents who adopt a child with a disrupted attachment, is a research area that is rich with detail and meaning.
Chapter Three: RESEARCH METHOD

In this chapter, I articulate the purpose of the study and the specific research questions to be answered. I identify the participant sample and discuss the appropriateness of a qualitative research approach to answering the questions, considering the concepts of phenomenology. I show the suitability of phenomenology as a method to explore the experiences of adoptive parents who pursue parent psychoeducation and filial therapy as a method of helping their adopted child with disrupted attachment create a new family with them, and explain how a phenomenological study supported participants in their description of their lived experiences. I discuss issues related to participant selection, interview development, data collection and analysis; review the role of researcher as an instrument; and identify biases and assumptions, ethical considerations, and issues related to the quality of the study.

Research Approach and Design

The purpose of my study was to learn how parents who adopted children with attachment difficulties described their experiences with filial therapy, a form of parent psychoeducation. Dewey (1938/1998) defined continuity as the carrying over of learning from an earlier experience to a current one, as the learners applied their knowledge toward a more effective understanding and method for effectively handling a subsequent experience (p. 42). A phenomenological approach offered the basis for a rich and conceptual description and analysis of the lived experience of adoptive parents who used therapeutic play in filial therapy to help their adopted
children and how that practice fit with their prior thoughts and beliefs about parenthood and parenting techniques.

The following research questions guided the study:

1. What life experiences shaped the context for the parent’s decision to adopt?
2. How did the parents describe their experiences with their adoptive child after placement? What factors did they identify as influencing their seeking help in managing their child’s behaviors?
3. How did the parents describe their experiences with parent psychoeducation?
   a. What meaning did the parents derive from being their child’s therapist?
4. What types of learning were reflected in the experiences parents described?

The study sample consisted of parents who had adopted children who were separated from their biological parents and who had experienced a disruption of their first attachment relationship. The study focused on adoptive parents who sought help for their child due to concern about the child’s adjustment, and who learned through parent psychoeducation from a trained therapist how to provide therapeutic play sessions with their child in their own home.

**The Appropriateness of a Qualitative Approach**

A qualitative approach was chosen as most appropriate for obtaining insights into the questions stated above. Although quantitative measures can be applied to assess the success of parent psychoeducation as reflected in specific criteria, qualitative research offered a richer, more nuanced comprehension of the
experience of parents of children with disrupted attachment who have engaged in parent psychoeducation. Understanding the personal perspective of the participants offered insight into the “heart” of the matter: the parent’s lived experience in learning to create a positive bond of attachment with a child who previously knew only a broken or negative one.

The design of qualitative research allowed a better knowledge of the meanings people give to their experiences, with “an important goal of qualitative studies... to understand how and why behavior occurs, rather than predict or control behavior” (McMillen & Wergin, 2010, p. 89). A clear explanation of the deeper causes of an experience and its results can be more important in understanding a phenomenon than describing its frequency and symptomatology (Flyvbjerg, 2006, p. 229). Lastly, qualitative researchers value the individual’s point of view in understanding how people made sense of their experiences.

**Phenomenology as a Research Approach**

Phenomenology in its broadest sense is “a philosophy or theory of the unique; ... interested in what is essentially not replaceable” (Van Manen, 1997, p. 7). Phenomenology is further described as the foundation for all knowledge, made from metaphoric “bricks” of scientific learning (Moustakas, 1994), with the word itself coming from *phaino* (transliterated Greek; originally faino), which means to bring to light, to become evident, to appear to the mind (Thayer & Smith, 1999).

Phenomenology maintains a double role in human science research, as it is simultaneously a theory of qualitative research and a methodology for the description and interpretation of lived human experience. Phenomenology seeks a
deeper understanding of the meaning of people’s daily experiences and offers the possibility of generating knowledge and understanding by reflecting on past experiences (Van Manen, 1997). The origins of phenomenology were traced to 1765 in philosophy, but the word was not defined until Hegel constructed its technical meaning (Moustakas, 1994). The German mathematician Edmund Husserl (1859-1938) was believed to have established phenomenology as a philosophical movement (Gearing, 2004, p. 1430), developing the concept of *Epoche*, which “requires the elimination of suppositions and the raising of knowledge about every possible doubt” (Moustakas, 1994, p. 26; Creswell, 2007, p. 58). *Epoche* is described as looking beyond the usual ways of perceiving and judging what appears before us (Moustakas, 1994). As a researcher I was directed through a thoughtful, mindful process of understanding how my own lived experience filtered my learning from my research.

Phenomenological research is popular in various human sciences, including sociology, education, psychology, and the health sciences (Creswell, 2007; McMillen & Wergin, 2010). The approach to phenomenology that had particular bearing on research into adoptive parents’ lived experience with parent psychoeducation in the care of their adopted children is hermeneutic phenomenology (van Manen, 1990). Aspects of transcendental or psychological phenomenology (Moustakas, 1994) offered additional bearing on my research.

**Hermeneutic Phenomenology**

Writing from the perspective of an educator, van Manen (1997, p. 180) defined hermeneutic phenomenology as “attentive to both terms of its methodology:
it is a *descriptive* (phenomenological) methodology because it wants to be attentive to how things appear... it is an *interpretive* (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena.” Hermeneutic phenomenology posits that lived experience is already meaningfully experienced; that human experience is imbued with meaning by the one having the experience. The goal of hermeneutic research is a rich understanding of the nature of meaning in our daily experiences, offering insights that “bring us in more direct contact with the world” (van Manen, 1997, p. 9). The ultimate aim of hermeneutic research is “the fulfillment of our human nature: to become more fully who we are” (van Manen, 1997, p. 12). Phenomenology is viewed “as an interpretive process in which the researcher makes an interpretation of the meaning of the lived experiences” (Creswell, 2007, p. 59). In my study of the experiences of parents who had adopted a child with a disrupted attachment, I sought an understanding of the nature of the meaning of being their child’s therapist to the parent and their insights of what that meaning had contributed to their sense of who they were.

Since parenthood is a major part of the life of most adults, and the decision to adopt a child an important one, research into the life experiences of adults who became parents of a child who might otherwise not have a family offered insight into the meaning of the experience as related by the research subjects. Hermeneutic phenomenology emphasizes the meaningfulness of lived experiences, in this case of adults who adopt children. Hermeneutic phenomenology “is interested in the human world ... in all its variegated aspects” (van Manen, p. 16). Particularly in
adoption, the combinations of individuals who formed families are indeed variegated.

**Transcendental Phenomenology**

The aims of transcendental phenomenological research determine “what an experience means for persons who have had the experience and who are able to provide a comprehensive description of it” (Moustakas, 1994, p. 13), and from those descriptions deriving a general meaning of the experience. In my study of parent psychoeducation, I wanted to know what the experience meant for parents who had adopted children with a disrupted attachment and turned to parent psychoeducation and filial therapy to help their child make a positive adjustment to their family. I sought parents who had adopted children and who could provide a comprehensive description of their experiences.

Moustakas, who made significant contributions to both the field of research and the field of psychology, particularly with families and children, defines the process of phenomenological research in three steps: the Epoche, The Transcendental-Phenomenological Reduction, and the Imaginative Variation (pp. 34–35). The Epoche requires researchers to examine themselves deeply, identifying any pre-existing knowledge and beliefs that could block the perception of the phenomena as it truly was. I examined my beliefs and assumptions as a researcher, finding Moustakas’ description of the Epoche helpful in understanding the process.

However, there are differences between hermeneutic phenomenology and transcendental phenomenology in the description of the shared experiences of participants, with the hermeneutic emphasis of finding meaning and the
transcendental emphasis of seeking essence. The processes of the Transcendental-
Phenomenological Reduction led to the description of the essence of the experience,
its real nature as perceived by the participants. My research purpose and questions
were focused on learning the meaning the participants assigned to the experience of
participating in parent psychoeducation and providing filial therapy to their
adopted child. The assignment of meaning is an individualized process, as
differences in family settings and family members are likely to yield individual
meanings of an experience. Hermeneutic phenomenology is suited to the
exploration of meaning, consistent with my research questions. In this study, part of
that exploration included the application of the perspectives of experiential, situated
learning, and relational theories. By focusing on the description of the experiences
given by the participants through the lens of appropriate theories, I was able to
move through those processes (Creswell, 2007, pp. 59-60) to convey an
understanding of the overall meaning of the experience as ascribed by the
participants.

The Concepts of Phenomenology

This section describes essential concepts of phenomenological research,
especially regarding qualitative research and specifically regarding the lived
experiences of parents who adopted children with attachment disruption. McMillan
and Wergin (2010) identified a number of characteristics shared by the different
methods of qualitative study (p. 89). Some of the more salient include the search for
meaning, the natural setting, the rich description, the concern with the process of
how and why behavior occurs, and the participant perspectives. Additional
important concepts are the lifeworld (Van Manen, 1997) and the Epoche or bracketing (Moustakas, 1994; Gearing, 2004).

**Searching for Meaning**

Searching for meaning is the thrust of hermeneutics, which seeks the meaning that people ascribe to their lived experiences. This qualitative study was designed to yield information that would help me better understand the meaning assigned to the experience, as my intent in the study was to look at the decision to adopt with the subsequent parent psychoeducation and practice of filial therapy skills through the lens of the continuity of learning experience (Dewey, 1938/1998) and the influence carried forward by learning through parent psychoeducation. The participant parents reflected on the life experiences that brought them to their decision to adopt a child. They also reflected on the experience of providing their child with therapeutic play.

**Natural Setting**

Qualitative studies are situated in places where behavior occurs in its natural setting. I considered where the behaviors studied would be most likely to occur, to allow the subjects to be comfortable without any constraints or controls. The natural setting for a study of parent-child relationships would be in the home, where families would be most likely to feel at ease. In addition, since play was the child's "natural medium of self-expression" (Axline, 1969, p. 9), the parents were working with the children in their natural setting. Since the goal of parent psychoeducation is to transfer the therapeutic play sessions between parent and child to the home, the lived experiences of the parents are most meaningful when they occur in the
natural setting of the home (McMillen & Wergin, 2010) and in the natural setting of
the child’s lifeworld.

**Rich Description**

A rich description affords a deeper understanding of the respondent’s experiences. In contrast to quantitative measures, which yield numbers, I designed a qualitative study to obtain the respondent’s story in narrative form, which could
draw from various descriptive media to enhance the description of the respondent’s experience. I interviewed the respondent and drew out the detail of the experience. The individual circumstances of each child’s adoptive placement varied, and qualitative methods are most suitable for exploring the meaning to parents of raising a child whose behaviors were challenging to them in terms of how they defined their ability to be parents.

**Participant Participation**

The rich description relates to the concept of participation as well. Qualitative researchers are interested in the story of the behavior. Data was collected directly from the respondents, and I sought to establish a close, trusting relationship with them, one where feelings can be discussed about the experience, comfortable language can be used, and viewpoints given about what has happened (McMillen & Wergin, 2010). In adoptive placement of children, both parents and the child bring a variety of experiences to the shared table.

**The Lifeworld**

The lifeworld is conceptualized as “the world of the natural attitudes of everyday life” (van Manen, 1997, p. 7). It is the world as we experience it in the
moment, without reflection or categorization. Phenomenological research seeks a deeper understanding of the meaning of those daily experiences, and tries to gain insightful descriptions of the way people experienced their worlds, without attempts to classify those experiences (van Manen, 1997, p. 9). Phenomenology describes these experiences with a certain degree of depth or richness. Since parenthood is a status that many adults experience, the lifeworld of parents as they adopt a child who may have a vastly different lifeworld seems a worthy subject for a phenomenological study. The techniques that the parent learns to use through parent psychoeducation prepares that parent to enter the lifeworld of the child through an understanding of the meaning of the child’s play. As the parents practice filial therapy with their adopted child, under the supervision of a trained, experienced therapist, they become agents in helping the child overcome the emotional and behavioral problems arising from early disruption in a primary attachment relationship (VanFleet, Sywulak, & Sniscak, 2010, p. 127).

**The Epoche, or Bracketing**

Bracketing is posited as “essential to construct the meaning of participants in phenomenology” (Creswell, 2007, p 142). Bracketing is the first step in Moustakas’s reduction, where researchers distinguish and set aside, as far as humanly possible, any preconceived experiences they may have in order to best understand the experiences of participants in the study (Creswell, 2007). However, Gearing (2004) challenged the exponential growth of qualitative research, describing that growth as “resulting in confusion, inconsistency, and misunderstanding of what was meant by bracketing” (p. 1429). As I evaluated my preconceived experiences, I noted that my
experience was drawn from the fields of education, social work, and clinical intervention with children and families. I learned that certain experiences presented a challenge to reduction as articulated by Moustakas for this study of the lived experience of adoptive parents who participated in parent psychoeducation and filial therapy with their adopted children. Having worked in adoption at the beginning of my career and in parent psychoeducation in my current clinical practice, I differentiated and clarified various experiences as I moved through this process, since my adoption work at the beginning of my career consisted in placing children. In my current practice, I provide parent psychoeducation to many of the families who bring their children to me for therapy. I attempted to become transparent amidst Gearing's (2004) “confusion, inconsistency and misunderstanding.”(p. 1429)

**Design of the Study**

Van Manen (1997) and Moustakas (1994) discuss what phenomenological research can or cannot do. Phenomenological research can support focusing on the wholeness of experience, searching for meanings and essences of experience, obtaining descriptions of experience through first-person accounts, and viewing experience and behaviors as an integrated and inseparable relationship of subject and object and of parts and whole (Moustakas, 1994, p. 21). Phenomenology cannot be used to show that one method is more effective than another, must take its point of departure from lived experience, and does not problem solve (van Manen, 1997, pp. 21-23).
**Understanding the Shared Experience of the Phenomenon**

Eight procedural steps that bear on the design of a phenomenological study are identified, using systemic steps in the data analysis procedure and guidelines for composing textual and structural descriptions (Moustakas, 1994; Creswell, 2007, p. 60). The first step establishes the importance of understanding several individuals’ shared experience of a phenomenon.

Since more children were coming into the child welfare system with trauma and attachment difficulties (Webb, 2003), these issues drove the need of parents to understand what contributes to the challenging behaviors of those children and the need for therapists to know evidence-based methods of helping those children. I believe that this is important since research was already showing that children who fail to attach risk multiple problems throughout life, including serious mental illness and imprisonment (Brown, 2009; Hughes, 2006; Lieberman & Van Horn, 2008). Parents who can share successful re-attachment experiences will build the knowledge base for helping others.

**A Phenomenon of Interest**

The second step involves deciding whether the problem is a phenomenon of interest. Since parenthood is an experience that many adults value, and since more children are coming into the adoption arena, the question of how to successfully care for those children was one of interest to me. A review of examples shows that many different human experiences are the subject of phenomenological research (Moustakas, 1994, pp. 120-153).
Specifying the Philosophical Assumptions of Phenomenology and Identifying Potential Sources of Bias

The third step explores my ability to articulate the philosophical assumptions of phenomenology and to identify elements in my own experience that could be sources of bias. Phenomenology focuses on the broad lived experience of the participant; van Manen saw the researcher having an interpretive process where an interpretation was made, whereas Moustakas relied less on the interpretation of the researcher (Creswell, 2007, p. 59). My articulation and identification of elements are presented later in this chapter, in the section “Contemplating the Researcher as an Instrument.”

Collecting Data from Individuals who have Experienced the Phenomenon

The next step concerns whether data can be collected from individuals who had experienced the phenomenon. The staff at an agency in southeastern Pennsylvania specializing in parent psychoeducation with families who adopt children, was willing to contact families who learned filial therapy to use with children they were adopting, and invite them to participate in the study. I was interested in families who were still in the practicing/supervision phase of filial therapy, as well as those who had completed the training and worked with their child at home. I was able to collect data from five families who were located throughout the learning and practicing phases as described.

The Participants’ Experience of the Phenomenon, and Contexts Influencing that Experience

Finding out whether the participants would be able to respond to two broad general questions was the next step. The questions centered on the participant’s
experience with the phenomenon of parent psychoeducation, and what contexts or situations influenced that experience. In this study, the broad questions involved interviewing the participants about their experiences in learning and providing filial therapy and concomitant changes in their child’s behavior, with the situations that influenced that experience being 1) the adoption of a child with challenging behaviors that did not respond to their established method of parenting, and 2) providing filial therapy for that child in their home. The five families in my study were able to respond to my broad questions. All the families had adopted children with challenging behavior either at the time of adoption or subsequently, and all the families participated in parent psychoeducation and provided therapeutic play to their children.

**Data Analysis**

The sixth step asks me to identify significant statements that provide understanding of how the phenomenon was experienced, and to determine whether those statements can be is establishing what correlates with the desired measure and formulate the questions accordingly (Dr. Paul Amato, personal communication, 3/25/11). I adjusted the wording of the questions to limit technical terminology and ensured that the questions were worded according to lay language. I developed several interview questions to reflect four markers of secure attachment between parents and children, which included the child

1) experiencing a sense of security;

2) being able to regulate affect and arousal;
3) being able to express feelings and communicate them to others; and

4) demonstrating the willingness to explore one’s environment. (Lieberman and Van Horn, 2008; Zeanah, 2000)

In addition, I incorporated language from the treatment goals and learning outcomes in parent psychoeducation and filial therapy developed by VanFleet, Ryan, and Smith (2005, pp. 243-244) for the parents and the entire family that corresponded with the markers of secure attachment. I asked the parents to describe a situation that permitted them to recognize the learning outcome. The treatment goals and learning outcomes can be found in Appendix B.

*Open coding* is described as breaking the data down into discrete parts, closely examining it, and comparing for similarities and differences (Babbie, 2007). I used open coding as described, using the subject matter of the questions to define the categories for coding, and examining participant responses to determine if common themes existed across the sample.

**Written Descriptions of Expressed Themes and Contexts**

The final two steps concerned whether descriptions of the statements and themes expressed by the participants could be written, as well as a description written of the context or setting where the phenomenon was experienced. Because the research questions were developed with a consideration of the markers of sound attachment and the goals of filial therapy, I believed that data analysis would assist in identifying significant statements and combining those statements into themes, yielding a textural description of what participants experienced. Participants provided information in two ways: a written demographic
questionnaire and an oral interview, which described the structural context where
the filial therapy was practiced currently, whether in the therapist’s office or in the
family’s home and sought the family’s lived experience providing filial therapy.

**Common Experiences of the Phenomenon**

Finally, I determined whether a composite description could be written that
“focuses on the common experiences of the participants (Creswell, 2007, p. 62)”
involved in parent education and filial therapy with an adopted child having a
disrupted attachment. I identified themes and distilled participant responses into a
description of the overall experience of all the parents as they brought an adopted
child into their family, learned through parent psychoeducation and filial therapy
how to help the child, and reflected on the meaning of being their child’s therapist. I
previously identified assumptions and biases to be aware of as I worked in coding
and thematization of the parents’ narratives to learn whether I could identify that
common experience in the responses.

**Phenomenology and the Process of Parent Psychoeducation
in Creating Families with Adopted Children**

The purpose of this phenomenological study was to describe the lived
experiences of parents who adopted children with attachment difficulties and who
used parent psychoeducation from a therapist trained in providing filial therapy,
and to understand these experiences from the perspective of the participants and
within the theoretical framework discussed earlier. As explained in Chapter One,
this study concentrated on learning the lived experiences of adults as they chose to
become adoptive parents and brought a child with disrupted attachment into their
homes. The parents wanted to learn how to help their adopted child. They were
offered the opportunity through parent psychoeducation therapeutic techniques, which would aid them in helping their child themselves. I sought to learn how the parents perceived the opportunity to become their child’s therapist and if doing so changed their relationship.

Previous studies have investigated parent psychoeducation, but most of these studies focused on biological parents and children (VanFleet & Guerney, 2003), using quantitative measures. I could find no studies that explored the experience from a learning perspective or from the lived experiences of the parents. Additionally, although rating scales can be used to determine the effect of skills training, and qualities of a relationship can be broken down into component parts and quantified in a scale, only an individual can detail in his or her own words the perception of the learning experience and its outcomes.

