Module #10

Working with Adoptive Parents on Managing Children’s Behaviors

Student Packet
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Overview of Module

In this Module, students will reviews the behavioral implications of early trauma and attachment disruption. Students will work with case examples to strengthen skills in differential diagnosis and multidisciplinary team planning. Focus will be given to clinicians’ knowledge and skills in helping adoptive parents identify child behaviors of concern and managing behavior problems. Students will examine the role of genetics in a variety of medical and psychological conditions and the potential impact of behavior. Focus will be given to how clinicians can assist adoptive parents in managing and using appropriate interventions, such as Cognitive Behavioral Therapy, with the children and adolescents who are engaging in severe behaviors. The Module concluded with additional considerations and tools for adoptive parents in managing their children’s behavior.

Learning Objectives

Students will be able to:

#1. Describe two impacts on a child’s later behavior as a result of trauma and two impacts as a result of attachment disruption.
#2. Define differential diagnosis.
#3. Describe two methods that a clinician can use to better understand what parents mean when they say that their child is “difficult.”
#4. List four behavior management competencies for adoptive parents.
#5. List four key principles that adoptive parents can use to help them create structure and consistency for their children.
#7. Name four mental health conditions for which genetics are believed to play at least a partial role.
#8. Describe 5 features of a behavioral management plan.
#9. Describe the use of Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) with adopted adolescents.
Module #10: Working with Adoptive Parents on Managing Children’s Behaviors

Pre-Module Assignments

Students’ Assignments
None for this Module.
Module #10: Working with Adoptive Parents on Managing Children’s Behaviors

Agenda

9:00AM – 9:15AM  Welcome and Announcements

9:15AM – 10:00AM  Introduction; Behavioral Consequences of Early Impacts on Brain Development, Childhood Trauma and Attachment Disruption

10:00AM – 10:30AM  Differential Diagnosis and Teaming

10:30AM – 10:45AM  Break

10:45AM – 1:30PM  Working with Adoptive Parents to Identify Behaviors of Concern

11:30AM – 12:30PM  Helping Adoptive Parents Manage Their Children’s Behaviors

12:30PM – 1:30PM  Lunch

1:30PM – 2:30PM  Helping Adoptive Parents Manage Their Children’s Behaviors: Self-Regulation

2:30PM – 2:55PM  Genetics and the Impact on Behavior

2:55PM – 3:10PM  Break

3:10PM – 4:10PM  Helping Adoptive Parents Manage Severe Behavior Issues

4:10PM – 4:25PM  Additional Considerations for Adoptive Parents in Managing Behaviors

4:25PM – 4:30PM  Closing and Summary
Reading List

Web-Based Resources

Adoptive Families Magazine. *Expecting the Unexpected*. Available at: http://www.adoptivefamilies.com/articles/2300/older-child-adoption-behavior

Brand, A.E. & Brinich, P.M. *Behavior Problems and Mental Health Contacts in Adopted, Foster, and Nonadopted Children*. Available at: http://www.lib.washington.edu/subject/Psychology/psych305/a.pdf

Brodzinky, D.M. *Long-term Outcomes in Adoption*. Available at: http://futureofchildren.org/futureofchildren/publications/docs/03_01_12.PDF

Bruce, J., Tarullo, A.R. & Gunnar, M.R. *Disinhibited Social Behavior Among Internationally Adopted Children*. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2629385/


Parenthood in America.  *Media and Parents: Protecting Children from Harm*. Available at: [http://parenthood.library.wisc.edu/Cantor/Cantor.html](http://parenthood.library.wisc.edu/Cantor/Cantor.html)

Perry, B.D.  *Self-Regulation: The Second Core Strength*. Available at: [http://teacher.scholastic.com/professional/bruceperry/self_regulation.htm](http://teacher.scholastic.com/professional/bruceperry/self_regulation.htm)