Qualitative research allows the development of a rich narrative, built on the multiple perspectives of an adult through various life experiences. I was open to the shading, tone, and colorations of the experience by each individual studied. Transcendental phenomenological research is described as seeking the meaning of an experience for the person who experienced it, and learning through that person’s own language and descriptions what that experience meant (Moustakas, 1994). Gathering stories from different persons having the same experience may aid me in formulating a general meaning of the experience. However, each child coming from a disrupted attachment had different experiences and descriptors, and every parent has his or her own story of what life has meant to them. Exploring how created
families made meaning of their experiences was a topic well suited to a phenomenological study.

**Contemplating the Researcher as Instrument**

Applying my understanding of the role of bracketing and the concept of the qualitative researcher as an instrument of data collection to my proposed study of adoptive parents’ lived experience with psychoeducation in the care of their adopted children required me to examine my background as a social worker, educator, and therapist, and identify previous beliefs about children coming out of the state foster care system and the families who adopt them. This process focused on “the way things appear to us through experience, or in our consciousness as we seek to provide a rich textured description of lived experience” (Kafle, 2011, pp. 181–182). As I worked through the early processes of my doctoral studies, I reflected on my multiple experiences with adoption and filial therapy, from my earliest years as a caseworker specializing in adoption and teaching positive parenting skills, to my current practice as 1) a children’s therapist who offers parent psychoeducation and filial therapy; 2) as a supervisor of therapists who may be working with adopted, foster, or maltreated children as part of their caseloads; 3) as a trainer of play therapy, which includes an overview of parent psychoeducation and filial therapy, and 4) as a fulltime instructor of Human Development and Family Studies and an adjunct instructor of graduate social work. For the purpose of my research, I pondered whether I held the etic perspective, maintaining objectivity as an outsider, or the emic perspective, which tried to adopt the beliefs, attitudes, and viewpoints shared by the culture being studied (Rubin & Babbie, 2014, p. 498). I felt a stronger
resonance with the emic perspective, given my experience, but it is possible to hold both positions, sometimes shifting viewpoints at will.

As I delved into the meaning of the concept of bracketing (Creswell, 2007; Gearing, 2004; McMillan & Wergin, 2010), I came to an understanding of the concept of researcher as an instrument (Kafle, 2011; Lincoln, Lynham, & Guba, 2013, Xu & Storr, 2012). I began to see bracketing more as awareness, openness, and transparency rather than as exclusion, and to see the potential of the researcher as instrument. Gearing (2004) offered a typology that distinguished the different types of bracketing employed in different qualitative research approaches. I concluded that reflexive (cultural) bracketing was appropriate for my role in this research study. Reflexive bracketing is used with a wide epistemological base, and is guided by most qualitative theories (Gearing, 2004, pp. 1444-1445). Its focus is to make the researcher’s personal values, background, and cultural suppositions transparent and overt. The researcher identifies “his or her personal suppositions and ideas about the phenomenon prior to investigating the phenomenon in an effort to minimize their impact on the phenomenon under investigation” (Gearing, 2004, p. 1445). The researcher is encouraged to develop a thoughtful, conscious self-awareness, but the impossibility of removing the context, culture, and environment from the phenomenon is acknowledged. Bracketing as explained facilitated greater transparency in the research process. In the analysis stage of the work, the researcher “unbracketed” to ensure that his or her personal suppositions did not overly affect the research (Gearing, 2004, p. 1445). As a clinical social worker I found that this was a familiar process to me, because I am constantly aware of my
personal beliefs and biases when working in client mental health. At the same time, I must be aware of the knowledge accumulated over four decades of practice.

As I reflected on those experiences, I saw what assumptions and biases regarding parents and children had shaped me. Those identified assumptions included:

- The desire of adoptive parents to develop secure bonds with their adopted child, to have an understanding of how the child’s history influenced present behaviors, and to increase their own strategies for parenting a troubled child;

- The perspective of children who come into adoptive placement after a disruption of a primary relationship that included trauma, abuse, and/or neglect may be that adults cannot be trusted. These children may act out in challenging ways;

- Attachment disruptions and disorders affect not only the families involved, but may negatively affect the broader society;

- Learning positive parenting skills helps parents feel more confident in their abilities;

- Play was a critical component of communication for children... [and] allowed them the freedom to explore emotions, experiences, and relationships (Axline, 1947);

- The learning by parents to use play therapeutically with their child improves the child’s mood and behavior, and a perception of the parents’ parenting skills as effective;
• Discharging children from the formal mental health system to home with their parents, who took over the play sessions, decreases the likelihood that formal mental health interventions would be necessary in the future;
• And lastly, due to the parents learning the skills and participating with their children in filial therapy, their responses to one another would yield a rich narrative as they described their lived experience in adopting, learning through psychoeducation, and becoming their child’s own therapist.

Prior to and concurrent with my research, I have been a children’s therapist who provided parent psychoeducation and filial training to parents of children I worked with in my practice. My therapy work at a large public agency began in 2000, and I left there in 2006 to start my own practice. As a registered play therapist/supervisor with extensive training in parent psychoeducation and filial therapy, I offered parent psychoeducation to every parent who brought a child to me for therapy. The majority of those parents accepted my offer. However, none of my filial cases had been adoptive families. I offered parent psychoeducation to three adoptive families whose children I was working with, but those families declined to participate.

Of the approximately fifty families who completed filial training with me, only two of those families eventually brought the child back to me for continued therapy. The first family had a parent who was an alcoholic and the second family experienced a bitter and contentious divorce. I believe that my experience with families permitted me to maintain a nuanced perspective about the success or
failure of parent psychoeducation, and to recognize the variety of factors that contribute to that success. My experience prior to becoming a children’s therapist was with families and children in a broad range of settings that included child welfare work, health care, and mental health intervention, which all contributed to my fund of information.

To meet the requirements to be licensed as a clinical social worker and to be registered as a play therapist, I had to be supervised. After I completed the supervision process, I found that I continued to benefit from discussing difficult cases with others who had significant experience in the field, engaging in peer supervision as needed. I am a reflective practitioner. I have learned to work with my feelings of countertransference and can support my clients as they move toward resolution of their issues in ways that are appropriate for them.

I realized that it was not possible to separate me, the researcher, from my experience as a practitioner, but at the same time my training and practice as a social worker encouraged me to begin where my participants were and be open to their experiences. As interviewing is a core skill in social work, as a researcher I had skill in interviewing, due to many years of practice. Another advantage to my skill in interviewing is my ability to concentrate completely on the client. These skills enhanced my ability to articulate the research subjects’ lived experience according to the broad assumptions of phenomenology.

However, there was a facet of me separate from my professional training that contributed to this and merits mention. It was the significant hearing loss that I have lived with for all but the first three years of my life. The hearing loss drives my
ability to focus on what people are saying to me. The technology of my hearing aids is such that ambient sound would be decreased when the aids detect the sounds of a human voice, which further enhances my ability to focus on what someone is saying. I found that when I concentrate on capturing what someone is telling me, there was very little room for distraction or flights of fancy.

Articulating my assumptions and biases was ongoing during this study. Reflexivity is described as “the process of reflecting critically on the self as researcher, the ‘human as instrument’ “(Lincoln, Lynham, & Guba, 2013, p. 254). Chesla (1995) posits that reflection is required with each step of the research process, since bracketing is counterproductive due to our pre-understandings being the foundation for our understanding of families’ meanings and actions (p. 68). Reflexivity requires “researchers [to] continually reflect on how their own experiences, assumptions, and biases [exert] influences on what they do” (Rubin & Babbie, 2014, p. 499). In my journaling and in my teaching of research at both the undergraduate and graduate level, I am constantly reflecting on what I do, examining what I know and how my knowledge develops. In interviewing my research participants, I was able to completely focus on what they were saying to me. Their occupations and professional experiences did not overshadow their role as the parent of an adopted child who had experienced a disruption in their primary caregiving role. My increased awareness helped me in writing about my experience and understanding what I knew.
Data Collection

This section explains my approach to the collection of data from the study participants. I start with the unit of observation and how it is determined. I describe the target population and the changes in adoption laws and circumstances that have shaped that population over the last twenty years. Next, I identify the factors that influenced the choice of purposeful sampling for this study, and the means through which the sample was identified. The section closes with a discussion of the events that led to a revision of the criteria for subject selection, and describes how the interview to collect data was designed.

The Unit of Analysis

The unit of analysis can be defined according to what the researcher wants to say after the research was done (Patton, 2002, p. 229). This study sought the lived learning experiences of adults who had adopted children that had experienced a broken attachment, and who participated in parent psychoeducation to practice filial therapy to form a bond of healthy attachment with the child. The study examined how the parents’ description of their own practice of filial therapy created a strong bond of mutual affection between parent and child. Although the unit of observation was individual parents, in order to understand their experiences as adult learners the unit of analysis was the parent-child relationship, as it developed and was described by the parents.

Target Population

The target population as initially conceived for this study was parents of children who were adopted after the age of three, who came from the United States
foster care system. The children had experienced a broken attachment with their primary attachment figure, and as a result of that or other adverse situations such as abuse or neglect, had been removed from home by the courts and placed in foster care or other placement setting. The children were ultimately adopted, and in time the family turned to the mental health system for help in dealing with behaviors that were beyond the reach of their established parenting skills.

This study assumed that as the adoptive parents learned the skills and participated with their children in filial therapy, their responses to one another would yield a rich narrative as the parents described their lived experience in adopting, learning through psychoeducation, and becoming their child’s own therapist.

**Purposeful Sampling**

There are many paths to a sample. In qualitative studies, a purposeful sample selection is determined on the basis of the population, elements of the population, and the purpose of the study (Babbie, 2013, p. 190). The basis of the population was the group of parents who have adopted children and turned to parent psychoeducation to help those children become part of their family. Elements of the population in my study included children who had their primary attachment disrupted, and who were eventually placed for adoption. The purpose of my study was learning how adoptive parents describe their learning experiences with parent psychoeducation in providing filial therapy with their adopted children.

Nevertheless, as I entered my doctoral studies, I realized that my long-term interest in adoption was leading me toward a qualitative study of parent
psychoeducation with families who adopt children with disrupted attachment. I approached the primary therapist at the Aspen Valley Center (pseudonym), who specialized in working with adoptive families, using parent psychoeducation as the cornerstone of treatment, to see if I could draw my sample from families who had worked with her. I believed that my study would be enhanced if the therapist involved were thoroughly trained and consistent in the provision of parent psychoeducation and the provision and supervision of filial therapy. Patton (2002) notes that in purposeful sampling, one seeks “information rich cases ... from which one can learn a great deal about issues of central importance to the purpose of the inquiry” (p. 230). I believed that those information-rich cases would come from this particular parent psychoeducator/filial therapist.

A maximum variation sample is defined as one that aims to capture and describe the central themes that cut across a great deal of participant or program variation (Patton, 1987, p. 53). Any common patterns emerging from great variation are of particular interest and value in capturing the core experiences and central shared dimensions of a setting or phenomenon (Patton, 2002, p. 234). The varied characteristics of my small sample are listed in Tables 3.1 and 3.2, and show variation in family composition, in age of parents, in point of origin of child, and in child characteristics. I believed that my sample, not intended to be such in the beginning, could be considered at the end as a maximum variation sample.

**Contacting Participants**

After obtaining Institutional Review Board (IRB) approval, I contacted the primary therapist and owner of the Aspen Valley Center, who looked through her
records and identified families that met the criteria. She sent a letter to the families under her signature, explaining the research and obtaining their consent for me to contact them. The known sponsor is someone who has legitimacy and credibility with the target population, and loans that legitimacy and credibility to the researcher (Patton, 2002, pp. 312-313). I believed that the therapist at the Aspen Valley Center had legitimacy and credibility with the potential respondents and would help me be a less fearsome quantity to them.

Screening criteria included

1) A child who was being adopted or already adopted, who originated through the US foster care system, and
2) Parents who met one of the following conditions:
   a. In the training process for filial therapy, which takes place in the therapist’s office
   b. Providing filial therapy with the child at home, but still seeing the therapist for supervision of the sessions
   c. Have completed the training/supervision process and were no longer involved with the therapist.

There were eleven families who met the criteria. Three families still came with their child for skills practice during the training phase in the office, two families performed sessions at home but still saw the therapist for supervision, and five families had been discharged from services. The first recruitment letter was mailed under the Aspen Valley Center’s name to the eleven families on October 21, 2013. Three families contacted the therapist and gave her permission to release their names and contact information to me.

I contacted each of them by telephone, introduced myself, offered to send the consent for them to review and the demographic sheet to complete, and set the first
meeting for a location of their choosing. The friendliness of the families and their knowledge of my research gave credibility to the concept of the known sponsor.

Another family contacted the therapist and explained that they were now living in a southern state. Another current family explained that they were just too busy to participate. Six families did not respond, all from the category of being discharged from services. On November 16, 2013, a second letter was mailed to each of those families, again under her signature, giving them a little more information about the study and again inviting them to participate. The second letter yielded no further participants.

**Revising the Criteria**

In examining the logic of sampling in qualitative research projects, Babbie (2013) notes “sampling of subjects may evolve as the structure of the situation being studied becomes clearer”, p. 191). The dilemma was clear to me. If I continued to search for families who adopted a child from the United States foster care system and participated in parent psychoeducation/filial therapy, I would have to contact additional therapists. In preparing to make my decision, I contacted two other registered play therapists trained in filial therapy by either the Guerneys or VanFleet. Neither of these therapists had current or past clients who met my criteria. Since I am a long-term trainer and supervisor of therapists, I know there is a great deal of variation in the effectiveness of therapists. I was not willing to sacrifice the quality of the parent psychoeducation to meet the criteria of the child coming out of the United States Foster Care System.
In further conversation with the therapist at the Aspen Valley Center, I learned that she had some queries about my study from parents who had adopted internationally and who were presently or formerly bringing their children to her for therapy and learning filial therapy. Although the children were somewhat younger at the time of adoption than the ones coming from the foster care system, they too had disrupted attachments. Many of them prior to their adoption were living in countries where there was internal strife and uprooting of families. Since the disrupted attachment was a major contributor to the difficulties experienced by adopted children regardless of how they come into adoption, I changed the title of my research from “Creating families: Parent psychoeducation and the experience of parents adopting children from the United States foster care system” to “Creating families: Parent psychoeducation and the experience of parents adopting children with disrupted attachments.”

After submitting revised documents to the IRB, I again received approval to proceed. The therapist had identified four more families who were interested in talking to me. Three of those families had adopted children from Central America and one family had adopted from eastern Europe. Two families were willing to meet with me. One father withdrew due to some unexpected circumstances and one family did not respond to any of my phone calls and messages.

Table 3.1 describes the parents who participated in the study. The first names were all pseudonyms, chosen by the participants at the time of the first interview.
Table 3.1 The Research Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Level of Education</th>
<th>Family Composition</th>
<th>Employment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlee</td>
<td>50</td>
<td>Caucasian</td>
<td>Two years college</td>
<td>Two adults, one child</td>
<td>Retired</td>
</tr>
<tr>
<td>Kate</td>
<td>29</td>
<td>Caucasian</td>
<td>Master’s Degree</td>
<td>Two adults, three children</td>
<td>Part time; health care setting</td>
</tr>
<tr>
<td>John</td>
<td>29</td>
<td>Caucasian</td>
<td>Master’s Degree</td>
<td>Two adults, three children</td>
<td>Full time; professional setting</td>
</tr>
<tr>
<td>Morgan</td>
<td>50</td>
<td>Caucasian</td>
<td>Master’s Degree</td>
<td>Two adults, one child</td>
<td>Full time; business setting</td>
</tr>
<tr>
<td>Julie</td>
<td>35</td>
<td>Caucasian</td>
<td>Master’s Degree</td>
<td>Two adults, one child</td>
<td>Full time; educational setting</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>52</td>
<td>Caucasian</td>
<td>Master’s Degree</td>
<td>Two adults, one child</td>
<td>Part time; business setting</td>
</tr>
<tr>
<td>Stella</td>
<td>51</td>
<td>Caucasian</td>
<td>Master’s Degree</td>
<td>Two adults, two children</td>
<td>Full time; educational setting</td>
</tr>
<tr>
<td>Andrew</td>
<td>44</td>
<td>Caucasian</td>
<td>Master’s Degree</td>
<td>Two adults, two children</td>
<td>Full time; managerial setting</td>
</tr>
</tbody>
</table>

Developing the Interview

Overview of Information Needed

Necessary information to answer the research questions falls into four areas: contextual, perceptual, demographic, and theoretical (Bloomberg & Volpe, 2008, p. 69).

The contextual information concerns the context where the participant lives or works. For the participants in my study, the parent psychoeducation began in the therapist’s office as parents learned the philosophy and steps of filial therapy. After the therapist demonstrated child centered play with their child, the parents had as many practice sessions as needed with their child in the therapist’s office. After they began sessions at home, the parents returned to the therapist’s office for supervision of their sessions. When the parents and therapist agreed that they no longer needed to meet, they were discharged from the therapist’s services with the skills to conduct sessions at home for as long as the sessions were desired.
Demographic information is specific to the participants and describes who they are. Demographic information is useful in identifying underlying factors in the participants’ perceptions, and demonstrates similarities and differences among the participants. The following table afforded a demographic description of the children of the adults in my study.

Table 3.2: Demographic Description of Children in the Study

<table>
<thead>
<tr>
<th>Participant</th>
<th>Origin of Adoption</th>
<th>Child’s Ethnicity</th>
<th>Site of Research Interview</th>
<th>Child’s Gender</th>
<th>Age of Child when placed</th>
<th>Age of Child when first taken to therapy</th>
<th>Current age of Child</th>
<th>Stage of Filial Therapy at time of Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlee</td>
<td>Kinship</td>
<td>Caucasian</td>
<td>Office #1 Home #s 2 &amp; 3</td>
<td>Female</td>
<td>8 months</td>
<td>3 years</td>
<td>6 years</td>
<td>Home sessions, supervision with therapist</td>
</tr>
<tr>
<td>Kate and John</td>
<td>Foster Care System</td>
<td>Caucasian</td>
<td>Home</td>
<td>Male</td>
<td>26 months</td>
<td>3.5 years</td>
<td>5 years</td>
<td>Discharged from therapist, still doing sessions</td>
</tr>
<tr>
<td>Morgan and Julie</td>
<td>Foster Care System</td>
<td>African American</td>
<td>Home</td>
<td>Male</td>
<td>3 years</td>
<td>4 years</td>
<td>7 years</td>
<td>Sessions in therapist’s office</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>International</td>
<td>Guatemalan</td>
<td>Community Setting</td>
<td>Male</td>
<td>10 months</td>
<td>2 years</td>
<td>8 years</td>
<td>Discharged from therapist; planning to resume sessions</td>
</tr>
<tr>
<td>Stella and Andrew</td>
<td>International</td>
<td>Guatemalan</td>
<td>Office</td>
<td>Male</td>
<td>5 months</td>
<td>5 years</td>
<td>10 years</td>
<td>Discharged from therapist; thinking of resuming sessions</td>
</tr>
</tbody>
</table>

Perceptual information was described by the participants as they shared their lived experiences becoming adoptive parents, learning about parent psychoeducation and filial therapy, practicing with their child and any differences they perceived, and reflecting on the meaning of providing help to their child. In qualitative research where interviewing is the primary means of gathering data,
perceptual information is “the most critical of the kinds of information needed” (Bloomberg & Volpe, 2008, p. 70).

Theoretical information is collected from a variety of literature sources to assess what is presently known about the research topic. Much of the research involving filial therapy focused on biological parents and their children (VanFleet & Guerney, 2003). Research into the depth of behavioral and emotional reactions by children who had a disrupted attachment is limited, as is research on the perceptions of filial therapy by adoptive parents and their perceptions of the learning process through parent psychoeducation. Research is needed to determine whether parent psychoeducation/filial therapy could result in long-term gains for this population.

**The In-Depth Interview**

I was guided by my research questions as I developed my interview questions, and determined that the interview questions were designed to yield information that would provide answers to the research questions. I wanted to give parents the opportunity to reflect on their lived experiences, while focusing on what they learned and how they learned it. I hoped to develop a conversational, reciprocal relationship with the parents in my study, creating a relaxed situation for them where they could comfortably talk about their experiences.

The purpose of qualitative interviewing is described as not to get answers to questions, nor to test hypotheses, and not to ‘evaluate’ as the term is used. At the root of in-depth interviewing is an interest in understanding the lived experience of other people and the meaning
they make of that experience, ... an interest in other individuals’ stories because they are of worth (Seidman, 2006, p. 9).

One way to assess validity in a questionnaire is to ask whether it brings about the results intended. Zeanah (2000) and Lieberman and Van Horn (2008) have written extensively about four markers of secure attachment between parents and children. I developed questions where I rephrased each of these markers into lay language and asked parents to comment on each one, giving me an example of how they knew something was different with their child.

Treatment goals and learning outcomes in parent psychoeducation and filial therapy for the child, the parents, and the entire family that corresponded with the markers of secure attachment had been identified (VanFleet, Ryan, & Smith, 2005, pp. 243-244). These goals and outcomes were incorporated into my questionnaire using lay language, with the situation described and the parent asked to comment about it. The questionnaire also asked participants for their evaluation of the skills learned, and for suggestions on how to increase the effectiveness of parent psychoeducation and filial therapy (Chen Foley, 2010),

Seidman’s three-interview format (2006, p. 34), and research on attachment and parent psychoeducation and filial therapy outcomes resulted in the following sections for participant interviews.

1) *Life History:* How did the participant become an adoptive parent? A review of the participant’s life history up to the time he or she became an adoptive parent would be taken, with reflection about experiences that made him or her receptive to adopting. What happened that made the participant believe
their adopted child needed therapy? How did the participant learn about filial therapy?

2) *Contemporary Experience:* What was it like participating in parent psychoeducation and learning to provide filial therapy? What was it like when the participant did filial therapy with the child at home? What were the changes that occurred? Was the participant still conducting filial sessions with the child? Did the participant legally adopt the child?

3) *Reflection on Meaning:* What did it mean to the participant to be their child’s filial therapist? Had there been an impact on the participant’s connection to the child? How had their understanding of their child’s past life changed since they had the parent psychoeducation? How did they make sense of their present life in the context of filial therapy? Now that the participant has done filial therapy, what suggestions would he or she have for improving the process for families that adopt children?

Prior to beginning the actual interview, I discussed the informed consent with the parents (Appendix C). I mailed a copy of the consent several weeks before the first meeting, and all the parents had read the consent and were ready to discuss it. Prior to their signing the consent, I explained that I was a doctoral student in adult education, an instructor of human development and family studies and a trainer in play therapy, an instructor of graduate social work, and a private practitioner who worked with children and families. I also explained the research purpose, of talking with parents about their experiences having adopted or being in
the process of adopting children, and the goal of the research in learning how their experiences with filial therapy affected their relationships with their adopted child.

I needed to be aware of the issues raised by qualitative interviewing. The qualitative researcher is cautioned to recognize that “qualitative inquiry may be more intrusive and involve greater reactivity than ... quantitative [measures]” (Patton, 2002, p. 406). Lived experience is not stagnant; it is alive and full of meaning and perspective. In gathering lived experience, the researcher enters the participant’s world and asks for sharing of what is inside. I was advised to have an ethical framework for dealing with painful experiences that the subject may not be comfortable discussing (Patton, 2002, p. 407). I included a point in the informed consent acknowledging that difficult issues could be raised and that the participant could refuse to answer any question that provoked anxiety or discomfort.

As I structured the interview, I envisioned it taking three meetings, one for each segment of the interview (Appendix D). Prior to meeting my first participant, I practiced the interview with one of my student interns and found that some of the questions flowed smoothly into the next ones and that the total interview did not take the time I anticipated. I offered the parents the option of meeting three times, or combining sections two and three into one meeting and meeting twice. Other than Carlee, who had a great deal to talk about, all the other participants opted for two meetings. All the participants were very generous and giving of their time, with the total interview time lasting from two to three and one-half hours per participant(s). I found in the actual interview that the participants answered some questions in advance of their being asked and that there was a flow of experiences
into other experiences. There were no occasions of refusing to answer a question, but there were occasional pauses before participants answered.

**Field Notes**

I completed field notes throughout the process of the research interviews from the first phone call until the final interview. I tracked phone calls, text messages, and emails from the subject families and noted them, as well as writing my personal reflection following each interview, exploring the impact the interview had on my thoughts and feelings. I hired the individual who does the billing for me in my private practice to transcribe the interviews, since she is a trusted person with a demonstrated understanding of confidentiality and need for accuracy. I listened to the audio recordings to reflect on the experience of the interview, and confirm the accuracy of the transcripts. I transcribed my last interview with Andrew and Stella to experience the transcription process.

**Data Analysis and Synthesis**

Data analysis in qualitative research is characterized as a process of preparing and organizing data from the written transcription of the interviews, including locating themes in the data through coding and condensing, and then representing the data through discussion (Creswell, 2007, p. 148). Moustakas (1994) offers an approach to analysis that is applicable to the analysis of the data represented in this study. There are six steps to the analysis (Creswell, 2007, p. 159). First, the researcher describes personal experience with the phenomenon. Secondly, the researcher identifies significant statements in the interviews about how the individuals experienced the topic. Thirdly, significant statements are
grouped into themes. The fourth step provides a textural description of the experience and includes verbatim examples. The fifth step describes where the experience happened, including the setting and context in which the phenomenon was experienced. In the final step, the researcher writes a composite description of the phenomenon, based on the interview transcripts of the participants’ experience and how they experienced it. I explain my involvement with each step in the following paragraphs.

**Step One: Personal Experiences with the Phenomenon**

The phenomenological researcher is cautioned to see what was before him/her, to understand the influence of past experience (Moustakas, 1994, p.33). As a researcher I needed to be clear and honest about the perspectives I brought to the inquiry, including the potential for bias. I believed that my experience permitted me to maintain a nuanced perspective about parent psychoeducation, and to recognize the variety of factors that contribute to its success or failure.

**Step Two: Developing a list of significant statements**

The process of the researcher listing every significant statement pertinent to the topic and giving each statement equal value is the second step of phenomenological analysis, or horizionalization (Moustakas, 1994). I approached this process on two different levels. First of all, my interview was developed to support parents in giving a rich account of their experiences, with questions in the interview designed to encourage the sharing of information specific to adoption, parent psychoeducation and learning processes, filial therapy skills and practice,
and the experience that flowed from the mixing of those concepts and practices. I structured the interview according to my research questions.

Secondly, since my sample was small, I decided to pursue my analysis by reflecting on what the adults had shared, thinking about core consistencies and meanings (Patton, 2002, p. 453), and by writing about my findings by hand rather than using a computer program. My study consisted of eight adults, members of five families. I became aware of repeated themes from families who would not have known one another outside of my study, since they all lived in different parts of the suburbs of a large southeastern Pennsylvania city. The families were involved with the Aspen Valley Center during different time periods, where they would not have sat in the waiting room together. During the process of my interviews, I made notes about these recurrent themes. Following the completion of my interviews and their transcriptions, I took each family’s response to each question and pasted it to a new document, where I would have each question and each family’s response so that I would see all eight responses on the same page. The next step was to take each response and remove the errs, umms, reiterations, and nonessential parts of the sentence. These steps were taken to help me understand whether the meaning of parent psychoeducation, “the core meaning of an individual’s experience that makes it what it is” (Kafle, 2011, p. 182), was present.

**Step Three: Searching for Themes**

I studied each segment of the total interview and carefully pondered the segments to identify themes expressed in the experiences related in answer to each of the questions. I used highlighters to color code the themes identified in each set
of responses. In this study, themes included coming to adopt, experiencing the learning from parent psychoeducation, difference in feelings toward child, meaning of being the child’s therapist, and identifying types of learning.

Participation in the parent psychoeducation program and filial skills training is a series of learning experiences delivered consistently across the spectrum of parents, modifiable in content according to parent and child characteristics rather than in structure. My interview guide was a list of questions about issues to be explored in the course of the interview. The questions were covered in the same order for each family.

**Step Four: A textural description**

A textural description, the “what” of the experience, is written from the first three steps in phenomenological analysis (Creswell, 2007). Interview One covered the “what” of adopting a child and the decision to seek help, seeking the lived experience of the eight adults in the study as they moved through these aspects of creating a family, reflecting on life contexts that drew them to adoption, taking a living child with a disrupted attachment into their family, and the path to the help offered by the Aspen Valley Center.

Interview Two took the parents through the steps of learning filial therapy, from skills demonstration and practice with the therapist, to the first time with the child in the therapist’s office through the first time at home while continuing to see the therapist for supervision, to eventual discharge and the continuing of special play time on their own. Four markers of attachment (Lieberman & Van Horn, 2008;
Zeanah, 2000) were explored with the parents who discussed their experience in learning each step of the filial process.

Interview Three discussed the meaning the parent ascribed to being their child’s change agent, or filial therapist. Parents described the meaning of their experience and continued with identification of changes in their relationship with their child, in their relationship as parents, and in their relationship as members of a family. Parents also reflected on their experience working with the therapist, and identified changes that could be made in the process to make it more helpful to families like theirs.

**Step Five: A structural description**

This section describes the setting and context in which parent psychoeducation and filial skills training took place. Parents sought sources of help for a child who was acting out or displaying other behaviors of concern to parents. The parents located a therapist and made an appointment. They met with a child therapist trained in play and filial therapy, and talked about their issues with the child. The parents were educated about filial therapy and selected it as a method to help them help their child. The steps of this process were found in Appendix A.

**Step Six: A composite description**

Creating this final composite description incorporated both the “how” and the “what” of the participants’ lived experience and was based on the identified themes from the interview transcripts of the participants’ experience and how they experienced it. There were several places in the interview where parents were given the opportunity to add information about their experiences with parent
psychoeducation and filial therapy, and to comment on how the process could be changed to make it more helpful. They were given a hypothetical example of friends calling for advice in adopting a five-year-old child, and asked about what they would say. Their responses to these questions yielded a composite description of what the experience meant to them as they created a family with their adopted child. Several of the parents gave examples of difficult situations that arose for their child, and how they used their filial skills to help the child work through the situation.

**Ethical Issues**

The dangers of exploitation in interviewing research made me wary of “[turning] others into subjects so that their words can be appropriated for the benefit of the researcher” (Seidman, 2006, p. 13). I believed that discussing the elements of the study before participants joined was important. I informed my participants that their participation was voluntary and that they could stop at any time without repercussions. I also explained that I would likely write a professional article and submit a paper to a conference as part of my use of their stories. In addition, participants were advised about protection of their confidentiality, and received some biographical information about me so that they would know my perspective and potential sources of bias.

Since the literature recognized that the failure to obtain informed consent was another ethical issue, I ensured that the participants were informed verbally and visually about the purpose of the study, the procedures to be followed, discomfort and risks, benefits, duration, statement of confidentiality, right to ask
questions, any payment for participation, voluntary participation, and permission for audio-recording (See Appendix C).

A third ethical issue in qualitative research was identified, with researchers cautioned that when telling a participant’s story, to guard against re-writing it in such a way that it became the researcher’s story (McCormack, 2004, p. 234). The participant’s story resonated with meaning to me, both in its echoing of scholarly knowledge and in the resilience and power of humans who have learned how to create a family from broken pieces. I carefully reviewed and coded my transcripts so that the participant’s words remained exactly as stated. The parents were also given the opportunity to check the transcript for accuracy.

**Quality of the Study**

Because the researcher is the instrument in qualitative inquiry, a qualitative report should include some information about the researcher... The principle is to report any personal and professional information that may have affected data collection, analysis, and interpretation – either negatively or positively – in the minds of users of the findings (Patton, 2002, p. 566).

I discussed the experience, training, and perspective that I bring to this study earlier in this chapter. Several other questions raised by Patton merit consideration here. Regarding *funding for the study*, I provided all the funding through personal funds for travel costs, printing of materials, and use of the computer and telephone. Although I applied for several small grants, I was not successful in obtaining any of
them. However, my employer provided me with gift cards to present to several of my families as a small token of appreciation for their participation in the study.

In terms of access to the study site, since parent psychoeducation and filial skills training took place first in a therapist's office but was carried out in the home, I offered parents choices about where to interview them. Three families invited me to their homes, one met with me in their therapist's office, which she willingly allowed me to use, and one met me at a restaurant.

Personal connections to people, program, or topic came through my professional relationship with the therapist who worked with these families. I did not do filial therapy with my own child but have used reflective responding with both my husband and my now adult daughter, as well as with friends and all of my clients. I revealed information about my background to my participants prior to beginning their interviews, so they could question me about my qualifications if they desired, or opt out of the study.

Finally, I handled potential researcher bias through member checking, allowing research participants to review transcripts of their interviews to ascertain that their responses were recorded accurately (McMillen & Wergin, 2010, p. 92). I included a consent for member checking in my informed consent, and all families agreed to read over their transcripts. I emailed the typed transcript to the participant for checking, upon receipt from my transcriber. I received feedback from all five of the families that the transcriptions were accurate.

In addition, for an external audit I asked a colleague of mine, a licensed social worker with over ten years of experience working in adoption, to review my
dissertation against her knowledge of the adoption field. She provided substantial feedback in a number of areas, showing me where to make my narrative clearer, pointing out strengths in the portrayal of family experiences with adoption as well as noting areas where more information was needed to give an accurate picture of children or families. Her experiences working with child placement and preparation, and following up with families, helped me ensure that my work accurately reflected the real world of adoption.

**Chapter Conclusion**

Individuals come to parenthood with perspectives and meaning schemes learned both from their own childhoods and from previous experiences with parenting. Both perspectives and meaning schemes specific to that individual influenced a particular individual’s experience with the challenging behaviors presented by an adoptive child. Phenomenology’s emphasis on meanings and essences of experience contributed to its fit as the initial theoretical and methodological underpinning of this research project. The operationalization of phenomenology in the design of the study was outlined, and the process of data collection and analysis was explained. Ethical issues were identified and the quality of the study was examined.
Chapter Four: FINDINGS AND ANALYSIS: THE PARENTS’ STORIES

The purpose of this qualitative study is exploring the parents’ experiences with psychoeducation/filial therapy within a sample of adoptive families, and learning the meaning it had for them in the process of creating a family with their adopted child, one who came from a background of disrupted attachment. I sought to arrive at an understanding both of the meaning the experience had for them, as well as the meaning it would have for professionals who aspire to work with this population, within the context of the theories that frame this analysis and the research questions that guide it.

Interviews with the five families followed them as they described their experiences with the process of adopting, the arrival of their child at their home, the decision to seek help, moving through the steps of parent psychoeducation and filial therapy, and reflecting on the experience of being their child’s therapist, with discussion that was rich in detail and emotion. This chapter presents the findings from the interviews with the eight adoptive parents involved.

Human beings come into the world as infants. They begin to build their life experiences immediately, through childhood into adolescence, and finally into adulthood, engaged in a process of constant accumulation and distillation of experiences into the perceptions that shape them as adults. The first interview in the series addressed the first two research questions as I explored with the parents how the decision to adopt was formed, asking them to reflect on the life experiences that contributed to their decision. The second part of the first interview asked them to describe their adopted child upon arrival at their home, and how they discovered
a need to learn about their child’s behaviors so that they could understand and help the child. The second and third interviews were combined for four of the families. Following the second, third, and fourth research questions, the family’s experience with the process of parent psychoeducation and the meaning of being their child’s therapist was explored in the latter two combined parts of the interview, and the family’s detail of their experiences yielded information on the types of learning they experienced.

**Coming to Adopt**

The experiences shared by the parents as they came to adopt provided an understanding of the first research question, which sought the life experiences that shaped the parents’ decisions. Elizabeth, a single parent, and Stella and Andrew, a married couple, stated that their decision to adopt was related to either infertility or difficulties sustaining a pregnancy. Morgan and Julie were members of a same sex couple who had opted to become parents through adoption. Kate and John decided as teenagers that they would build their family through adoption even though fertility was not an obstacle for them. Carlee was a grandmother in a kinship care situation.

Elizabeth, an adopted child herself, came to the decision to adopt later in her life, because she wanted to experience life first through travel and a career. On the other hand, Kate and John, growing up knowing adopted children in a family friend’s home, said, “It seemed like a normal thing to do. When we started going together in high school, we knew that was what we would do when we got married.”
An issue shared by several of the families was the inability to have biological children coupled with a deep desire to be a parent, to give love to a child who needed it. Stella and Andrew noted that their efforts to conceive began shortly after their marriage, and they moved to adopt after no results in five to six years of trying. Julie and Morgan talked about their individual experiences coming to their joint decision to adopt. Julie believed that she always wanted to be a parent, and due to learning she was attracted to women, she knew that adoption would be her choice. Morgan, 15 years older than her partner, would have liked to give birth, but described “the social climate when I came out as still having issues about childbirth for lesbians.” Elizabeth spoke of a number of failed pregnancies and began to think of adopting as a single mother. Carlee, raising her six-year-old granddaughter, stated, “Her biological parents were not capable of caring for her. I did not want her to go into the foster care system, so I chose to step in and petition for custody.”

**Influences in Making the Decision to Adopt**

Additional understanding of the first research question was provided as five of the parents described positive childhood experiences and desires to create a similar positive family as influential in their decision. Morgan spoke of her parents’ home as the place where everybody hung out. Her first career, as a teacher and coach, involved being with her students and having a chance to see them grow up, a very fulfilling experience for her. Elizabeth had very supportive adoptive parents. Kate described the time spent babysitting the adopted children of her mother’s friend as a formative experience for her. Carlee and Julie spoke of difficult
experiences growing up and emerging with a desire to do better with a child of their own, wanting to give a child a better childhood than the one they had lived through.

Carlee, for example, gave this explanation:

I love kids. I believe that every child deserves to have a happy full childhood.

I had a mother who didn’t want to be a mother. I was very unhappy as a child. It took years to overcome what happened to me. My mother physically and emotionally abused me. I knew what she was doing was wrong.

Julie shared a similar motive:

I had a difficult relationship with my parents and was raised primarily by my grandparents. With some of the issues with my own parents and their own mental health issues and things that I just didn’t want to bring another child into the world that might have that genetic background.

John, Stella, and Andrew did not speak of their childhoods, instead describing experiences as adolescents and adults that had influenced them. During his first interview, John was holding his two-year-old adopted son and his one-year-old biological daughter in his lap while his four-year-old adopted son played at his feet. He said that knowing Kate and being involved with the adopted children of her family’s friends generated an inner desire in him to create their family through adoption.

Stella and Andrew described their decision to adopt as a couple. Stella, “never that firm about filling a house with my own children”, was drawn to the idea of adopting a child from one of the developing countries. Although Andrew liked the idea of “going natural first” he and Stella wanted to be parents and adoption was the
outlet that allowed them to do that. Sitting next to Stella on the couch, he related a
time when “Someone said to Stella that we were saints for adopting and she said
“No, this was our opportunity to be parents.’ We weren’t trying to be ‘do-
gooders’. We were lucky because David came to us.” Stella added, “David created a
family with us.”

The Arrival of the New Member of the Family

The stories of the participants were more varied in this section, which
addressed the first part of the second research question as parents described the
arrival of their adopted child. Differences were noted between the two families that
adopted internationally and the three who accepted a child who would have
otherwise either gone to or remained in the United States Foster Care System.
Carlee became the primary custodian of her granddaughter Katelyn at age 8 months.
As she explained, Katelyn’s parents were unable to take care of her due to drug
addiction, and the Child Welfare Agency was poised to take action.

Both David and Dee came from Guatemala. Both sets of adopting parents
worked with an adoption agency in the United States, but had to go to Guatemala
several times during the adoption process. Andrew and Stella received their son
David at age five months. Elizabeth received her son Dee at ten months of age.