Purvis, K.B. & Cross, D.R.  *Facilitating Behavioral Change in Adopted Children Suffering from Sensory Processing Disorder*. Available at: [https://www.hagueadoption.org/registration/Purvis_SID.pdf](https://www.hagueadoption.org/registration/Purvis_SID.pdf)


**Dialectical Behavior Therapy**


**Research**


The Impact of Parental Substance Abuse on Children

American Academy of Pediatrics. Fetal Alcohol Syndrome and Alcohol-Related Neurodevelopmental Disorders. Available at: http://pediatrics.aappublications.org/content/106/2/358.full

British Columbia Ministry for Children and Families. Parenting Children Affected by Fetal Alcohol Syndrome. Available at: http://www.fasaware.co.uk/education_docs/daily_guide_for_living.pdf

Liberty House Child Abuse Assessment Center. The Risks of Methamphetamine Exposure to Children. Available at: http://www.libertyhousecenter.org/docs/RisksofMethExposure.pdf


Module #10

Working with Adoptive Parents on Managing Children’s Behaviors
Handouts
Handout #10.1  A Case Example: Using our Knowledge of Early Brain Development

Case Scenario: Anna and Charles, the adoptive parents of six-year old Howie, come to you feeling overwhelmed by their son’s behaviors. They do not feel that they can control him and say that they simply do not know what to do next. They provide the following background information on Howie:

- He was placed in foster care at age 2 after being physically abused by his mother’s boyfriend. He had belt marks and burns on his body when he entered foster care.
- He had probably been abused for at least 6 months but perhaps as long as a year.
- His mother was only 19 at the time he entered foster care and was abusing cocaine. It is not clear whether she used cocaine during her pregnancy but it is possible.
- While in foster care, Howie was initially placed with older foster parents but they asked that he be moved because he cried so much and could not be consoled. The next two foster care placements ended in the same way. At age 4, he was placed with a single, older, experienced foster mother, Lou, who was able to provide him with nurturing and assurance and he was able to calm himself more often. He still had many disruptive behaviors but they were not as frequent or as serious.
- Anna and Charles adopted Howie at age 5 and he soon began engaging in aggressive behaviors toward the family’s dog and toward neighborhood children. He continues to be aggressive at home and at school, frequently being sent to the principal’s office. He recently hit Anna when she told him to turn off the TV. Two days ago, he cut his leg with a knife to see “how it feels.”

Anna and Charles believe that they may be parenting Howie “all wrong.” They say that they are “desperate.”

Review the information below and develop 3 or 4 talking points that you would use in helping Anna and Charles understand the impact of Howie’s early life experiences on brain development and current behavior.

Early Brain Development

The core “mission” of the brain is to sense, perceive, process, store and act on information from the external and internal environment to promote survival.

Some Brain Basics

1. At birth, the brain is underdeveloped.
2. The brain develops in sequential fashion.
3. Brain development follows a “bottom up” structure.
4. Development of the brain is guided by experience.

**The Evolution of the Brain**

There are actually three brains within the “brain” – each devoted to increasingly complex and hierarchical functions:

- **The Brain Stem** (sometimes called the Reptilian Brain – developed at birth): Activation/arousal, physiological homeostasis, reproduction, reflex

- **The Limbic Brain** (sometimes called the Mammalian Brain -- primitive at birth; develops through infancy and childhood): Learning, memory, and EMOTION

- **The Cerebral Cortex** (sometimes called the Human Brain – not fully developed until the mid-20s): Conscious thought, higher processing, engagement with the world: control, inhibitions, modulation of sub-cortical and limbic activity