Michael and William, coming from the foster care system, showed more
evidence of disrupted attachment and particularly for Michael, trauma and injuries
from serious physical abuse. When Kate and John went to meet 26-month-old
William at his foster home, they experienced an instant connection with him that
both described during their interview.
Michael had been in the hospital in a southern city where Julie and Morgan were living. Julie was a physical therapist at the hospital, and was on the team of therapists that evaluated Michael for rehabilitation services. Michael had been in a coma due to a traumatic head injury from severe physical abuse by a grandmother. At four years old, he had also had a stroke on his left side. As Julie worked with him she noted symptoms of the trauma – fear at taking a bath, being terrified to go in the bathroom, fear of being touched when she needed to change his clothes, being afraid of what she was feeding him, and on top of all that, his physical disabilities posed additional limitations for him. As he began to respond to her, she found herself being increasingly drawn to him and thinking, “I could be his mom.”

Michael left the hospital in a wheelchair but after a month with Morgan and Julie, he was walking, something that the hospital staff thought he would never do. I was able to meet Michael during the interview process since Morgan and Julie preferred that I came to their home to interview them. He was an engaging boy with sparkling brown eyes and a big smile.

**The Decision to Seek Counseling Help**

Children who were the age of the children in this study when their parents sought help were more likely to show their difficulties through their behaviors than through their words. In all of the families in this study, unfamiliar behaviors often shown by children with disrupted attachment and lingering trauma from previous adverse actions were emerging, perplexing the families who may not have ever seen behaviors like this before and providing some insight into the second part of the second research question, which sought the parents’ account of factors that
influenced their decision to seek help. The families were looking for learning experiences that would help them intervene with their child in a positive and beneficial way, turning to a therapist who specialized in parent psychoeducation and help for children with deeply rooted trauma. Considering that children with disrupted attachment were likely to present with defiant, acting out behavior, programs such as the Aspen Valley Center offer an alternative for parents looking for help to change troubling child behavior.

All five of the families took their child’s previous and current experiences seriously in the decision to seek professional help. Kate and John, Morgan and Julie, and Carlee were all concerned about the impact of previous trauma and adverse effects on William, Michael, and Katelyn as they grew older and made references in their play to things that had happened to them. Kate and John wanted guidance in helping William deal with his issues. The therapist Michael, Julie, and Morgan saw prior to returning to Pennsylvania advised them to work on developing attachment bonds with Michael. Morgan described Julie and herself as two different people and Michael had to attach to both. Michael was remembering being sexually abused and having to eat dog food while living with his grandmother. When Morgan and Julie began working with the therapist at Aspen Valley Center, they learned that Michael’s issues were related to his past trauma, and when he acted out, something was triggering one of those issues. Morgan said, “It wasn’t about us, and the more we understood that, the easier it became.” Julie added, “I think the filial therapy improved our own emotional and mental health.” They attributed the learning
through parent psychoeducation as instrumental in their understanding of Michael's behaviors and actions.

Behaviors that emerged as their children moved through the toddler and preschool years baffled Elizabeth, Dee’s mother, as well as Stella and Andrew, David’s parents, who found themselves searching for a way to understand the changes in their boys. Although little was known about the birth and early life of either David or Dee, studies had shown that children from troubled countries who had experienced civil unrest and separation from their families can hold traumatic memories in their bodies and minds that ultimately emerge in disruptive and troubled behaviors (Eth, 1998; Figley, 1998). Dee was on the verge of being expelled from day care, and Elizabeth said she had to do something because she had to work. She wanted to learn about filial therapy, saying, “It was my last resort.”

Stella and Andrew learned that their existing parenting skills were ineffective for understanding or helping David as his behaviors intensified. As Stella explained,

We were not prepared for the natural separation that takes place when the child recognizes you are not part of them. We didn’t get it. We didn’t parent well. I was impatient. He would throw these 45-minute tantrums. We knew we couldn’t get through this in a healthy way. We thought we were screwing up. We were really at a loss with what to do.

Andrew offered his perspective:

Most of the time he was good, but the tantrums could get violent... throwing stuff, kicking the car, destroying things. We approached him from too much of an adult perspective, logic and reasoning. He didn’t understand. Being an
engineer, I was plotting the course and looking at the outcome and it wasn’t good.

The descriptions of child behavior and parental response in this section corresponded with experiential theory, in terms of intellectual growth requiring “a reconsideration...of impulses and desires in the form in which they first show themselves” (Dewey, 1938/1998, p. 74). As the five families in the study began to recognize the variety of troubling behaviors shown by their children, they experienced that intellectual growth, resulting in a reconsideration of their current parenting skills and recognition that they needed to explore expanding their repertoires as parents. As Elizabeth said, “I knew I had to do something.” Andrew and Stella reported being at a loss about what to do. While Morgan and Julie, Kate and John, and Carlee listened to their respective children at play, they noted references in the play to traumatic things that happened to Michael, William, and Katelyn. All five of the families became receptive to new learning in order to help their children. In the following section, the families talked about their experiences learning filial therapy and its effect on both the parents and the child.

**Introduction to Parent Psychoeducation**

The parents described their first experiences with learning filial therapy at the Aspen Valley Center, addressing the third research question, which asked how parents portrayed their experiences with parent psychoeducation and the application of filial therapy skills. Also integrated throughout this section and the following ones are reflections of the type of learning that occurred, the subject of the fourth research question. Several pointers for practice of situated learning were
conceptualized, including learning as part of the relationship between people, and the intimate connection between knowledge and activity (Smith, 2009). The parents reported that the concepts were readily learned. I asked them to describe aspects that influenced that “learning readily.” All of the parents noted the relationship with their therapist as promoting their learning, describing her as warm and friendly, concerned about them and their children, and accepting them where they were in their confusion of how to help their children. “Readily learned” was enhanced as Morgan, Elizabeth, and Stella learned to reflect feelings, discovered the background of filial therapy, and had the techniques modeled to them by the therapist. They described their experiences as helpful and interesting. Andrew described reading about the steps of parent education outside of the session, and having a reference to turn to after his and Stella’s formal involvement with the therapist ended. He spoke of the reference materials as increasing the skills he was learning to help his son, which exemplified the interaction between knowledge and activity. Kate echoed continuity in learning (Dewey, 1938/1998), as she described relief in knowing that there was a way for her to help William at home, finding a resonance between the filial skills and skills that she had learned in professional nursing education.

The activity [context] where learning occurs was an integral component of the learning (Brown, Collins, & DuGuid, 1989; Caffarella & Merriam, 2000). John initially acknowledged that he didn’t know what to expect when first learning about parent psychoeducation, but discovered that role play with the therapist, discussions with his wife Kate, and the practice with William in the therapist’s office
were all activities that were important pieces of his growing comfort with the process.

Julie spoke about learning to respond to Michael in the present moment. As she described this process, she said

I found myself really over-thinking almost, it in a way, instead of just relaxing and letting myself just be present in the moment with what he was doing - I was trying to make it mean something deeper. Sometimes it didn’t necessarily mean anything deep. It was just whatever it was at that moment: not something, oh, big and catastrophic.

Julie’s learning corresponded with the description of “reflection-in-action” (Caffarella & Merriam, 2000, p. 60), which allowed Julie to make adjustments in her learning as she learned it. She was evaluating some of her prior ways of reacting to situations and revising them in light of her new learning of the tenets of parent psychoeducation and the practice of filial skills with Michael under the therapist’s supervision and coaching of the process.

The structural dimension in the context of adult learning provides us with additional insight into the learning process by taking into consideration such factors as race, gender, and ethnicity (Caffarella & Merriam, 2000, p. 60). Carlee’s initial response to my question about her experience learning the filial skills was that it made sense, since she had always been able to interact with children at their level. In providing parent psychoeducation, we are challenged to consider the parent or parent figure’s own background since we tailor the training to fit the needs of the adult learner. Carlee, a middle-aged female, had her own worldview shaped by
abuse from her mother as a child. Speaking openly about her abuse during her first interview, she identified finding herself pregnant at age 19, vowing to be “a better mother than the one I had.” One outcome of trauma experienced in childhood was identified as the survivor being prone to low self-esteem and self-criticism (Johnson, 1998, p. 72), struggling to feel competent in what they know. As adult educators, we must understand the factors in an adult learner’s background that could “inhibit learners from speaking ... [or] challenging predominate views and ideas (Tisdell, 1995, p. 83). Carlee’s initial description of the ease in learning skills was tempered later in her interview by her description of “being nervous the first few times... that I would do something wrong,” “that I might make a mistake.” The combination of the situated practice and the relationship with the therapist helped her reach the point where she said, “Then it was just like if I make a mistake, I make a mistake. Things just went very smoothly. It was very easy.” As she moved through her practice of the filial skills with her granddaughter, she said, “[The therapist] felt since I was such a natural at it that I wouldn’t have any problems.”

**The Skills of Filial Therapy**

The parent psychoeducation aspect of filial therapy taught four foundational skills: 1) empathic responding, to verbally track the child’s behavior and reflect the emotions expressed in the child’s play; 2) structuring, to verbally state the boundaries for the session; 3) limit setting, to help the child learn which behaviors were not permitted; and 4) imaginary play with the child, to use when the child invited the parent to pretend (VanFleet, 2000). In addition, parents were coached in the technique of child-centered non-directive play, which included best usage of
words and language for the age of the child in question, and understanding the level of cognition available for that child.

The participants in this study were asked about learning and applying the skills in working with their children, providing further insight into the third research question about parental experience with parent psychoeducation, and the fourth research question, which examines the type of learning reflected. In the training of a therapist to offer psychoeducation and filial therapy, the steps of the process were clearly delineated and the trainer practices with the therapist in training much like the interaction between the therapist and the parent in training. The adult learner’s concrete learning experiences must be available for the learner’s reflection and construction of new knowledge, with a focus on making meaning (Merriam, Caffarella, & Baumgartner, 2007, p.160). Parent psychoeducation was designed to be offered to a set of parents, or a small group. The interplay of the printed materials, the actual discussion and practice, and the therapist seeking information from the adult learners about their understanding of the skills and the applicability to their child’s situation were all part of the learning process. The skills of filial therapy, although simple, require practice in real situations, which correspond with situated learning’s call to situate training in real-life problem solving. Situated learning occurs through thoughtful, insightful practice that allows the learner to utilize learning based on experience and prior knowledge, descriptions that are integral to the practice of parent psychoeducation and filial skills training (Caffarella & Merriam, 2000).
Parents were likely to recall their own experiences in childhood with imaginary play, or play with a younger relative or friend as they learned how engaging in imaginary play was a fundamental skill of filial therapy, for imaginary play offers a window into an adopted child’s previous experiences. Four parents identified engaging in imaginary play as the easiest skill to learn. Two parents found reflective responding the easiest skill, and one described structuring as easy. Carlee reported that she encountered no barriers in learning the skills, because she was very motivated to learn in order to help her granddaughter.

Regarding skills that were more challenging, the majority of the parents found the different aspects of reflective responding more difficult to learn. The challenge of learning a thoughtful skill such as reflective responding requires learners to quiet their own busy minds and focus on what was before them (Ragg, 2011). Since the majority of my participants were professional people who were working full time and managing busy schedules that characterize the age where we live, learning the skill of reflective responding was difficult for many of them. Morgan and Julie found that identifying the feeling expressed was demanding. John described reflection in general as a “different way of talking” that he had to learn. Stella described the filial training as different from other parent training she had experienced in her search to find the skills to help her son, and that “it was harder for me to reflect and track the play.” Stella also struggled, as did Kate, with not asking questions and not directing the child toward specific toys or actions. Not asking questions and not directing the play were two skills that in my experience with training adults in the filial skills were more difficult to master. The influence of
what had gone before in the adult learner’s experience provided continuity (Dewey, 1938/1998), but that continuity can also present the learner with a conflict to resolve when the new learning was counter to what was known before. Parents were accustomed to asking children questions in the daily pace of life. Kate, a registered nurse, was in a profession where questions were routinely asked to find information. Reflection-on-action is the “thinking through a situation after it has happened” (Merriam, Caffarella, & Baumgartner, 2007, p. 174). In discussions with the filial therapist, parents engaged in this process as they reviewed their past experiences, reflected on how filial training was different, and then decided to practice that different skill.

Stella wondered why children responded so well to the simple statement, “If there is something you should not do, I will tell you,” without pushing to find out. As Stella described her experience she said,

I always wondered why they were comfortable [when I said that]...

and [the therapist] tried to explain this, when they [the children] don’t know what the limits are, but they know I will say something if they cross over into something they aren’t supposed to do. Yes, they know when you say, “that is something you shouldn’t do.”

That was so counter to a lot of my thoughts, a lot of it was a little counter from what my parent training was, all those parent training seminars.

**The Parent’s First Play Session**

Dewey’s theories concerning genuine and continued growth were echoed in the framework and philosophy of parent psychoeducation with parents who adopt
children with attachment difficulties. The combination of expressed parental warmth, empathy, acceptance, and therapeutic limit setting, skills learned and practiced under the supervision of the parent educator, allowed the parents to create a setting for the child that contributed to intellectual and emotional growth for both the adults and the children, and provided additional description of their experiences with applying their learning from parent psychoeducation and the types of learning that occurred as the process unfolded.

The general flow of parent psychoeducation ranges from two to four initial sessions, where the philosophy and skills of filial therapy are explained. The therapist initially demonstrates the skills with the child in a play session while the parents observe. In subsequent sessions, each skill is explained, demonstrated, and then practiced by the parent with the therapist playing the role of the child. As the parents talked about their experiences, interplay of the factors in learning was demonstrated, which included the “tools” of filial therapy (the skills and the responses), the context of the play (the toys and setting), and the activity (the relationship between the parent and the child as the play evolves) (Brown, Collins, & DuGuid, 1989).

After some initial discomfort and fear of making a mistake, all the parents found themselves feeling comfortable in playing with their child and receiving feedback from the therapist following the session. All of the parents commented about how helpful the filial therapist was to them, not only in learning the specific skills but also in understanding the influence of their child’s background on their current issues. As Elizabeth spoke of her experience, she related how she was ready
to give up, asking herself what more she could do, and being particularly hard on herself. She said,

[Dee] was a biter and he wasn’t listening. He was in the process of being expelled from a daycare center. Yeah – it really hurt. So she just kept telling me about how wonderful he was and, you know, how in our sessions he was just so nicely attached to me, and I think, that in particular helped me.

Morgan, Kate, and Julie described their previous work experience with children (teaching, nursing, physical therapy) as helpful. Julie was fascinated with the application of her learning when she connected what was going on in Michael’s daily life with what he was doing in his play. She also noted his working through issues that were separate from his life with Morgan and herself.

Since much of a parent’s daily routine with a child concerns structuring and directing them in certain activities, Stella found that not directing was very challenging to her. She said, “I struggled with wanting to steer him toward certain toys but he always gravitated to the sand box. Thinking about doing the right thing in the sessions was exhausting for me.” Learning is not a static activity.

**Transferring Learning to the Home**

As the structure of parent psychoeducation moved to home practice with supervised sessions with the parents at the therapist’s office, we saw the application of the concepts of situation, interaction, and continuity, with adaptations being made as new learning occurred. Were the training to consist only of the two sessions in the beginning and parents left to figure out the rest on their own, the
effectiveness of parent psychoeducation would diminish and disappear. Although Dewey situated his theory in the interaction between teacher and child, the experience is transferable to the interaction between parent and child, particularly when the material is adapted to their needs and abilities. The practice by the parent of the skills taught and their effective use at home depends on the success of the parent in the office-based practice and the supervision that occurs after the therapeutic sessions begin at home.

Morgan and Julie’s son Michael and Carlee’s granddaughter Katelyn had experienced deeper levels of trauma and abuse. These two families underwent a different course of sessions with the therapist, with their experiences demonstrating the adaptability of parent psychoeducation to differing family needs and giving further understanding of the third and fourth research questions. The usual sequence of parent psychoeducation included the training sessions and another 3-5 practice sessions in the office, with the decision to start sessions at home made jointly between the therapist and the parents. The unique situations of Morgan and Julie’s son Michael and Carlee’s granddaughter Katelyn meant that they would be involved with the therapist longer. Michael’s play was heavily trauma-based and although Morgan and Julie were comfortable in play with him, they were still doing their work under the therapist’s supervision and coaching in her office. Katelyn’s complicated custody situation was managed by Carlee being able to go back to the therapist’s office from time to time to make sure that she was not missing anything in Katelyn’s play. Carlee provides a weekly session with Katelyn at home, as she has done over the past three years. In both of these circumstances,
Morgan, Julie, and Carlee worked with the filial therapist in the present to establish healthy parent-child behaviors that began to repair the damage of Michael’s and Katelyn’s past. Relational theory holds that growth occurs within relationships rather than apart from them (Freedberg, 2009), and since the parents provide warm, loving attention to the child coupled with acceptance of the events portrayed in the child’s play, the healing of past hurts occurs. The situated learning that occurred as Michael's parents and Katelyn's grandparent practiced filial therapy under the supervision of the therapist allowed them to adapt their skills to the needs of Michael and Katelyn. Those adapted skills were then practiced in the therapeutic session, allowing the adult learner/parent to gain confidence in managing difficult behaviors.

Adult learners benefitted when skills training elicited their own expertise and needs, appropriate for the particular context and circumstances. Elizabeth, Kate and John, and Stella and Andrew were able to begin home sessions according to the usual sequence of office practice followed by home practice. They discussed their experiences providing play sessions at home, including examples of their learning in action.

John and Kate had two other children younger than four-year-old William, which complicated the situation somewhat. John described William as much more relaxed in the home sessions, which he believed were easier to carry out. Kate thought that it was harder to carve out time at home, but she noted that it was only in the home sessions that William’s theme came out, a need for rescue that could not be completed. This theme did not emerge during the sessions in the office, and was
consistent with trauma theory, which states that traumatized persons must experience a supportive environment where they can feel safe to share feelings and experiences (Johnson, 1998; Cain, 2006). William’s reaching this point relates to his father’s description of his being more relaxed in home sessions, with the two people he has come to accept in his four-year-old way as his parents. His mother, Kate, described William’s rescue theme as persistent over whatever toys he might choose to play with on a particular day. The toy in the role of rescuer could not find the tools needed to complete the rescue, or became lost on the way to the toy needing rescue. During their final interview with me, when they discussed this, they described how parent psychoeducation had helped them create the safe space that allowed the trauma theme to emerge, due to their increased awareness of their child William’s prior experiences. William, at four years old, lacked the cognitive sophistication to think about his experiences in the way an adult could, but felt the difference in his relationship with Kate and John, who were emotionally attuned to him (Freedberg, 2009) and gave him a safe place to act out his experiences.

**Persistence with Learned Behaviors in Play Sessions at Home**

The participants spoke about continuing the play sessions at home following their discharge from the Aspen Valley Center, which was the final stage of parent psychoeducation and filial skills. They added additional description of parental experiences and the types of learning reflected. Carlee, Morgan and Julie were still actively involved with the Center, while Elizabeth, Kate and John, and Stella and Andrew were the three families who have been discharged. Their description of their skills as positive additions to their parenting tool kit and their growing ability
to tell when Dee, William, or David needed a session validated their positive feelings about their use of filial skills and illustrated the premise that "every experience influences in some degree the objective conditions under which further experiences are had" (Dewey, 1938/1998, p. 29).

Elizabeth continued the home sessions with her son Dee for a long time after they were discharged from the Aspen Valley Center. She said there were several times that they did sessions for a short while when Dee was struggling with something. She spoke during her interview about thinking of starting sessions again, since she has remarried and the family has relocated to another area of the state, introducing some significant changes for young Dee to process.

During the time of my study, John, Kate, and their three children moved from their condominium to a spacious home in the country. Despite the move and three children under the age of five, they continued with the sessions and noted they could tell when William needed a session, even when circumstances prevented them from offering sessions regularly.

Andrew and Stella described their home sessions as working very well for them and their adopted son David. They were also doing sessions with their biological son, Charlie, who was three years younger than David. Both parents described the sessions as enhancing the affectional bond between themselves and their sons. Stella said that they could always tell when David needed a session, and were amazed that the little bit of control that they were taught to give him by the child-centered approach could make such a positive difference in his behavior.
Learning to Recognize Differences in the Child following Play Sessions

The parents participating in the study were all able to describe differences in their children as the play sessions continued. Trust is described as “... necessary for effective reflective ... discourse to occur. Developing trust [was a] way in which relationships [were] evident in the ... learning process” (Taylor, 2000, p. 306). In the training process, trust developed between the parents and the filial therapist. In the relationship of an adoptive parent and adopted child, the child gained a sense of trust and caring in the parent's response, and the parent saw the trust returned in the child's response to the parent's action. Morgan and Julie spoke about how learning the meanings of Michael's play contributed to better understanding of his behavior. They noted that Michael was less fearful and more able to engage in independent play, due to his trust in their acceptance and response to him.

Elizabeth thought that she and her son Dee were more present in the moment with one another, since both experienced the cyclical movement of trust in their relationship. These experiences reflect on the second part of the third research question, which asks about the meaning parents derive from being their child's therapist.

Parents spoke about their children increasingly expressing emotions verbally and in improved listening when an adult was speaking to them. Children experienced decreases in outbursts and tantrums, and decreases in anxiety and mistrust. Dee, who had problems controlling outbursts and tantrums at school, became much more manageable in the school environment.
At ten, David, the son of Stella and Andrew, was the oldest child in the study. Stella and Andrew recalled their discussions with the therapist at the Aspen Valley Center about how David’s developing cognitive fluency could contribute to revisiting some of his issues. As Stella described David’s recent difficulty with outbursts and listening to his parents, and increase in anxious and fearful behaviors, she recognized that

[David] is starting to think a little more abstractly so we have to recognize and honor the things he is going through. He is [having] some fear about things, and I think back to how we were before the play [filial skills]. ...we are more fluid about that rather than falling back on the parenting we used before the play. We would have ... done this a lot differently if we hadn’t had that experience. [Now] we know that we can just reflect and let him figure out a lot of his own fears, and as long as we are respectful and not directing him in his thoughts, he knows he is safe to talk [to us] about his fear.

Stella and Andrew were discussing starting sessions with David again, with adaptations being made for his age. In relational theory, an outcome such as this is likely, because persons in a relational interchange must be capable of recognizing the subjective feelings, rights, and experiences of each other, in order to have a meaningful experience in one another’s presence (Freedberg, 2009, p. 26)

Learning to Read the Markers of Secure Attachment

The markers of secure attachment between parents and children include
1) the child experiencing a sense of security; 2) the child’s ability to regulate affect and arousal; 3) the child being able to express feelings and communicate them to others; and 4) the child’s willingness to explore the environment (Zeanah, 2000; Lieberman & Van Horn, 2008). I developed questions where I rephrased each of these markers into lay language and asked parents to comment about each one, asking them to give an example of how they knew something was different with their child. In addition, parental descriptions of learning to read the markers of attachment provided further understanding of the meaning they derived from being their child’s therapist, the second part of research question three.

First, parents were asked if they noticed their child experiencing an increased sense of security with them. The parents were unanimous in saying that they believed their child experienced increased security with them. Behavior changes noted included the child separating from them without distress, better self-regulation, speaking up for themselves, and being comfortable with themselves. John qualified his statement by adding that William did manifest insecurity in certain situations, giving examples of when his brother was adopted and his sister was born, in the recent move to a new home, and when his mother injured her foot and required crutches. Stella expressed concern that David appeared to be struggling with different sorts of anxieties as he moved into a higher level of cognitive functioning.

Secondly, parents were asked about their children’s ability to understand feelings and calm themselves when upset. Although all the parents believed there was improvement here, there was more variance in their answers. Parents were
more likely to describe this ability as a “work in progress.” Morgan and Julie said they continue to work on this with Michael, who has difficulty interpreting feelings.

Carlee described a different aspect of difficulty with feelings:

Katelyn holds her feelings in. I’ve since learned that is why she has the sensory problems she has. It’s tough for her to go from one place where she is not allowed to express herself to where she can come here and we expect her to express herself.... Going back two years ago, I made sure there were a lot of sensory items in the play, because I wanted her to experience the different textures and smells. I have since learned that certain smells help her calm herself.

John believed that William had a good understanding of where he was for his age, because he returned to John or Kate to apologize for his misbehavior, and he asked for special play when he needed to. Stella described David as learning to cool down, but they had to give him space to do that. Andrew added that they have learned how to approach David.

The third circumstance concerns being able to express feelings and communicate them to others. Once again parents were unanimous in their responses, citing increases in empathy, expressiveness, and intuitiveness in their children. Morgan and Julie specifically identified their learning of filial skills as helping them explain things on an emotional level. Although William had always been able to talk about his feelings, his mother Kate believed that their learning through the play sessions and use of filial skills have advanced William’s abilities in this area. Stella gave several examples of ways she has learned to work with her son
David, including snuggle time with him after dinner, going for walks together, and
drawing pictures about his feelings.

Lastly, parents were invited to describe their children’s willingness to explore
the environment. Four of the five families believed their children were doing very
well in this area, from being like any other children of that age to being willing to
confront things that once scared them. The fact that their children were doing
things that other children of that age were able to do was very reinforcing and
meaningful to the parents.

Andrew and Stella are both environmentalists, and believed that their work
has provided David with plenty of opportunity to explore nature. Morgan and Julie
pointed to the nature of Michael’s traumatic injuries holding him back from willing
exploration of his environment, as he fell easily due to his physical limitations. They
were concerned because Michael remembered the times when he was able to
control his body prior to his abuse. Morgan saw Michael’s difficulty controlling his
body as impacting his self-esteem and his willingness to conquer an obstacle.

**The Affective Outcomes of Learning**

Participants were given an opportunity to talk about how their own feelings
toward their child had changed over the course of providing play sessions, another
aspect of making meaning through parent psychoeducation. In the earlier stages of
parent psychoeducation, the parent and the therapist, now functioning as an adult
educator, met to discuss the structure and form of parent-directed therapy. The
therapist drew from the parent’s experiences and existing knowledge to augment
those through the training. The practice settings were strengths-based, with the
therapist noting the positive actions of the parent, and encouraging the parent to identify any areas where improvement may be needed. The parents learned to feel safe and accepted as they learned the practice of filial therapy through parent psychoeducation. The transaction between the individual (parent learner) and the environment (the child’s behavior, the play session, and the actions of the therapist) influenced the parent’s desire to continue the experience (Dewey, 1938/1998, p. 41).

Since the parents in the study had all been providing filial therapy with their children for some time, they spoke of their own improvements and described a variety of feelings, including a deeper love for the child but also for one another, and a belief they were capable of helping their child deal with problems. Andrew spoke of feeling anxious at first, waiting for the next explosion. Stella agreed that they both feared losing control, but the parent psychoeducation not only helped them understand David’s behaviors, but to understand that they as parents were capable of handling them. Stella described herself being much more relaxed as a parent and enjoying both her sons much more since she and Andrew do play sessions with them.

Carlee, Julie, and Morgan all described a deep, abiding love for their children, with Julie and Morgan both saying that it didn’t matter that Michael was not their birth child. John reported feeling more confident that filial therapy was helping and more confident that he and Kate can help William through his problems. As John and Kate described their work with William, Kate said,

We realized that a lot of his struggles were anxiety related. I don’t
think we realized how scared he was of not being rescued, and how alone he felt, even though he seemed so okay on the outside. It made us realize that his anxiety was real and there were more issues than we understood he had. He's suffered more trauma than we understood.

The increased confidence parents felt in helping a child with lingering issues from disrupted attachment was a thread running through their narratives. In the first interview parents spoke of feeling out of control and uncertain how to handle behaviors they did not expect or to which they had no previous exposure. After moving through the parent psychoeducation and the actual practice of play sessions, the majority of parents considered themselves able to help their children through their issues. Much adult learning was “located in everyday tasks and interactions, [including] home and family activity” (Fenwick, 2001, p. 243). The overall goal of parent psychoeducation was to transfer the learning to the home, where parents learned to apply the skills to their everyday tasks and interactions with their children.

The only parent that spoke of her own issues in the sessions was Elizabeth, who said, “I didn’t enjoy the time as much as he did. He loved it and having a sense of control was big for him. It gave him a sense of power and reduced his need for control at school, where he became more cooperative. But I had a hard time keeping focused in the sessions.” Elizabeth, herself an adopted child, spoke about her own adoption during each interview. During her last interview, she said in response to my questions:
JC: What has all of this meant to you – being your child’s filial therapist; that you did not need to participate in the mental health system, that you were able to...
E: to solve the issues?
JC: Yes. Can you talk about the meaning that you derived from that?
E: That’s interesting. I’ve thought about that because I’m a big believer in the mental health system and I had my own therapy for years and it helped me, but I think I feel – I liked the fact that I was able to do these things, and of course, [the therapist] was a big help.
JC: Yes.
E: And I think about – and probably a reminder from – as a refresher would be helpful if I were doing this again, but she did send me something about two years ago – but yes, I’m glad he didn’t have to go to a therapist’s office and go through that process.
JC: Right.
E: Yeah. Yeah I am glad. I hadn’t ever thought about that before. I know – I think, probably I brought my own attachment issues to this, being adopted; and I remember my parents taking me to a therapist, and I was very, very young. And I can still remember it – it was terrible experience – very traumatic, and I was so shocked – I’m the opposite of my son.
J: Yes.
E: So, yeah – I’m glad to have saved him from that experience. I hadn’t thought about it, but yeah.

The parents’ own attachment history plays a role in the relationship with their child (Hughes, 2006; Lieberman & Van Horn, 2008). Elizabeth recognized that her own childhood attachment issues and history seeing a therapist had entered the therapy with Dee, and could have contributed to her difficulty focusing on what was going on in the present. A child with “significant difficulties due to trauma and attachment problems [can activate] the foster or adoptive parents’ own attachment histories” (Hughes, 2006, p. 198). A reciprocal relationship can develop between a child’s temperament and personality and the parent’s psychological needs (Lieberman & Van Horn, 2008). Elizabeth had characterized herself in her first interview as a “gypsy,” one who traveled throughout the world and who had a career. She did not adopt until she was in her mid-forties and was a single parent at
that time. Elizabeth, a vivacious woman, spoke of going to Guatemala, where she was handed 10-month-old Dee, a stack of diapers, and a bottle, to spend four days alone with him in a motel room, unable to take him outside due to not having any legal authority over him at that time. She spoke about thinking on the first night that she had gotten in over her head, but decided to stay focused on the goal of adopting a child. She described Dee as “a very intense baby, and he was intense when I brought him home. Very, very serious, you know, and the first time he looked at me it was like, ‘who the hell are you?’” At age ten months, Dee’s worldview would have been under construction. Elizabeth mentioned the conflict in Guatemala at the time. Although a ten-month-old child cannot speak, he can see, feel and remember in his body (Johnson, 1998).

Elizabeth’s description of Dee as a very intense baby raised the question of what this child experienced in his first months of life, and gave credibility to the behaviors that emerged during his toddler years that brought Dee and his mother to the Aspen Valley Center. Adult educators must understand the factors in an adult learner’s background that could “inhibit learners from speaking ... [or] challenging predominate views and ideas (Tisdell, 1995, p. 83). Elizabeth, bright and articulate, was not inhibited from speaking but had not connected her own experience as a child with her experience in parent psychoeducation and filial therapy until her second interview in this research study.

**Continuing the Sessions at Home after Discharge from the Therapist**

At the time of my study, Elizabeth, Andrew and Stella, and Kate and John were discharged from the Aspen Valley Center. Kate and John, the most recently
discharged, were finding difficulty fitting home sessions into their schedules, but reported that William would ask for a session or they would offer one when they saw rising anxiety in him.

Describing additional experiences with parent psychoeducation and the types of learning reflected, Kate and John, as well as Andrew and Stella, commented on the portability of the skills, and how they used structuring, limit setting, and reflective responding at various times with their children, describing positive results with behaviors in the children such as calmness and increased verbalization about their feelings. These two families were the only families in the study that had other children in the home.

Elizabeth stated that reviewing the experience with me helped her see that Dee might benefit from special time again, since he has experienced a number of changes in the past year. She had stopped doing the sessions regularly a while ago. Andrew and Stella have also stopped doing regular sessions, but find that their mini-sessions of reflecting David's feelings when he was upset reinforced the positive bonding between them. They were also considering adapting the sessions to David's current age and doing special time with him again. The adaptability of filial skills allowed parents to adapt sessions as the child grew, giving them another opportunity to situate their work in real life problem-solving, and providing additional information about the fourth research question, the types of learning reflected in the parents’ experiences.
Parental Perspectives About the Process of Parent Psychoeducation

The parents were asked at the end of the second interview if there was anything else they wanted to talk about concerning their experiences with parent psychoeducation and filial therapy. All the parents noted seeing improvements in their children’s behavior as well as finding a deepening attachment with them. The two families who have additional children at home spoke of the applicability of the responses to help those children deal with issues. Home and family activity (Fenwick, 2001) provided a convenient and appropriate site for the parents’ application of the filial skills.

Julie and Morgan noted that prior to their involvement with the Aspen Valley Center, they were unaware that filial therapy existed. Having seen the benefit of filial therapy to themselves and to Michael, they would recommend it to anyone who wanted a deeper relationship with a child. Carlee also commented that she thought about all the other children out there who would benefit from a parent or guardian knowing filial therapy.

Elizabeth, the parent with more ambivalence about the process, noted that her son Dee needed the security that the sense of control in the session gave him. Elizabeth recognized that the feelings of boredom and the concern that the toys were not adequate were hers alone. She described her biggest challenge as finding the same amount of toys [as available in the filial therapist’s office]. She was concerned that Dee would play with the same things and the same game in their home sessions and she wondered whether it was because she didn’t have enough variety or whether it was because of his own issues he was working through.
Elizabeth spoke of discussing this with the therapist, and although the therapist had told her that the toys she had were ample for Dee to explore his themes, there was still a part of her that wondered whether she had enough for him to explore all the themes he needed to explore. Elizabeth said, “I never really felt like I got that right, like I had the right variety, age range, enough range of...so that always was a little difficult.” Both Elizabeth and Stella had expressed concern that they could not offer the array of toys that the therapist did, but I have found in my experience as a play therapist that children find what they need to work through their issues. Nevertheless, a professional playroom can create unnecessary anxiety for parents when they seek their own toys for home sessions. Parent psychoeducators can be aware of this and work with the parents to address their issues about quantity of toys.

Both Kate and John, and Stella and Andrew spoke of their happiness that they had the skills and could use them with family members of all ages when needed. Andrew said, “It [filial therapy] put the fire out and defused a lot of scary situations. It gave me a plan and a lot more tools to use.” Stella added, “If we could all learn to talk to one another like we do in special time there would be a lot less hassle in the world.” Stella, who was at a point in her own career comparable to the women in Carter’s (2000) study, echoes Carter’s findings concerning the humanistic theoretical underpinnings of feminist relational theory that emphasizes the development of genuine respect and acceptance for the strengthening of human relationships. Parents and therapists alike found that the communication skills and
techniques that promote the development of respect and acceptance that are part of the filial training are adaptable to many human relationships.

**Reflecting on the Meaning of Education and Practice**

The third and final interview gave the parents the opportunity to reflect on the meaning of being their child’s therapist, part of research question three, and on our discussions in the first two interviews. As the parents in the study moved through the three interviews, they exemplified how “new moments of perception [brought] to consciousness fresh perspectives, as knowledge was born that unites past, present, and future, and that increasingly expands and deepens what something was and means” (Moustakas, 1994, pp. 53-54). Parents spoke of their realization how parent psychoeducation and filial therapy helped them redefine parenting and the meaning of helping their child (giving them a fresh perspective), and further confirmed the premise that “every experience influences in some degree the objective conditions under which further experiences are had” (Dewey, 1938/1998, p.29).

The following table summarizes the parents’ concerns for their children. The parents identified these concerns in the questionnaire they completed at the beginning of the research. The table shows the depth of issues that these children and their parents confront, and shows that some of the concerns were ongoing as the child developed.
Table 4.1: Ongoing Issues and Expressed Parental Concerns for the Future

<table>
<thead>
<tr>
<th>Child</th>
<th>Age</th>
<th>Ongoing health/mental health issue</th>
<th>Expressed Parental Concerns for Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katelyn</td>
<td>6 years</td>
<td>Sensory issues; receives OT</td>
<td>Interactions and dynamics of maternal side of family</td>
</tr>
<tr>
<td>William</td>
<td>5 years</td>
<td>Global developmental delays, sensory issues. Receives OT, PT, and Speech Therapy</td>
<td>Significant emotional/behavioral struggles and physical needs; worry about scars from past and how they continue to affect him</td>
</tr>
<tr>
<td>Michael</td>
<td>7 years</td>
<td>Traumatic brain injury; receives OT and PT</td>
<td>Living with his injury; being adopted; having two moms; different race, and impact of all these factors on him</td>
</tr>
<tr>
<td>Dee</td>
<td>8 years</td>
<td>None identified</td>
<td>None identified</td>
</tr>
<tr>
<td>David</td>
<td>10 years</td>
<td>None identified</td>
<td>Lack of confidence; thinks he is a victim</td>
</tr>
</tbody>
</table>

Key: OT: Occupational Therapy; PT: Physical Therapy

The Parents’ Personal Meaning of Being a Filial Therapist

All of the parents described their experience with learning and practicing filial therapy as meaningful, finding meaning in such matters as being able to work with their child themselves, understanding the child’s play as communication, and bringing the family closer together emotionally. These experiences enrich our understanding of the meaning parents derive from being their child’s therapist, a concern reflected in the third research question. John spoke about his increased comfort level with William’s issues and feelings, and Kate described the developing inner locus of control for her, knowing that she can help William by responding to his feelings. Carlee explained her ability to understand Katelyn’s needs through watching her play, and how to change things in the day-to-day routine to better meet those needs.

Elizabeth, herself a trained therapist and also an adopted child, realized she brought her own attachment issues to her relationship with her son Dee. She remembers her parents taking her for individual therapy when she was quite young,
and the experience of leaving her parents in the waiting room was very traumatic and shocking for her. She appreciated being able to work with Dee with the therapist present, and to bring the sessions home, sparing Dee from an experience like the one she had.

Morgan and Julie spoke about how the three of them grew closer as a family, and how the therapist’s grasp of Michael’s trauma issues deepened their understanding of what he had experienced prior to coming to their home. Without this, Morgan believed that Michael would not have made the progress that he has. Julie described the amount of progress through filial therapy as astronomical compared to typical individual therapy, and noted that the progress was much faster.

Andrew looked at the deepening bond between himself and his sons, saying that the experience was made meaningful by his being able to perform the therapy himself, which strengthened and enhanced the affectional bonds between them. Stella took a longer view, characterizing the filial therapy as a whole new way of living, one that built a strong foundation for their family, one that would sustain them through time.

A Changing Relationship with the Child

The underlying feeling as the parents described changes in their relationship with their children over the past several years was one of growing trust, from the parent’s perspective being able to help the child with troubling behaviors, and the child appearing to be more trusting in the parent being there for them. The examples given by parents showed the sense of movement that parents perceived as
their child grew and the relationship between parents and child continued on its journey. The principle of continuity reflecting the carrying over of learning from an earlier experience to later ones was noted in this sense of movement, as the parents told their stories about their learning “in the way of knowledge and skill in one situation [becoming] an instrument of understanding and dealing effectively with the situations that follow” (Dewey, 1938/1998, p. 42), and providing rich detail that enhanced understanding of research questions three and four, the parents’ experience with parent psychoeducation, and the types of learning reflected.