**The Limbic System: Emotions and Behavior**

- Emotions originate in the brain, specifically in the limbic system.
- Memory involves the limbic system.
- The limbic system interprets and directs emotion and behavior.
• Emotions arise from memories and reactions to current events. Our emotions are formed by how we think about past and present experiences. We all try to explain our own behavior and that of others.
• Prolonged and continuous exposure to stress hormones can cause serious damage to these parts of the limbic system and, thus, disrupt mood regulation, memory, and one’s way of interpreting the environment.
• Usually, damage to the left hemisphere is associated with poor verbal development, but, more importantly, with aggression, self-destructive behavior and suicide.
• Many of the brain abnormalities that have been studied in abused and neglected children are located in the left hemisphere. Children who show abnormal results in the left hemisphere demonstrate self-destructive or aggressive behavior, as well as certain disturbances in behavior, thinking and physiology (higher blood pressure, heart rates temperature, hypervigilance).
Handout #10.2. Sweetpea

This blog was posted on the Internet:

Hi all!

I am strongly considering taking a kiddo that has a disruption in her history. Has anyone walked in those shoes and can offer advice?

Background: Sweetpea is 8 years old. She is bright, animated, and can attach. She has PTSD. She suffered abuse and neglect. She was placed in care at age 6. She was placed for adoption recently but disrupted due to severe behaviors. The adoptive parents reported non-stop tantrums, raging, destruction of property, and one heck of a bad case of potty mouth. However, Sweetpea was not prepared for this adoption. She was moved quickly due to abuse in foster home. Yes, this little girl has had it hard.

Sweetpea has been in self-contained classrooms due to her behavior. Teachers say she is getting better but really needs permanency. I am getting different reports on her. Some foster parents report no problems. Others report problems. CASA says she believes she is bad and no one wants her, due to her past and the disruption. Everyone says she has potential but has never had anyone she trusted. She was bonded to her abusive mom.

So...has anyone adopted a kid who disrupted? If I proceed, any advice? Please, please and thanks!

__________________
Adoptive mom to kids from foster care.

Assignment: Imagine that this prospective adoptive mother came to you for guidance. In your small group, discuss how you might begin to help this prospective adoptive mother think about Sweetpea’s behaviors and her own decision about possibly adopting this little girl.
Handout #10.3 Responses to Sweetpea’s Situation

Here are two responses to the blog in Handout #7.2.

Response #1:
I recently had a 10 yr old boy placed with me who was taken into care as an infant, adopted at the age of 4 and removed from the home at 8 (safety concerns with him remaining there). He's spent the last 3 years in a residential setting. He also has a RAD diagnosis. So far things are going pretty good, but we're still in the honeymoon phase.

My kiddo also believes he is bad and nobody wants/loves/cares about him. So far I've had no behavioral issues with him. He does well in school, but sometimes lacks motivation. He can behave and do well in the right setting.

No real advice to offer as I'm just beginning the journey, but I'd recommend posting in the special needs adoption forum.

Educate yourself, and talk to her therapist & prior placements if you can. That helped me make a decision.

Good luck with your decision.

Response #2:
She does sound hard-core, but she sounds like she has it in her to behave also. But she's had SUCH a hard little life.

*I* would expect her to pull out all the stops in terms of behavior. Why on earth would she trust y'all? Poor kiddo. And she may seem to get better then worse than ever.

But if you cannot take all that personally, the rewards of getting through all that will likely be beyond compare.

And of course, there are all sorts of things you can do to deal with the behaviors (diet, supplements, exercise, therapy, discipline, etc). You're just going to have to be willing to be educated and try until you get through to her. And no doubt there will be good moments throughout to keep you going.
Handout #10.4  Danny

Laura and Don adopted 4-year-old Danny from an orphanage in Russia six months ago. They have struggled in parenting him. He is withdrawn and refuses to be comforted by them. When Don tries to give him a hug, Danny twists away from him in an angry way. Laura can sometimes stroke him just before he goes to sleep at night but during the day, he keeps a distance from her. They don’t know what to do. They have done some research and come to you, asking, and “Is this Reactive Attachment Disorder?”

Discuss:

1. How might you respond to the question about whether Danny is suffering from RAD? Are there other possible explanations for his behavior?