Morgan and Julie, and Kate and John were the two families whose children came from the foster care system. They described their experiences finding a deepening attachment between themselves as parents and their adopted child. Kate and John believed that William has embraced them as his parents, and John expressed confidence in William being a good brother to his two younger siblings. John said, "From where he started, he was doing some things that I thought were just scary and pretty dangerous, but I don’t see that now." John and Kate have both learned a deeper understanding of why William’s behaviors were as they were, and have confidence in their skills to help him with his emotions.

Morgan and Julie saw the effects of filial therapy as creating a journey with their son Michael, as they learned to evaluate their own behaviors and verbalize their feelings, while supporting Michael in feeling safe expressing his. Morgan added that she and Julie evaluate their own behaviors more than they did before, and try to talk about things calmly, without over-reacting. They both agreed that
their family has grown closer throughout the process of parent psychoeducation, and were able to derive a rich meaning from their experiences.

Carlee, Katelyn’s grandmother, who stepped in to prevent her granddaughter from going into the foster care system, learned how to provide a safe space for her, and to give responses that allowed Katelyn to express and release her feelings knowing that her grandmother accepted them. Carlee noted the sense of power to do what she needs to do to keep the peace, and characterized that as the most important thing that a family can experience.

Elizabeth acknowledged that her son Dee has had several transitions in the past few years, including her marrying a man who in her words was “a much better parent than I.” At eight years, Dee was going through his own changes, straining his relationship with his mother at times. Elizabeth thought that Dee was figuring out his new relationship with two parents, and reconfiguring his relationship with her as a single mother. Plus, the family lived two and a half hours from Elizabeth’s parents, where Dee spent his first five years. Elizabeth recognized the significance of those changes for Dee, and believed her recognition of these events and review of her previous experience with filial therapy had taught her to identify the impact of those changes and to see the need for them to resume their special play sessions, reflecting another type of learning in accordance with the fourth research question.

Stella and Andrew’s son David, ten years old, has gone through several periods of developmental and cognitive growth in his lifetime. As Stella said, “David was starting to think a little more abstractedly so we had to recognize and honor the things he was going through.” They thought back to their experiences prior to
parent psychoeducation, where they had a tendency to cover things over and move on. Now they acknowledged where David was and what he was feeling, and their ability to reflect permitted them to be more fluid in their response to him, allowing him to figure out his own fears. David knows that his parents will be respectful and not direct him in his thoughts, allowing him to feel safe to talk about his fears.

**Increasing Parental Understanding of Their Child’s Play**

The parents identified several themes of helpfulness in reviewing the talks that they had with the filial therapist, exemplifying additional types of learning for each family as studied through research question four. One of those themes was understanding the meaning of the child’s play, seeing it as communication and recognizing it as a portrayal of what the child was thinking and experiencing. As Kate reflected on their experiences, she spoke of understanding her son William’s background but not understanding how it affected him. She described seeing his theme of abandonment and failed rescue unfold in play sessions and understanding that he was working through his fear of needing to be rescued and fearing that no one would be able to rescue him. Carlee said that prior to parent psychoeducation, she would have looked at Katelyn’s play and wondered if she was recreating something she saw on television. The filial therapist had helped her understand that Katelyn’s play was reflecting what was going on in her life. Carlee commented that if a person understood the family dynamics from the maternal side, they would understand why Katelyn’s play was filled with violence, anger, and hatred. “The therapist pointed things out to me,” said Carlee.
A second theme concerned the role of reflective responding, as parents learned to identify the feelings the child was having both inside and outside of the special play sessions. Julie spoke of the importance of dealing with feelings in the moment; thinking about what Michael must be feeling, and reflecting that back to him. Stella added that as she recognized where David’s feelings were coming from, rather than deflecting them or overpowering them, she validated them, which she saw as the only way to truly defuse escalating behavior.

A third theme reflected in the participants’ comments about parent psychoeducation was the importance of incorporating child development theories into the work with the child. As parents reflected on their experiences with their filial therapist, they cited three important learning outcomes that helped them: 1) understanding the child’s level of development and how that impacted understanding and responses; 2) learning how the child’s understanding would change as development continued, and 3) applying specific information about abandonment issues to their particular child’s behaviors and responses.

The parents’ responses in the three themes reflected in their comments about parent psychoeducation followed the findings in the literature review of Schwartz (2002), Scott, and Dadds (2009) where they urge that parents in foster care and adoptive situations be taught skills that elicit the parents’ own expertise in caring for children, as appropriate given their own context and circumstances. Schwartz, Scott, and Dadds also urge professionals to consider parents’ thoughts and feelings as an essential component in treatment success.
Several of the parents spoke about the impact of what they had learned on their own feelings of competence. Elizabeth identified the therapist’s wording of responses, her enthusiasm, her encouragement, and her thinking that Elizabeth’s son Dee was just wonderful were all things that kept her going. Stella said following her session with the therapist where they discussed abandonment issues, she “realized what a gift she had been given and actually had to go home and go to bed because it had such an enormous impact on her.” Emotionally warm relationships were more likely to promote instances of learning than did relationships that were practical and career-oriented (Carter, 2000). The warmth and approachability of the therapist at the Laurel Valley Center were highlighted in the responses of the parents.

**Participants’ Perception of Their Post-Psychoeducation Parenting Skills**

During interview one, parents spoke of their increasing feelings of not knowing what to do to help their child, of seeing behaviors that they did not understand, and in general, feeling helpless. In the final interview they were given the option of assessing how their parenting skills had changed since participating in parent psychoeducation.

All the parents described their learning and usage of more skills and feeling more confident in their role as parent as another experience gained from participating in parent psychoeducation. Several parents saw themselves as “a work in progress.” Elizabeth noted a need to be more patient, wanting to do better, and working on her own skills. She characterized being the mother of a boy as difficult and was thankful that her husband was supportive to both herself and Dee.
Kate and John thought they were doing the best they could, citing a wish to be more consistent and seeing their three young children, working and the various accouterments of a busy life being barriers to consistency. They identified limit setting and parent messages as valuable skills that the therapist taught them. Kate said, “I remember leaving there and both of us saying we should have done this a year ago, and every parent should have to see [a filial therapist].” Kate and John were planning to begin filial therapy with their second adopted son, who was now three years old.

All the other parents in the study described feeling more equipped to handle difficult moments. Morgan and Julie explained about the “time-in”, where instead of isolating the child in time-out, one or both parents sat down with the child and talked about what happened. Morgan described Michael as being able to reflect on what happened, get himself grounded, and talk about the impact of his behavior. Carlee noted that the skills of filial therapy were portable. She used them when she volunteers at Katelyn’s school and was viewed by the teachers as the woman who can settle kids down.

Andrew broke down his learning of tools to cope with difficult situations into several parts:

1) To stay somewhat removed from the situation and not get caught up in it
2) To reflect for David, let him experience it
3) To not become the problem because I am too involved
4) To let David figure out how to get through it and support him and guide him if he has trouble.

Stella added that by following these steps, everyone became calm. She noted that when David became anxious they purposefully did things to help him realize their
bond with him was still strong. Both Stella and Andrew believed that they were better equipped through the skills they have learned to handle things with their younger son, Charlie, having done special play sessions with him as well. They said that although the two boys were very different, they get along very well, accepting each other’s differences. By doing so, they have set an example for their parents to accept their differences too. The experiences related by the parents as they described their perceptions of their skills provide additional understanding of the types of learning described (research question four) and the meaning attributed to the experience (research question three).

Several parents identified future additional learning needs. Elizabeth described how Dee’s personality emerged, saying she saw differences in the two of them in their approach to life. She was also concerned because “he’s a boy,” expressing her gratitude for now having a husband who enjoys having a son. Morgan and Julie, still involved with the therapist, spoke about their ongoing learning of parenting skills and being able to discuss those with the therapist. Stella and Andrew discussed several books they recently read about brain development and indicated they would continue to take advantage of information that would increase their parenting skills as it became available. The other two families felt that given their particular circumstances they were working very well with their children.

**Changes in the Parents**

The process of triangulation in qualitative inquiry is described as involving supporting information from other sources to further illuminate a theme or
perspective (Creswell, 2007, p. 208). VanFleet, Ryan, and Smith’s (2005) identification of treatment goals and learning outcomes in filial therapy that corresponded with the markers of secure attachment (pp. 243-244) assisted me in understanding the processes that supported parental learning in these outcomes. My study’s underlying theories, which include experiential learning theory (Dewey, 1939/1998), situated learning theory (Lave and Wenger, 1991), and relational theory (Freedberg, 2009), added additional understanding of parental description of their experience with parent psychoeducation and the types of learning that flowed from this experience. VanFleet’s learning outcomes (Appendix B) were incorporated into the questionnaire, with the situation described and the parent asked to comment about it. In this section, the goals for the parents were used in developing statements about changes in the parents’ consideration of events. Parents were asked if they had noticed changes like the one described, and to tell how they had noticed it. They were asked to comment about whether parent psychoeducation and skills in filial therapy had helped create the condition.

**Statement One: To increase your understanding of child development and set more realistic expectations for your children.**

Several parents said that rather than receiving new information, they received information that helped them refine and expand their existing ideas about child development and realistic expectations. Some of that information included understanding gun play, and incorporating emotional and cognitive aspects of development. Kate’s understanding of where William should be developmentally was validated by the psychoeducation.
Statement Two: To increase your understanding, warmth, trust, and acceptance of your children.

Two of the parents, Carlee and Elizabeth, believed they were already adequate in this area. The other parents talked about improved understanding of where their child was developmentally. Morgan and Julie both commented on how integrating their professional training with parent psychoeducation had increased their understanding of their son Michael’s emotional level. Stella reported that understanding the developmental changes had resulted in incredibly deep conversations among father Andrew, sons David and Charlie, and herself.

Statement Three: To learn the importance and interplay of your child’s play, emotions, and behaviors.

All of the parents stated that learning about the interplay of play, emotions, and behavior was exceptionally helpful. This learning corresponds with the premises of situated learning (Lave & Wenger, 1991) because it is only in working with the child in play, with a highly trained, registered play therapist like the one these families worked with, that parents can truly grasp the meaning of what their child’s play means. This is not a skill that can be transferred in a conversation or by watching a video.

Carlee, Elizabeth, Julie, and Kate all gave examples of how understanding what they were seeing helped them understand what was important to their child. Carlee stated that Katelyn’s play reflects what was going on in her life. Elizabeth noted that the “big thing” for her was learning that Dee’s play was his work. Kate gave several examples how their recent move and an injury to her foot had activated deeply rooted anxieties in William, which came through clearly in his play and
responses. She noted that the filial therapy skills had helped both her and John respond to William’s anxieties with expertise and compassion outside the session and within it.

Morgan and Julie related how their understanding of Michael’s play has allowed them to be alerted to developing difficulties in school or somewhere else that they were not with him by seeing it coming out in his play before they became aware of it in his behavior.

**Statement Four: To communicate more effectively with your child.**

Parental responses followed the pattern in Statement Two, with the same two parents, Carlee and Elizabeth, reporting that this was not a problem area for them. The other parents gave examples of how the different responses of filial therapy had helped them be better communicators with their children. Morgan explained how the skills gave them a guideline to follow. Rather than addressing the behavior first, she and Julie have learned to stop and verbally recognize the emotion, which validates Michael and permits an easier resolution of the situation. Julie added that the skills “help me be present in the moment, so I can call it like it was instead of dancing around it. Being able to do that for Michael made me feel a lot better about myself.”

John and Kate echoed one another, with John saying first that he learned a different way of communication, one that allowed children to communicate back to the parent, and Kate adding that it helped parents understand the child’s communications better. Andrew described how the skills helped him and Stella to truly connect with their children.
Statement Five: To develop greater confidence as parents.

The parents were unanimous in saying that being able to do special play sessions with their children and using the skills outside the sessions had increased their confidence as parents. Carlee believed that she was on the right track. Elizabeth experienced feeling better after the sessions, believing that she had done her part to help Dee.

The participants described parent psychoeducation as strengthening and expanding their skills as parents, relating a number of positive feelings. Morgan said that “learning that there are peaks and valleys, and that being in the valley forever was unlikely” was reassuring. Julie described learning not to push her emotions onto other people as helpful. John was relieved to have positive disciplinary strategies when needed. Stella said she has recommended the program at the Aspen Valley Center to at least a half dozen other parents, telling them “if nothing else it will calm them down.”

Statement Six: To reduce the frustrations experienced with your children, and to enjoy them more.

The majority of parents described their increased understanding of difficult behaviors and their meaning, along with more realistic expectations based on their child’s place in the development cycle, as reducing their frustrations and making parenting more enjoyable. Fewer outbursts had resulted in Julie and Morgan enjoying “just hanging out” with Michael. Kate identified understanding troublesome behaviors as emanating from a place of hurt rather than trying to tick the parent off as helpful to her in reducing the frustration of parenting three young children. Carlee said that when Katelyn released her stress in play sessions, she
created more harmony for herself and also for her grandmother, who was happy knowing that she had learned the skills that created this opportunity for Katelyn. Forming more realistic expectations following psychoeducation with the therapist and incorporating knowledge of child development was key for Stella in finding that parenting was much more fun.

The overall responses of the parents in the study to the changes that were indicators of positive attachment showed that all of the parents have experienced an increase in secure affectional attachment to their children.

**Changes in the Family**

The statements in this section of the study are based on the treatment goals and learning outcomes in filial therapy for the entire family (VanFleet, Ryan, & Smith, 2005, pp. 243-244) and provide information regarding the third and fourth research questions concerning parental experience, the meanings given, and the types of learning afforded. Parents were asked to consider whether the statement applied to their family and to give an example that confirmed that the statement applied. They were asked to consider the contribution of parent psychoeducation and filial therapy to their feelings about the statement.

**Statement One: Presenting problems and conflicts were reduced or eliminated.**

The study participants all stated that the presenting problems and conflicts had at least been reduced to a more manageable level. Carlee said that her husband has little tolerance for Katelyn’s emotional outbursts, so being able to do a session whenever Katelyn needed one kept peace in the family. Elizabeth reported that Dee’s need to control at school became much more manageable, considering that his
problems were located mainly at school. Although Michael's issues were deeply rooted, Morgan and Julie believed that the therapy gave him the best possible chance for positive development. John believed that William was in the regressive phase of play therapy, but Kate saw him making progress. Andrew described his family as having a much better direction, and their sons knowing that their parents would be there to help them deal with situations.

Statement Two: Family relationships and bonds are strengthened.

The parents expressed more of a variance in response to this statement. Elizabeth spoke about the time when it was just the two of them while she was doing play sessions. They had recently moved into her grandparents’ old house, and their bond was strong. Julie and Morgan described themselves as closer as a family than ever, citing an ease of being with each other, mutual respect, and trust. Kate wasn’t certain how much to attribute to filial therapy, saying that improving relationships and bonds was their aim with all three children. Carlee reiterated her husband's difficulties, saying when he was upset no one wanted to be around him, and in order to keep harmony in the home, everyone needed to be peaceful and in control. Stella thought that the unifying features of both parents being trained in filial therapy resulted in parents being more consistent, soothing, and calming. She said this helped her because “I can go off the deep end, too.”

Statement Three: Greater mutual trust and higher cohesion exists.

The parents in the study all believed that this was happening in their families, although still being a work in progress for most of them. Carlee noted that her husband had been abused as a child himself, and what she was learning through
parent psychoeducation and filial therapy had helped her understand the aftermath of child abuse better. Morgan and Julie described a mutual trust and respect to a greater degree than before, and a willingness to accept each other’s different ways of doing things. Kate spoke of their recent move and being able to see as a couple how the move affected William. Families described being able to look more realistically at the events that occurred in their lives, and to maintain a more even demeanor through changes.

**Statement Four: Communication and coping skills are improved.**

Some of the parents described this as a work in progress for them. Carlee believed that her husband expected Katelyn to be functioning at a higher level cognitively than the little girl was able to. Morgan and Julie believed that working in filial therapy has helped them reflect one another’s feelings and validate them. They can take a step back in a situation and try to be more realistic. Kate believed that some of the techniques have helped her with her two younger children.

**Statement Five: Having more enjoyable interactions with one another.**

All of the parents expressed positive statements about family interactions. Morgan drew from her past experience as a teacher and coach to cut the tension in the home with laughter. Soon they would be all laughing and Michael would be realizing that it was all right to laugh and have fun. Elizabeth saw Dee becoming more open and cooperative, and they were able to enjoy their times together. John and Kate thought that as William came to know them as his parents, he knew what to expect. He played well with the younger children and sometimes they heard him saying things to the younger ones that they said to him in special time. Andrew and
Stella spoke about being more open to each other’s stress, and stepping up to take more of the load from the one who was stressed. They felt attuned to one another’s needs to a greater degree, which promoted enjoyable interactions.

**Statement Six: Being more flexible and adaptive overall.**

All of the parent participants agreed that their skills in being flexible and adaptive were improving. Some unifying threads in their conversation were the importance of communication and being able to be realistic with expectations. Carlee intended to continue improving communication within her family. Morgan indicated that the lesson she learned from Michael, a child dealing with trauma, was that things became skewed quickly and easily, and you had to be flexible. Julie believed that the whole process with Michael had changed her priorities, and she was more at ease with him in the moment, both emotionally and physically. Stella reported that she realized now that if she lost her temper it was not the defining moment for her son’s entire life.

**Statement Seven: Developing relationship tools to serve them now and in the future.**

The parents thought deeply as they reflected about this, sharing personal beliefs about what was valued and important. Elizabeth spoke about the process with the research study as bringing her back to know that she and Dee needed to have special time again. As she reflected, she identified benefits for him, and recognized that there were new challenges for Dee that were difficult for him. Julie and Morgan talked about changes in their perspective about life.
Julie said:

I've learned that everyone is on their journey, and what is happening to you is not happening to me, and it doesn’t necessarily mean that it’s about me. Michael is changing and growing, he doesn’t need the same things he needed four years ago. You miss the things he needed four years ago, but you’re excited about the things that he needs and where he is now.

Morgan added:

As you live together your life goes on. The relationship that each of us has with Michael is evolving as he gets older.

Stella spoke about the transferability of the skills, having used them within her family of origin, and finding that the skills assisted her in understanding and knowing family members better. Both she and Andrew had used the skills with Andrew’s mother, and described the differences made as amazing. Kate and Carlee had spoken in other parts of the interviews about the transferability of the skills to other settings, whether to other members of the family or in settings such as a school.

Carlee added:

It has helped with me trying to explain things to my husband. Now together we have always been good, but we have our explosions, sleeping upstairs and downstairs, but we are still married and a big part of that is communication. But now that this little girl is part of our life the dynamic has changed. We will continue to learn. When
you’re done learning you might as well die.

What to Say if Your Friend Decides to Adopt a Child

Parents were asked to imagine a hypothetical situation where the phone rang and they heard a good friend saying, “We are going to adopt a five-year-old!” The friend was calling for their opinion on what to do to help the child feel part of their family.

The parents responded unanimously that the first thing they would tell the friend would be to call the Aspen Valley Center and arrange to take the child there. They would tell their friend about parent psychoeducation and filial therapy and how helpful that process was to them in creating a strong bond within their families.

Carlee, Elizabeth, Morgan, and Stella would all talk about the situation the child was coming from, noting that removing the child from a bad situation wasn’t going to change what’s inside the child. Stella said they “would have to have room in their child’s life for those other people you don’t know that had an impact.” Morgan said that they would learn to recognize when the child was working through issues that they didn’t know about, and receive the power from knowing that the child’s behavior was not directed at the new parents, but coming from old hurts. Elizabeth would warn that the process was not easy and to guard against romanticizing it.

Julie would explain to the couple to hold and cuddle the child, read to him/her, speak softly, get down on the floor to play with the child, and think about the experiences of loving and caring that the child might not have received in prior settings.
Kate said in her work as a registered nurse at a major medical center’s pediatric division that she has made referrals to the Aspen Valley Center directly from the medical center, citing an example of a family adopting an eleven-year-old Haitian girl who had never been out of the orphanage. John added that he and Kate talked about the center with the mother of a teenage girl who had babysat for them, since the girl was adopted and spoke with John and Kate about some issues she had.

Making Parent Psychoeducation and Filial Therapy More Helpful

During the final portion of the third interview, parents were given the opportunity to reflect on how the process of parent psychoeducation and filial therapy could be made more helpful to families like theirs.

The five families were unanimous in saying that they believed that the actual process of parent psychoeducation and learning filial skills was helpful just as it was carried out in their case. However, they offered a variety of opinions on other aspects of parent psychoeducation and filial therapy.

Four of the mothers said that having a playroom that could be rented by the hour for filial therapy would be very helpful. They talked about how some families were limited on space, and other families struggle with getting the right mix of toys. Also mentioned was the presence of other children in the home when the parent wanted to have special time with the identified child. Work schedules and busy lives in general were other reasons why scheduling a room that was already set up was an attractive alternative to those mothers.

Two of the families recommended better outreach. They said that many people do not know about the help that the Aspen Valley Center can provide. Since
almost all of the parents in this study were professionally trained, they all spoke about how more child therapists needed training and supervision in providing filial therapy, and that parents needed to know how to find a child therapist who was trained and registered as a play therapist. Another suggestion made was going to graduate schools to talk with groups of graduate students about studying filial therapy.

Suggestions made to improve the process included having filial therapists teach parents all the different ways that filial techniques can be used in daily life. Kate and John described how using reflection when William was feeling anxious, and talking to him in the ways they learned in parent psychoeducation helped him reduce his anxiety regardless of where they were physically when William became anxious. Stella and Andrew also spoke about using reflection in multiple settings with David and Charlie, as well as adult family members. Two fathers stressed that filial therapy was not about toys, it was about the relationship.

Several other suggestions had merit for anyone who works with children and families. Morgan and Julie thought that school guidance counselors needed to know aspects of the filial responses to use with children in school. They also stressed that children and youth services workers should know about filial therapy, and refer to a filial therapist those families who were being reunited with their children after the children had been removed from their care. As Julie said,

People go for drug rehab, but you could do family rehab. You have a family that’s falling apart, and you have that filial therapist working every day with the family. I don’t know, maybe that’s a dream.
As a researcher and therapist who provides parent psychoeducation in my private practice, I believed that the ideas of expanding the use of the filial techniques to other settings and emphasis of the relationship rather than the toys had merit. Giving guidance counselors and children and youth workers a modified training on the filial skills would in my opinion, increase their efficacy when working with children. However, I would try to be more sensitive to the needs of the parents who struggled with feelings of inadequacy over the array of toys and space they had to offer, since the design and content of a professional playroom can create unrealistic expectations. Andrew's and John's statements about the process being more about the relationship reflected a good understanding of what really matters to the child.

**Chapter Conclusion**

The five families in this study reflected on their experiences and shared deeply moving stories about their decision to adopt, the challenges presented by the children, and their decision to seek help. Through their work with the therapist at the Aspen Valley Center, they found support, encouragement, and the skills they needed to begin the process of healing their adopted child’s disrupted attachment and creating a healthy affectional bond among all the members of the family.

As the parents responded to the various questions in the interview, they described what the experience meant to them as they created a family with their adopted child. Because the families all had different needs and compositions, their descriptions varied accordingly. Several parents spoke of difficult situations that arose for their child, and how they used their filial skills to help the child work through the situation and return to a sense of balance and calm in the family.
The emphasis and perspective described by the study participants were consistent with the emphasis and perspective of filial therapy and the tenets held by specific theorists in the field of adult education. The adult learners (parents) were involved as partners with the adult educator (filial therapist) in the process, learning culturally and contextually appropriate skills for working with their child in their home (Lindeman, 1926; Vella, 2002). Since play was considered the child’s language (Ginott, 1960), parents were taught and supervised in therapeutic play sessions with their child as they learn to create safety for the child, giving the child the opportunity to express thoughts and feelings while being met with acceptance and positive regard (Van Fleet & Sniscak, 2003). When the parents were discharged from the services of the filial therapist, they left with skills that will serve them throughout the rest of their lives. From the perspective of the adult educator, the primary change agent was the adult learner (Merriam, Caffarella, & Baumgartner, 2007). From the perspective of parent psychoeducation and filial therapy, the primary change agent was the parent.
Chapter Five: DISCUSSION, RECOMMENDATIONS, AND CONCLUSIONS

The final chapter of my dissertation reviews the findings from this phenomenological study of eight adults who created their families through adoption and turned to parent psychoeducation and filial therapy in learning to help their child work through the issues of disrupted attachment and to form a new and positive bond of emotional attachment between the parent and the child. Five major themes were found in the findings of the previous chapter:

1) The desire to be a parent but not necessarily through childbirth;
2) The decision to seek education about increased parenting skills due to escalating concern the parent was not able to help the child;
3) The ease in learning filial skills with the help of the skilled parent psychoeducation process;
4) A systemic positive change in behaviors and emotions of all members of the parent-child dyad or triad, and
5) The reflection on their experiences yielded information about the different types of learning that the parents had experienced.

The bearing of the theories of Dewey, Lave and Wenger in adult education, and of Freedberg in feminism to the lived experiences of the families will be discussed, and aspects of trauma, attachment, and contextual issues that challenged learning are introduced to provide additional understanding of underlying factors for both parent and child. I review the findings in light of the four research questions, and present my conclusions on the role of parent psychoeducation as part of adult education. The chapter concludes with recommendations for
improvement in the use of parent psychoeducation with adopted families and for future research into the subject, and identifies some of the limitations of the study.

**The Lived Experience of Creating A Family through Adoption**

This phenomenological study sought to describe and to understand the lived experiences of parents in adopting children with attachment difficulties and using parent psychoeducation from a therapist trained in providing filial therapy. Specifically, this study emphasized how the adults chose to be adoptive parents, how they selected parent psychoeducation/filial therapy as a way to help their child, and how they described their experiences providing therapeutic play at home. The final phase of the study asked the families to reflect on the meaning of being their child’s therapist. Throughout the study parents described the types of learning they experienced. The study was comprised of participants from various points in the parent psychoeducation cycle: those who were still in the training/supervision stage, others who were actively providing sessions at the present time, and others who had completed the process with their child. The eight adults who participated in the study consisted of seven individuals who had adopted their child, and represented two married couples, one same-sex unmarried couple, and one single parent. The eighth adult was a grandmother who was providing kinship care to her granddaughter, a child who was not legally free for adoption. The five children involved had all experienced a disruption in at least their primary mother-child relationship, with some of the children experiencing multiple disruptions. All the parents had sought help for their families through parent psychoeducation and filial therapy, and represented the three phases of the process.
The last step of a phenomenological study developed a composite description of the phenomenon that elucidated the participants’ experience and how it was experienced (Creswell, 2007). In the next sections I discuss the composite description of the their lived experiences that made them what they were (Kafle, 2001), with successes and challenges, as they moved through their decisions to adopt, to accept a child for placement, and to become involved in parent psychoeducation and filial therapy.

**Choosing Adoption to Create a Family**

The first research question explored how the parents came to adoption, and what life experiences had influenced that decision. Seven of the parents in the study discussed openness to accepting children into their families who were not related to them through blood. They spoke of a desire to be a parent but not necessarily through childbirth. Two of the couples, Andrew and Stella, and John and Kate, did have biological children following their adoption, with Kate and John adopting two sons before the birth of their daughter. The parents reflected on various influences that had shaped their decision, including baby-sitting as teenagers for adopted children, coming to terms with their sexual orientation, and experiences with infertility and failed pregnancies. Their stories showed that much thought and introspection had contributed to their decision to adopt.

**Deciding to Seek Help**

The second research question inquired about the family's experience as the new child settled into the home. The parents were asked about the factors that influenced their decision to seek help. All the parents in the study came to the
conclusion to seek help in learning increased parenting skills due to either behaviors that baffled the parents or a concern about the influence of previous adverse events upon the child and a desire to help the child work through these issues. The children displayed behaviors that did not respond to the parents’ existing skills. Parents were not always aware of specific factors in the children’s previous lives that could be influencing present behaviors, but suspected that there would be issues due to the information they did have. Parents wanted to receive education and supervision on the best ways to help the children.

Although the parents all expressed concern for their children, there was a difference in this finding related to the point of origin of the child. Stella and Andrew, along with Elizabeth, were the two families who adopted children from Guatemala, receiving them as infants. The younger of the two was five months, and was described by his parents as “happy and delighted with everything.” The older infant was ten months, and according to his mother “was very intense and strong-willed.” The challenging behaviors emerged during the preschool years, and the parents expressed a sense of desperation since their efforts to control the behaviors did not work. Parents expressed the frustration of not knowing where to turn to manage behaviors such as violent tantrums, throwing things, biting others, and an intense need to control by the child. The families were not prepared for the emergence of these troubling new behaviors, which were consistent with the literature on children with disrupted attachment and concomitant behaviors of defiance, acting out, and an extreme need to control (Cain, 2006). Elizabeth’s son
Dee was on the verge of being expelled from day care. She considered parent psychoeducation and filial therapy to be her last resort.

Kate and John, and Julie and Morgan were the two families who adopted children who were removed from their biological parent(s) by court action and placed either with extended family or in foster care. Carlee, the grandmother caring for her son’s child, also received her granddaughter through court action to remove her from her biological parents. These families encountered a different path to therapy. Three of the five parents in this subsection of the study were trained professionals who work with children. The combination of information shared at the time of placement with the parent’s existing knowledge of children in general led these families to see that mental health services for their child and themselves as well would be helpful. While reflecting on their experience, these parents said, “We needed advice on some of the issues”, or expressed concern about “the effect of the adversarial relationships” in the custody situation of kinship care. Julie responded eloquently, saying, “We needed to develop attachment with him. We are both very different and he needed to attach to both of us. Filial therapy improved our emotional and mental health. His issues were his issues and it wasn’t about us. The more we understood that the easier it became.”

Reflecting on the Experience of Parent Psychoeducation and Filial Training

The third research question sought parental reflection on their experiences with parent psychoeducation, their experiences offering therapeutic play sessions to the child, and the meaning derived from being their child’s therapist. Three of the study participants spoke of not knowing what to expect at the beginning of their
experience with parent psychoeducation. The remaining participants expressed relief that there was a way to help their family, found that the child-oriented communication skills made working with their child easier, appreciated the demonstration of skills and the associated reading material, and overall, discovered that the experience was fun for them. The parents found that the receptivity of the parent psychoeducator to their concerns, her validation of their concerns about the child, and her overall warm and approachable manner allowed them to develop a relationship with her that promoted and expedited their learning.

As the parents reflected about the meaning of the experience, the meaning of the relationship was clearly important to them, since they spoke about “recognizing and honoring the things he has gone through”, and “the creating of a strong and sustaining bond among us.” Parents described the meanings they had realized through understanding the themes of the child’s play. John and Kate explained the confidence that grew in the two of them as parents, realizing they had learned skills that could help William, learning that “we can understand him and help him get through his feelings.” Carlee described her ability to transfer her learning about and understanding of the issues Katelyn displayed during special time to make changes in the day to day routine as very meaningful for her. Andrew believed that his and Stella’s ability to work with David at home strengthened and enhanced their bonds as a family, saying that the experience was very meaningful for him.

Types of Learning Reflected in the Experiences Parents Described

The fourth research question explored the types of learning reflected in the experiences that the parents described. Parent psychoeducation addressed the
principles of flexibility, continuity, and intellectual growth, and included a plan, which identified what was to be done, and how it was to be done (Dewey, 1938/1998). Although a trained filial therapist would modify the training schedule to fit the needs of each family, the general process involved demonstrating the skills and providing the parents with one on one practice of the skills with the therapist, along with discussion for the particular child and parents of the impact of child development, attachment history, and histories of trauma and abuse, if needed. The parents then practiced with their child in the therapist’s office, eventually transferring the sessions to home with continued supervision from the therapist. Ultimately the therapist discharged the family, who continued the sessions as needed. Some of the parents found that certain skills were similar to skills they learned in their professional training, which expedited learning for them. Skills that they believed needed work for them to master included focusing on the child’s emotions and play in order to correctly reflect what they were seeing, and refraining from asking questions and directing the play. These two skills required the most intellectual growth for the parents, because they had to work through previous learning and practice that differed from the child-centered, non-directive approach that characterizes the practice of filial therapy (Dewey, 1938/1998; VanFleet & Guerney, 2003). However, the practice of the skills with their child in the therapist’s office and the supervision with the therapist helped increase parental confidence about the correct performance of the skills. The circumstances where learning occurred were those of situated learning, where learning was carried out in the real-life interaction between the parent and child in the filial session. The deepening
relationship between the parent and child as the learning proceeded emphasized the nature and quality of connectedness to others, an essential tenet in relational theory (Freedberg, 2009). Parent psychoeducation addresses two central components of positive parenting: the relationship between parent and child, and skills for parents that can be used outside of the therapy session (VanFleet and Guerney, 2003).

**Positive Changes in Behaviors and Relationships**

Giving additional insight into the third research question that explored parental experiences with parent psychoeducation, the parents spoke of overall improvement not only in their relationship with the child but also in their relationship with each other. They noted a decline in problematic behaviors, an increase in the child’s manageability, and a feeling of confidence that they now had skills to help their child, skills that were transferable to settings outside of the special playtime and to other relationships within their nuclear and extended families. Three parents noticed that their child was more adept in expressing emotions, and four remarked about less acting out. Other positive behaviors noted in the children were improved ability to listening, less anxiety, being more present with the parent, feelings of physical closeness, and increased trust. Parents also commented on their increased understanding of child development and behaviors.

All the parents noted some progress toward the four markers of attachment that were outlined in Chapter Three, page 67. The marker still needing work was the child’s increased ability to understand feelings and understand what to do to become calm. Parents described their experience as a work in progress and several
commented about having skills to approach their children about feelings. The other three markers were endorsed to a greater degree by the parents. Seven parents believed that they and their child were better able to talk about feelings and communicate them to one another. Six parents described their child as more willing to explore new environments, with two additional parents noting that their child's physical disabilities influenced his willingness to explore. Six parents thought that their child was experiencing a greater sense of security with them, with one of the six commenting that the child could be situationally insecure. Two parents believed that insecurity with them had not been an issue for their child.

In conclusion to this section about the findings and themes of the study, the parents’ discussion of increased trust, confidence, and security loaned itself to a systematic, circular influence on the increased affectional bond between the parents and child. As the parent became aware of the child’s positive response to them in special playtime, the parent felt rewarded and the child sensed the parent’s increasing acceptance of their play. The parent’s responses and confidence in using the filial skills helped the child feel safe, decreasing the need for the defensive behaviors and increasing the likeliness of the child’s positive response to parental directives and suggestions outside of the special playtime. If both parents were using filial skills, seeing the progress of the child reduced some of the stressful feelings between the parents, and positive responses from one parent to another produced similar positive feelings to the ones between parent and child. The filial process supported improved communication all around in the family, and gave the
parents a feeling of competence about their actions, which was rewarding to the adult.

**Integration of Parent Psychoeducation, Theoretical Perspectives, and Phenomenological Studies**

Chapter Two identified three theoretical perspectives that I believed to be helpful in understanding the responses of adult learners in the parental role to their experiences with parent psychoeducation and filial therapy. Two theoretical perspectives from the field of adult education included Dewey’s (1938/1998) experiential learning, and Lave & Wenger’s (1991) situated learning. The final theoretical perspective, drawn from feminism and social work, was Freedberg’s (2009) relational theory.

As parents described their journey through the training and practice aspects of filial therapy, Dewey’s words, “experiential learning... depends on the quality of the experience which is had” (1938/1998, p. 16) resonated through their stories. The specific aspects of parent psychoeducation that address the child’s particular life circumstances and their contribution to the child’s behaviors provided quality to the “experience which is had” as did the practice, supervision, and eventual transfer of the skills to the home setting. The parents’ positive reactions to the filial process and their ability to apply the skills in multiple settings with multiple recipients attested to the quality of their learning.

The fact that the skills of filial therapy can only be learned through practice in their use echoed the premises of situated learning (Lave & Wenger, 1991), that learning develops as an activity proceeds. The learning process cannot be separated
from the situation where it occurs. From the earliest stages of the parent
psychoeducation, where the therapist demonstrates the skills and has the parent
demonstrate them back, to the practice of the skills with the child in the therapist’s
office, with therapist feedback after the session, to the eventual transfer of the
practice setting to the home, the learner’s learning was supported through the
utilization of current and prior knowledge due to the parents learning to adapt the
skills to the actual needs of their adopted child. The learning was situated in real-
life problem solving between parent and child.

Feminist relational theory avers that relatedness with others is a necessary
condition for physical survival. These relationships are characterized by mutuality,
empathy, and affinity, based on a relationship where each is seen as a whole person,
with accompanying awareness of the subjective experiences of each. Feminist
relational theory was found in the role of parent psychoeducation and filial therapy
as it developed a new worldview for the child with a disrupted attachment, where
the new growth was undergone in the presence “of a finely shifting balance of
connection and differentiation with significant others” (Freedberg, 2009, p. 22).

The parents’ discourse suggested something deeper in their stories of their
experiences. As I moved from the analysis of the findings to some conclusions and
recommendations about their use, I found the theoretical perspectives helpful in
thinking of ways that parent psychoeducation and filial therapy can be better
understood presently and be enhanced in the future.
The Role of Parent Psychoeducation in Adult Education

As the parents moved through the process of practice, supervision, and discharge, they found learning about their child’s behaviors and their contributing factors through the psychoeducation process was very helpful. Parent psychoeducation taught them about behaviors and their contributing factors. Specific characteristics of the child and parents were integrated into the teaching and learning since parents adapted the filial skills accordingly. Because parent psychoeducation and filial therapy are built on the existing strengths of the parents and the specific needs of the child, their process of seeking the adult learner’s own expertise and recognizing accompanying strengths was consistent with the tenets of adult education expressed in the works of Brookfield (2000), Lindeman (1926), and Vella (2002). The premise that “adult learning is best achieved in dialogue” (Vella, p.3) described the interaction not only of the therapist and the parent, but also of the parent and the child. The process was also consistent with principles of adult education that hold that adult learners bring their own experiences to the learning situation (Merriam, Caffarella, & Baumgartner, 2007; Heaney, 1995).

As discussed in Chapter One, a critical analysis of issues presented by parent education included such criticisms as being an instrument of social control, being a tool for assimilation of differences, maintaining the role of expert, and devaluing the mother’s experiential knowledge. Additional subtle issues concerned the educator/practitioner’s manipulation of parental goals, excessive pressure to alter behavior, and pressure by the practitioner for information that the parents may not want to disclose. Parent psychoeducation, as designed by the Guerneys and
VanFleet, sought and respected parental knowledge of the child’s behaviors and interactions and integrated that knowledge into the teaching process, tailoring every phase of the program to the unique aspects of each set of parents and child. However, if following a session where the parent psychoeducator/ filial therapist reviewed and explained the process, a parent was uncomfortable with the idea, the parent was not pressured to engage in the process. The filial therapist respected the goals and wishes of the parent. The process of engaging in parent psychoeducation is totally voluntary and tailored to the needs of each family, addressing issues of social control and assimilation of differences. As discussed in Chapter Three, when the parents seek the filial therapist, they are actively seeking an expert, one with demonstrated knowledge of both process and content. However, the conditions created by the experienced therapist also promote the parents’ increased expertise and application of the filial skills and provision of “special time” for the child.

The filial therapist, in the supervision role, actively describes to the parents the strengths they were demonstrating in the special playtime, validating their efforts. As Elizabeth said,

“I couldn’t have done it without her. Sometimes it was just as simple as remembering how she worded something, or remembering her enthusiasm that kept me going. And her encouragement and her thinking how wonderful my son was – that was helpful – I couldn’t have done it without that.”