2. Who might you want to involve in making a differential diagnosis of Danny?
Handout #10.5 Darla

Darla adopted Janine, now age 15, when she was 14 years old. Janine had been in foster care since a toddler. Her birth mother had mental health and substance abuse issues. Virtually nothing is known about her birth father. Janine entered foster care when she was 3 years old after she was found wandering in a playground in the winter with no coat and wearing only one shoe. Janine was in five different foster care placements before Darla adopted her. Darla got to know Janine at church. Janine’s last foster parents regularly took her to services and Janine was active in the youth group. Darla, as Janine’s youth group mentor, grew much attached to Janine and was thrilled to be able to adopt her. Janine has always been a highly sensitive child and as a teenager has been increasingly moody. Darla describes her as “a depressed kid.” Recently, her behavior has become disorganized and she seems to be “lost in her thoughts.” Darla is becoming increasingly worried about her and has come to you for help.

Complete the following quiz together and be ready to report to the larger group.

1. As part of the differential diagnosis, you might consider whether Janine is experiencing a mood disorder. Which of the following would be most important in considering a mood disorder as part of your differential diagnosis? Please check all that might apply.

   ____ A. Darla’s description of Janine as “a depressed kid”
   ____ B. Janine’s withdrawal and becoming “lost in her thoughts”
   ____ C. Janine’s moodiness
   ____ D. Janine’s history of neglect
   ____ E. Potentially, her birth mothers’ psychiatric history

2. Are there behavioral indicators that might suggest a diagnosis of schizophrenia? Please check all that are correct.

   ____ A. Disorganized behavior
   ____ B. Multiple placements in foster care
   ____ C. Potentially, her birth mother’s psychiatric history
   ____ D. Adoption at an older age
3. What other consideration(s) might you bring to your differential diagnosis? Please check all that might apply.

__ A. The possibility of substance use/abuse
__ B. Post Traumatic Stress Disorder (PTSD)
__ C. A conduct disorder
__ D. The risk of suicide
__ E. Reproductive health issues

4. Who would want to include in a multidisciplinary assessment of Janine? Please check all that might apply.

__ A. A physician with expertise in adolescent health issues
__ B. Help in obtaining a toxicology screen
__ C. A neurological consultation
__ D. Former and current teachers and/or guidance counselors at school
__ E. Janine’s former social worker who can help in exploring the impact of Janine’s history on her current status
Handout #10.6 Checklist: Which are the “Top Ten” Most Concerning Child Behaviors for Adoptive Parents?

___ 1. Anger Outbursts
___ 2. Biting
___ 3. Lying
___ 4. Cursing
___ 5. Stealing
___ 6. Defiance
___ 7. Teasing Other Kids
___ 8. Bullying
___ 9. Eating Disorders and Food Issues
___ 10. Sexualized Behavior
___ 11. Fire-Setting
___ 12. Sleep Problems
___ 13. Self-Destructive Behavior
___ 14. Running Away
___ 15. Wetting and Soiling
Handout #10.7  Approaches in Working With Adoptive Parents who Report that Their Child is “Difficult” to Manage

Approach #1:

Case Scenario: Travis is a single adoptive father of Garan, a 14-year-old who he adopted from foster care. He comes to see you and tells you that Garan is very difficult to manage. He has not parented before but he coaches sport teams for kids who are Garan’s age and he has always been able to make it work with them. Travis is very close to his mother who lives nearby and who has become quite upset by some of Garan’s behaviors when he is at her house.

Role play a meeting together using the following approach.

The Approach: Raise the following questions:

1. Do you find your child’s behavior hard to understand? Which behaviors are hard to understand?
2. Does your child’s behavior violate values that are important to your family?
3. Are you often battling with your child? What is this like?
4. Do you feel inadequate or guilty as a parent? When do you feel this way?
5. Is your marriage or family life being affected by the child? If yes, how?