From the beginning of the parent psychoeducation process, parents believed that eventually they would gain the skills to work with their child at home. The
skills were communicated to the parents by the therapist, and learned through the situated practice with the child. Parent psychoeducation, as executed by a trained filial therapist, is intended to return the locus of control to the parents and place the parents in the role of change agent for their children.

The emphasis and perspective described here are consistent with the emphasis and perspective of Lindeman (1926) and Vella (2002). The adult learners (parents) were involved as partners in the process, and learned culturally and contextually appropriate skills for working with their child in their home.

**Recommendations Specific to Adoption and Parent Psychoeducation**

Statistics have shown that the overall incidence of child maltreatment, domestic violence, and serious mental illness in parents is slowly declining (USDHSS, 2013). Nevertheless, we cannot think in aggregates alone when we are thinking of helping families. We must look at the child who is waiting for a family and at the parents who want to build a family through adoption as single entities in search of solutions.

The parents who participated in this phenomenological study on the experiences of adults who chose parent psychoeducation and filial therapy to help an adopted child with a disrupted primary attachment identified the following recommendations for parent psychoeducation and filial therapy in work with families who adopt children.

- Adoption needs to be more widely promoted as a way to create families among people who wanted to be parents
• Help for parents needs to be provided while the problem is active. Although many adoption agencies offer parent education about adoption as part of the approval process for adoption, this is not the kind of help that is useful when parents are perplexed about behaviors.

• More professionals who work with children and families in educational, healthcare, and service settings need to be knowledgeable about attachment, including the implications of disrupted attachment and concomitant behaviors; and to be knowledgeable about parent psychoeducation and filial therapy as an intervention that could address those problems.

• Parent psychoeducators need
  
  o to include information on the meaning of child responses in therapy to parents,
  
  o to develop confidence in the parents about the skills of filial therapy,
  
  o to include information about how children’s behavior changed as their feelings of safety and security increased, and the impact of these changes on the parental relationship, and
  
  o to discuss with parents the applicability of the filial skills outside of the special play time, and identify instances where the skills could be helpful.

In listening to the families speak about their experiences and needs as adoptive families, I identified some additional recommendations based on what the families said as well as from my experience as a board member for the Pennsylvania Association of Play Therapy and a trainer of play therapy.
• Families may benefit from support groups for post-adoptive families, because after the adoption is finalized and the filial therapist has completed treatment, the family finds itself alone, and may benefit from a way to periodically get together with other post-adoptive families.

• Training and supervision for professionals who work with children and families in educational, healthcare, and service settings needs to be more widely available and affordable.

• Training and supervision on attachment disruption in children and its concomitant behaviors, and on filial therapy as a means to address attachment disruption needs to be more widely available and affordable.

**Limitations of the Study**

The goal of a phenomenological study is to describe and understand the lived experience of adults who had chosen adoption as a means to create a family, and who chose parent psychoeducation and filial therapy as the way to help their child. To that end, I was provided with rich detail from five families as they told me of their experiences from the beginning of their desire to adopt through the present time. I am hopeful that the stories of these families will provoke additional questions in the readers’ thoughts about how to help families who adopt.

On the one hand, the families were diverse in their demographics, with differences in ages of family members, family composition, and ethnicity of family members. This provided a sense of across-the-board consistency in the experiences due to people who had no previous knowledge of one another telling stories that were similar. However, seven of the eight adults involved had master’s degrees,
giving them some resources that another population may have not enjoyed.

Additional studies need to be undertaken with parents from a broader spectrum of educational attainment, and of other demographics different from the ones associated with this study.

Another limitation may be the small number of participants in the study. What reasons did the nine families who were invited to participate but did not respond have for not responding? An effort should be made to learn how to best recruit families, and to better understand reasons for not responding. Whether or not the family had a positive experience with parent psychoeducation could have been a self-selection factor (Rubin & Babbie, 2014). The nine families that did not respond had all been discharged from the Aspen Valley Center, and may have not wanted to revisit their experiences. Another factor that could have possibly influenced the response rate was the time of year the recruitment letter was mailed (October/November). A request to participate in research, received just before the major U.S. holiday season, may have caused the family to think it had no extra time to spare.

This is the first known phenomenological study of the experiences of families who adopt children with disrupted attachment, with a focus on parent psychoeducation and training in filial therapy skills. One other study with solely adoptive families, quantitative in nature, was carried out as a doctoral dissertation at the University of North Texas (Carnes-Holt, 2010). One of the recommendations from that dissertation was for qualitative studies to be conducted “to provide greater insight and understanding of the CPRT [filial therapy] process and
experience with adoptive families” (p. 80). This study is the first step in providing that greater insight and understanding by offering the lived experiences of five families about their adoption and their practice of filial therapy.

**Recommendations for Additional Research**

Given the numbers of children being adopted at ages beyond birth in the United States, continued study of the outcomes of parent psychoeducation with this group is imperative. In FY 2011, in the United States Foster Care System, 50,516 children were adopted, and 104,236 were waiting for adoptive placement (USDHHS, 2012). The *Adoption USA Chartbook* (2009) estimated that 8% of all adopted children over the age of 2 years will have moderate to severe behavioral problems, and 12% of adopted children will have difficulties with attachment. These are the children who are likely to benefit from services designed to build a healthy attachment with their new family.

Based on the findings of this study and the discussion of limitations, recommendations for further research include

- continued study of the lived experiences of families who adopt children with disrupted attachment, seeking a broader range of family demographics
- a focus on long-term adjustment of families who had utilized filial therapy at one time, with adolescent or young adult children who had been the subject of filial therapy when younger invited to participate in qualitative research about their experiences
- Quantitative or mixed method studies that compared parent psychoeducation and filial therapy with other therapeutic models used with
adoptive families, such as theraplay (Jernberg & Booth, 1999), parent-child interaction therapy (Eyberg, Funderberk, et al., 2001) or dyadic developmental therapy (Hughes, 1997).

**Conclusions**

Stella responded to the question about what the experience of being her son’s therapist had meant to her by saying, “It taught us a whole new way of being. Our foundation is strong and is going to sustain us.” A little more than eighty years earlier, Gruenberg (1931) had urged recognition of the fact that most people were parents. She said, “No plan of education for adults can be complete that does not take into account this important aspect of adult life and interest” (p. 456). It would appear that parent psychoeducation can play a part in a solid plan of education for adults in creating sound parent-child relationships not only for families like Stella and Andrew, but for any other parent interested in forming a more positive relationship with a child.

Jordan (1991) described the essential relationship between two or more people, summarizing the experiences of the families in this study:

Mutual relationships in which one feels heard, seen, understood, and known, as well as listening, seeing, understanding, and emotionally available, are vitally important to most people’s psychological well being. In many ways we know ourselves through relationship.... We provide for the other, and we also receive the gift of ... “the accepting, confirming, and understanding human echo” (p. 96).
The lived experiences of the five families in this study revealed that not only did the bond of affection with the child grow and begin to flourish, so did the parent’s relationship with the other parent. Over time, parent psychoeducation and its accompanying filial therapy skills have established their robust nature by demonstrating their effectiveness in different parent-child combinations, different settings, and different cultures and ethnicities (VanFleet & Guerney, 2003). In this small study, there were several different parent-child combinations and different cultures and ethnicities, but the lived experiences described resonated with one another, as the adults spoke about their feelings of competence, increased positive regard for one another, and skills that could be used in different circumstances and other times. The courage and tenacity of these families as they worked to help their children was something that I shall always remember, and it is my hope that the rich detail of their stories will inspire others to appreciate the dedication of human beings in creating a family.
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## Appendix A: FILIAL PLAY THERAPY SEQUENCE

<table>
<thead>
<tr>
<th>Early Phase</th>
<th>Middle Phase</th>
<th>Closing Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Assessment:</strong></td>
<td>4. <strong>Training:</strong> Therapist conducts skills-training exercises and mock play sessions with parents.</td>
<td>7. <strong>Generalization:</strong> Efforts to help parents generalize skills throughout therapy</td>
</tr>
<tr>
<td>social and developmental history, family play observation, pre-measures.</td>
<td><strong>5. Filial Play Sessions:</strong> Parents conduct play sessions under direct therapist supervision</td>
<td><strong>8. Discharge Planning:</strong> Direct supervision of play sessions; discharge planning process</td>
</tr>
<tr>
<td><strong>2. Discussion:</strong> Filial therapy rationale and process.</td>
<td><strong>6. Transfer:</strong> Filial play sessions at home; therapist discusses with parents and teaches additional parenting skills</td>
<td><strong>9. Final Assessment:</strong> By parents and therapist; post-measures</td>
</tr>
<tr>
<td><strong>3. Demonstration:</strong> Therapist conducts child centered play session with child; parents watch.</td>
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Appendix B: THE LEARNING OUTCOMES AND TREATMENT GOALS OF FILIAL THERAPY

For Children:

• To understand, express, and regulate their emotions
• To develop problem-solving skills
• To reduce maladaptive behaviors
• To feel more trust and security with their parents
• To gain mastery while being responsible for their own actions
• To develop interpersonal skills.

For Parents:

• To increase their understanding of child development and set more realistic expectations for their children
• To increase their understanding, warmth, trust, and acceptance of their children
• To learn the important and interplay of their children’s play, emotions, and behaviors
• To communicate more effectively with their children
• To develop greater confidence as parents
• To reduce the frustrations experienced with their children, and enjoy them more.

For the entire Family:

• To reduce or eliminate presenting problems and conflicts
• To strengthen family relationships and bonds
• To develop greater mutual trust and higher cohesion
• To improve communication and coping skills
• To have more enjoyable interactions with each other
• To be more flexible and adaptive overall
• To develop relationship tools that will serve them now and in the future.

(Van Fleet, Ryan, & Smith, 2005, pp. 243-244)
Appendix C: INFORMED CONSENT FORM FOR SOCIAL SCIENCE RESEARCH

The Pennsylvania State University

Title of Doctoral Research: Creating Families: Parent Psychoeducation and the Experience of Parents Adopting Children with Disrupted Attachment

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TO BE DISCUSSED WITH PARTICIPANTS PRIOR TO THEIR SIGNING.

1. **Purpose of the Study:** The purpose of this research study is to describe the experience of parents who adopt children with attachment difficulties, and who use parent psychoeducation (filial therapy) provided by a therapist trained in filial therapy.

2. **Procedures to be followed:** You will be asked to talk about your experiences deciding to adopt a child, how you learned about filial therapy, your experiences working with your child in the therapist’s office, and your experiences after you began working with your child in your home.

   You will be asked to complete a short written survey about your family prior to your first interview. I will schedule three one hour interviews with you at your therapist’s office at a time that is convenient for you. If you prefer, the three interviews can be combined into two 90 minute sessions.
I will ask you about several topics:

- How you decided to adopt, reflecting on experiences that influenced you
- Your experiences with your adoptive child after placement
- Factors that influenced your seeking help in managing your child’s behaviors
- Your thoughts about filial therapy as you met with your therapist and learned how to practice it with your child
- Your experiences with playing with your child in the therapist’s office
- Your experiences with having sessions with your child at home
- Your experiences in being your child’s therapist
- Your reflection on whether your relationship with your child changed

You will be asked to consent to audio recording of your interviews. This is to assist me in understanding your experiences with filial therapy and to allow me to focus on what you are telling me without needing to take notes. The recordings will be destroyed at the end of the research.

3. **Checking the Transcript:** You will be asked to read over the transcribed record of your interview. This will allow you to ascertain that the transcript accurately reflects what you said. Any changes that you believe need to be made to the transcript will be made.

4. **Discomforts and Risks:** There are no risks in participating in this research beyond those experienced in everyday life. Some of the questions are personal and might cause discomfort. You may find it emotionally difficult to discuss the important relationships in your life and the feelings you may have about them. You may decline to answer questions with which you are uncomfortable, and I will ensure that you do not feel pressured to disclose any information that might cause you discomfort.

5. **Benefits:** You might learn more about yourself by participating in this study. You will learn more about your experiences in working with your child. This study will help therapists, supervisors and educators of therapists, and other parents contemplating adoption learn about the experiences of those who adopt children and how parent psychoeducation can help families form positive attachments with children and make them a part of the family.

6. **Duration:** It will take about 60 minutes to complete each of the three interviews. If you would prefer, the three interviews can be consolidated into two interviews that would take up to 90 minutes to complete. The study will take up to two months to complete with you.
7. **Statement of Confidentiality:** Your participation in this research is confidential. I will not use your name or any other identifying information in reports or other documents. I will ask you to give me a fake name to use in discussing your experiences in my dissertation or any article I may write or presentation I may make about my research. In the event of any publication or presentation resulting from this research, no personally identifiable information will be disclosed. I will use your fake name and a coding system to keep track of data from the research. I will keep recordings, tapes, and electronic documents on a password-protected computer system and/or in locked file cabinets in my office. Only myself or my transcriber will have access to these. The audio recordings will be destroyed after the study has ended. The Pennsylvania State University’s Office for Research Protections and Institutional Review Board, and the Office for Human Research Protections in the Department of Health and Human Services may review records related to this project.

8. **Right to Ask Questions:** Please contact me at (814) 590-2978, or my advisor, Dr. Thompson at (814) 863-0614, with questions, complaints, or concerns about this research. You can also call me if you feel this study has harmed you. If you have any questions, concerns, problems about your rights as a research participant or would like to offer input on the process, please contact Penn State University’s Office for Research Protections (ORP) at (814) 865-1775. The ORP cannot answer questions about research procedures. All questions about research procedures can only be answered by myself as the principal investigator, or by my advisor.

9. **Payment for Participation:** You’ll receive a $50.00 gift card for your participation in this study.

10. **Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions that you don’t want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

You must be 18 years of age or older to take part in this research study.

Are you still willing to participate?

YES  NO

May I audio-record your interviews?
Yes, I give my permission to be audio-recorded.

_______ (Initials of person obtaining consent)  _______ Date

No, I do not wish to be audio-recorded.

_______ (Initials of person obtaining consent)  _______ Date

Following your interviews, may I use the information for future research, education and training, such as conference presentations, journal articles, and university classes, with the understanding that no identifying information will be included?

Circle two options:

1. I give permission for my recordings to be archived for use in future research reports and publications.

2. I do not give permission for my recordings to be archived for future research reports and publications. The records will be destroyed after the completion of the project.

3. I give permission for my recordings to be archived for educational and training purposes.

4. I do not give permission for my recordings to be archived for educational and training purposes. The records will be destroyed 3 years after the completion of the project.

_______________________________________________  __________________
Printed Name of Participant  Date

_______________________________________________
Signature of Participant

_______________________________________________  __________________
Signature of Person Obtaining Consent  Date

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM
Appendix D: INTERVIEW FORMAT AND QUESTIONS

(Parents are to be given the choice of two or three interviews. Interviews #1 and #2 may be combined)

Points to go over before starting interviews

• Introduce myself as a doctoral student in adult education at Penn State, an instructor of human development and play therapy, and a former instructor of graduate social work; a private practitioner that works with children and families, and a licensed clinical social worker with 39 years of experience with families and children.
• Explain the research purpose which is to talk with families who have adopted or who are in the processing of adopting, children about their experiences
• Explain the goal of the research which is to learn how their experiences with filial therapy (parent psychoeducation) affected their relationships with their adopted child
• Obtain an informed consent form

Interview #1

This interview will focus on the participant’s experiences in becoming an adoptive parent, and learning about parent psychoeducation/filial therapy.

1. Tell me about how you decided to become an adoptive parent.
2. What do you think were some of the things in your life up to that point that influenced you in making the decision to adopt?
3. What was (child’s name) like when s/he came to live with you?
4. How did you find out about (therapist’s name) and (agency name)?

Interview #2

This interview will focus on the participant’s experience with filial therapy.

1. What was it like learning filial therapy?
   a. What skills did you find easiest to use?
   b. Were there any skills that were more challenging for you?
2. Tell me about the time when you started to play with (child’s name) here in (therapist’s name)’s office.
3. Tell me about how it was when you started doing sessions at home.
4. Did you continue to do sessions after you stopped seeing (therapist’s name)?
5. Tell me about any differences you observed with (child’s name) after special time began
6. Some people report changes like these ones:
   a. your child experiencing a sense of security with you
   b. your child being more able to understand feelings and what to do to become calm when upset
   c. you and your child are more able to express feelings and communicate them to others
d. your child is more willing to explore a new environment

7. Did you notice any changes like those with your child? Please tell me a little about how you knew something was different.

8. Were there any differences in your feelings toward (child’s name)?

9. Are you still doing sessions, or did you stop and then do them as needed?

10. Did you (and your spouse, if there is one) adopt (child’s name)?

11. Is there anything else you would like to tell me about your experiences?

Interview #3

This interview will give the participant the opportunity to reflect on the meaning of being able to do therapy with their child, and to reflect on the first and second interviews.

1. What has this experience meant to you, being your child’s filial therapist?

2. Can you think of some ways that your relationship with (child’s name) has changed over the past two years?

3. Did the discussions with (therapist’s name) and the information she shared with you help your understanding of what (child’s name) had been through before coming to your home? Can you give me an example of something that helped you?

4. How would you describe your skills as a parent now?

5. Some parents say that they have noticed some changes like these ones. Please tell me if you noticed any changes like this and how you recognized it.
   
   • To increase your understanding of child development and set more realistic expectations for your children
   • To increase your understanding, warmth, trust, and acceptance of your children
   • To learn the important and interplay of your children’s play, emotions, and behaviors
   • To communicate more effectively with your children
   • To develop greater confidence as parents
   • To reduce the frustrations experienced with your children, and enjoy them more.

6. Some parents say they have noticed changes like this in their family. Please tell me if you noticed any changes like this and how you recognized it.
   
   • To reduce or eliminate presenting problems and conflicts
   • To strengthen family relationships and bonds
   • To develop greater mutual trust and higher cohesion
   • To improve communication and coping skills
   • To have more enjoyable interactions with each other
   • To be more flexible and adaptive overall
• To develop relationship tools that will serve them now and in the future.

7. If tomorrow one of your friends called you to tell you that they were going to take a five-year-old child into their home, what would you tell her?
8. Are there any changes that could be made to filial therapy to make it more helpful to families like yours?
SARA JEAN CAMBERG, LCSW, RPT-S

Education
- **MSW**, concentration in health and administration, Marywood College, Scranton, PA, 1984
- **BS**, The Pennsylvania State University, University Park, PA, 1971

Professional Experience
- The Pennsylvania State University, Altoona Campus, Altoona, PA; (2012 to Present) Full Time Instructor HDFS
- Temple University Graduate School of Social Administration, Philadelphia, PA; (2005 – present), Adjunct Instructor of Social Work
- Harbor House Trainings, LLC, Clearfield, PA (2010 to present), Lead Trainer
- Private Practitioner, Clearfield, PA 16830 (2006 – present)
- Cen-Clear Child Services, Philipsburg, PA (1996 – 2007), Professional Social Worker
- DuBois Regional Medical Center, DuBois, PA (1979 – 1989) Professional Social Worker
- Children and Youth Services, Clearfield, PA (1974 – 1979) Caseworker

Certification And Licensure
- Academy of Certified Social Workers (ACSW) May 19, 1986
- License (LSW), Pennsylvania Board of Social Work Examiners, February 28, 1989
- Board Certified Diplomate in Clinical Social Work (BCD), American Board of Examiners in Clinical Social Work, February 3, 2003
- Clinical License (LCSW), Pennsylvania Board of Social Workers, Marriage and Family Therapists, and Professional Counselors, February 21, 2003
- Registered Play Therapist Supervisor, April 1, 2005

Professional Presentations
- Twenty invited presentations 2002 – 2014
- Primary topics related to play therapy with children, sandplay therapy, and hearing loss
- Provided through Pennsylvania Association for Play Therapy; American Association for Play Therapy; Pennsylvania Chapter, National Association of Social Workers; Pennsylvania School Guidance Counselors Association; Pennsylvania CASSP Conference, and Pennsylvania State Committee on Mental Health Needs of the Deaf and Hard of Hearing;
- Additional trainings provided through Harbor House Trainings, LLC