Approach #2:

Case Scenario: The prospective adoptive parent we met in Handout #7.2 adopted Sweetpea. Sweetpea remains bright and animated but continues to throw tantrums, goes into rages, has broken several dishes when angry, and maintains her potty mouth. The adoptive mother, MaryAnne, comes to you and says that she loves this child but she is so difficult to manage. She just doesn’t know where to begin.

Role play a meeting together using the following approach.

The Approach: This rating approach was developed by Stanley Turecki, M.D. and Leslie Tonner and is described in more detail in their book, The Difficult Child: Expanded and Revised Edition. It is a problem-oriented approach and does not focus on a child’s strengths. However, a therapist could use this tool to help adoptive parents focus on those behaviors which most are challenging while seeing that in other behavior areas, there is “no problem” – that is, the child is showing behavioral strengths in these areas.
1) **High Activity Level** - Very active, restless fidgety; always into things; makes you tired; over stimulated; gets wild or revved up; impulsive, loses control, can be aggressive; hates to be confined.

   0 = no problem  
   1 = moderate problem  
   2 = definite problem  
   3 = extreme problem

2) **Distractibility** - Has trouble concentrating and paying attention, especially if not really interested; doesn’t "listen"; tunes you out; daydreams; forgets instructions.

   0 = no problem  
   1 = moderate problem  
   2 = definite problem  
   3 = extreme problem

3) **High Intensity** - Loud and forceful whether miserable, angry, or happy.

   0 = no problem  
   1 = moderate problem  
   2 = definite problem  
   3 = extreme problem

4) **Irregularity** - Unpredictable. Can’t tell when he/she will be hungry or tired; conflict over meals and bedtime; wakes up at night; moods are changeable; has good or bad days for no obvious reason.

   0 = no problem  
   1 = moderate problem  
   2 = definite problem  
   3 = extreme problem

5) **Negative Persistence** - Stubborn; goes on and on nagging, whining or negotiating if wants something; relentless, won’t give up; gets "locked in"; may have long tantrums.

   0 = no problem  
   1 = moderate problem  
   2 = definite problem  
   3 = extreme problem

6) **Low Sensory Threshold** - "Sensitive"- physically not emotionally; highly aware of color, light, appearance, texture, sound, smell taste or temperature (not necessarily all of these); creative but with strong and unusual preferences that can be embarrassing; clothes have to feel and look
right, making dressing a problem; doesn’t like the way many foods look, smell, or taste; picky eater; bothered and over-stimulated by bright lights and noisy settings; refuses to dress warmly when the weather is cold or dresses too warmly when the weather is hot.

0= no problem  
1 = moderate problem  
2 = definite problem  
3 = extreme problem

7) Initial Withdrawal - Shy and reserved with new people; doesn’t like new situations; holds back or protests by crying or clinging; may tantrum if forced to go forward.

0= no problem  
1 = moderate problem  
2 = definite problem  
3 = extreme problem

8) Poor Adaptability - Has trouble with transition and change of activity or routine; inflexible, very particular, notices minor changes; gets used to things and won’t give them up; has trouble adapting to anything unfamiliar; can want the same clothes or foods over and over.

0= no problem  
1 = moderate problem  
2 = definite problem  
3 = extreme problem

9) Negative Mood - Basically serious or cranky; doesn’t show pleasure openly; not a "sunny" disposition.

0= no problem  
1 = moderate problem  
2 = definite problem  
3 = extreme problem

For Group Discussion:

1. How effective do you believe each of these approaches was?

2. Did you see strengths and weaknesses in each?

3. Which approach would you be more likely to use in your work with adoptive parents who tell you that their child is difficult to manage?
Handout #10.8 From HealthyChildren.org

The following is a list of general strategies developed by HealthyChildren.org to help parents of children who have “difficult” temperaments:

1. Recognize that much of your child's behavior reflects his temperament.

2. Establish a neutral or objective emotional climate in which to deal with your child. Try not to respond in an emotional and instinctive manner, which is unproductive. We will talk about this later when we discuss how parents can check their own arousal levels.

3. Don't take your child's behavior personally.

4. Try to prioritize the issues and problems surrounding your child. Some are more important and deserve greater attention. Others are not as relevant and can be either ignored or put "way down the list."

5. Focus on the issues of the moment. Do not project into the future.

6. Review your expectations of your child, your preferences and your values. Are they realistic and appropriate? When your youngster does something right, praise him and reinforce the specific behaviors that you like.
7. Consider your own temperament and behavior, and how they might also be difficult. Think how you might need to adjust yourself a bit to encourage a better fit with your child.

8. Anticipate impending high-risk situations, and try to avoid or minimize them. Accept the possibility that this may be a difficult day or circumstance, and be prepared to make the best of it. We will discuss this more lately in this training module.

9. Find a way to get some relief for yourself and your child by scheduling some time apart. We will talk about parental self care at the end of this training module.
Mary, a single mother, adopted Sarah, age 13, from foster care. Sarah was sexually abused by her uncle for three years before she brought into foster care at age 11. Mary has noticed that over the past several months Sarah has become sexually provocative. She is wearing very tight clothing and talks in a sexualized way with some of Mary’s adult male friends, especially Mary’s boyfriend, David, who sometimes stays overnight at the home.

1. How would you help Mary understand the impact of earlier experiences on Sarah’s current behavior? What information would you share?

2. What types of supervision would you help Mary develop to ensure her daughter’s physical and psychological safety?
Handout # 10.10  How to Find the Behavioral Triggers That Set Your Kid Off

Sara Bean, M.Ed., Parental Support Line Advisor, Empowering Parents

Full Article at:

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How can you identify your child’s triggers?

Observe and Investigate: Observation is one of your best tools for identifying your child’s triggers, especially with younger children who have less self-awareness. Simply pay attention and be aware of the warning signs. Watch and listen, whether your child is hanging out with friends at home, doing homework, or playing on the playground. You might start to notice patterns emerging. For example, maybe your child does well with her math homework but starts to get sassy and restless when it’s time to do her daily reading. That would alert you that there may be a trigger related to reading that you want to explore more. Or, you might notice that your teen starts acting strange and moody after she talks to her boyfriend on the phone or returns from his house. This might tell you that the trigger is related to something going on in their relationship. Keep your eyes and ears open at all times and look for patterns and connections. And remember, observing is not the same as searching. If you are going to search through your child’s room, social networking accounts, backpacks, etc. be up front with them and let them know that you might search through these things at any time for any reason.

You also should enlist the help of other adults in your child’s life to observe your child’s behavior and interactions. This could include your relatives, other parents, or your child’s teachers. If your child starts acting out while other adults are around, ask them what they saw happen right before the acting out started. If your child acted out in school, find out what the teacher saw happening or what other students reported to her. You can think of yourself as an investigator interviewing the witnesses so that you can piece everything together and start to make connections between environmental factors and your child’s acting out. Observation by you and other adults in your child’s life is especially important when dealing with younger children (preschool through early elementary school) who might have a hard time answering any questions you ask them to clarify what happened. As helpful as this tool can be, do not rely on observation alone. Instead, let it serve as a guide that points you in the right direction.

Perception is Everything: It’s vital to consider your child’s perception of the incident. Remember that children perceive things very differently from adults. You might assume you know what happened, but your child probably experienced it very differently. So ask him about it even if you think you know the answer. You might say “What were you thinking right before you threw your book at your friend?” or “What was going on for you before you pushed that kid in the hall at school?” (Again, some younger children might struggle to answer these questions, but it can’t hurt to ask.) Some kids can have trouble putting their thoughts into words at times. If your child is still wound up from the incident, give him time
to calm down before trying to have any sort of conversation about what happened. Emotions can sometimes be a block to clear, rational thought.

Here are 5 tips to help you make your child more aware of their triggers:

1. **With younger kids, talk about feelings:** Because feelings and triggers are directly related, having discussions about feelings when your kids are young can help you establish a foundation to build on when identifying your child’s triggers for him. This should be done when things are calm and going well, not right in the middle of or after a tantrum or outburst. Ask your child what makes him angry. What makes him happy? What makes him sad? The purpose of this is to teach kids how to identify various feelings, to learn what it means to feel angry, happy, sad, disappointed, etc., not to give them an excuse for bad behavior. This also enables kids to communicate their feelings to you clearly so that you are in the best position to help them learn how to cope.

2. **Connect the dots for them:** Let your child know what you have observed about the trigger and the acting out behavior. Use this as a framework: “Whenever ______ happens, you ________” or “I’ve noticed that when you ________, you ________.” For example, you might say “I’ve noticed that when you think something is unfair, you get verbally abusive and call me names.” By connecting the dots for them, you are helping them learn their triggers. It’s best if this is part of a problem-solving discussion that includes you and your child coming up with a plan for what your child will do differently next time he is in this kind of situation. Having a clear simple plan is necessary to help your child change his behavior in the future.

3. **Talk about the signs:** Often there are physical symptoms that come along with these trigger thoughts. The nervous system kicks into high gear when a trigger is present and can cause rapid heartbeat, warm flushed cheeks, rapid breathing, cold hands, muscle tension, and a lot of other signals. Ask your child what they feel in their body when the trigger you are talking about is present. When kids are aware of the warning signs their body gives them, it will serve as a natural cue to put the new plan you came up with during your problem-solving discussions into action.

4. **Cueing:** Cueing is a common behavior management technique. Choose one specific trigger to work on and then come up with some kind of hand signal or phrase that will serve as an alert to your child that the trigger is present. This allows you to make your child aware of the trigger subtly in social situations. Once you have alerted him, he’ll have the chance to self-correct, or in other words, respond using the new plan you came up with, with minimal help from you. Cueing works at home as well.

5. **Check in:** If you’ve cued your child but he didn’t use the response the two of you had planned on, have him take a break from whatever is going on and come speak to you in a quiet place, away from an audience. This is where you step in and help your child correct his behavior. Let him know you gave him the cue but you noticed he didn’t respond the way you had discussed.
Remind him of what you talked about and let him know what the consequences will be if he doesn’t use the plan the next time you cue him today, and remind him what the plan is. This can apply with younger kids and teens, in social settings or at home.

**What changes in behavior might you see?**

*Teaching your child about his triggers is not an easy process by any means. To really help your child become aware of his triggers takes time and repetition, as well as commitment and persistence on your part. Talking about it only one time and then forgetting about it will not get you anywhere; continuing to have calm, supportive and open dialogue about triggers is the key. Stick with it and allow room for some trial and error when coming up with new ways to respond to triggers. With time, most children not only learn how to respond more effectively when triggers occur, but they learn to anticipate them and even avoid situations that might set them off. As James Lehman says in the *Total Transformation Program*, “…Kids start to see triggers as real things that they can manage with real tools, that there are things you can do about this… But the bottom line is a lot of these kids’ minds construct ways of thinking that justify inappropriate behavior. And they’ve got to come up with alternative ways of thinking, alternative ways of perceiving the problem.”*

When your child realizes there are things he can do to manage his triggers appropriately, your pay-off is a child who knows himself well, has improved self-management skills, and feels more confident about himself. And when you’re able to help your child reduce his acting out behavior, you’ll feel calmer and more in control—exactly how you want to be.

...
Handout # 10.11 Trigger-Behavior-Response Checklist
(http://www.lehigh.edu/education/adhd/assets/pdf/trigger_br_checklist.pdf)
Directions: For each instance, check all triggers, behaviors, and responses that apply.

### PROBLEM BEHAVIOR

<table>
<thead>
<tr>
<th>Location:</th>
<th>Trigger</th>
<th>Date:</th>
<th>Time:</th>
<th>Behavior</th>
<th>Response:</th>
<th>What Happened After?</th>
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<td></td>
<td>What Happened Before?</td>
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<td>[ ] Could not get something he/she wanted</td>
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<td>[ ] Stopped from doing a like activity</td>
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<td>[ ] Loud environment</td>
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<td>[ ] Another person provoked the child</td>
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<td>[ ] Child needed to move from one activity ________ to another ___</td>
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<td>[ ] Attention being give to others</td>
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<td>[ ] Nothing – the behavior was “out of the blue”</td>
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<td>[ ] Noncompliance</td>
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<td>[ ] Property destruction</td>
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<td>[ ] Provoking or teasing others</td>
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<td>[ ] Running away</td>
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<td>[ ] Screaming/crying</td>
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<td>[ ] Tantrum</td>
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<td>[ ] Other (specify: ____________)</td>
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### GOOD BEHAVIOR

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<tr>
<th>Location:</th>
<th>Trigger</th>
<th>Date:</th>
<th>Time:</th>
<th>Behavior</th>
<th>Response:</th>
<th>What Happened After?</th>
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<td>What Happened Before?</td>
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<td>[ ] Asked to do something</td>
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<td>[ ] Receiving attention (parents/siblings)</td>
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<td>[ ] Alone</td>
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<td>[ ] Preferred toys/activities available</td>
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<td>[ ] Another child initiated play</td>
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<td>[ ] Playing with another child</td>
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<td>[ ] Given transition warning (e.g. in 5 minutes you will need to turn off the TV)</td>
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<td>[ ] Following directions</td>
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<td>[ ] Sitting quietly</td>
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<td>[ ] Staying on-task</td>
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<td>[ ] Waiting for turn</td>
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<td>[ ] Cleaning up</td>
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<td>[ ] Sharing</td>
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<td>[ ] Being kind to other</td>
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<td>[ ] Transitioning smoothly</td>
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<td>[ ] Playing nicely with other children</td>
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<td>[ ] Other: (specify: ____________)</td>
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Handout # 10.12 Setting a Calm and Consistent Routine: Zach

Lynn and Howard come to you about problems with their adopted son, Zach, age 15. They adopted Zach when he was 12 and things went well until the last year or so. Zach has become
extremely moody and refuses to cooperate with anything that they ask of him. He has on at least two occasions said that if things are going to be “like this”, he might as well find his birth parents and go back to them. Zach stays up all night, sleeps all day, refuses to do his homework, comes home at times obviously having been drinking, and tells his parents to “just leave me alone.” Lynn and Howard realize that they need to do something but they are afraid that if they do, they may lose Zach to his birth family.

1. How would help Lynn and Howard establish a calm and consistent routine with Zach? What strategies would you recommend?

2. How would you work with them about their fears of losing Zach if they take these steps?
Handout # 10.13 Example of Contract with a Teen

**CONTRACT**

Because it is illegal, I promise not to drink alcohol or take drugs. I will not drive while under the influence of alcohol or drugs. I pledge not to get in a car with someone who has been drinking alcohol or doing drugs. If I find myself in a situation where I feel unsafe or uncomfortable, I promise to you, my parent and guardian, for a ride home. I commit to this pledge and recognize that there are consequences for every decision I make.

___________________________
Teen Signature

As your parent/guardian, I promise to make myself available to you. You can count on me any time day or night. I promise that I will pick you up, no immediate questions asked. When you are safe at home, I pledge to respect you and listen to what has happened and help in any way I can.

___________________________
Parent/Guardian Signature
Handout # 10.14  A Quiz on Trauma and Self Regulation

1. Children learn to regulate their behavior:
   
   A. Through negative reinforcement
   
   B. By anticipating their caregivers’ responses to them
   
   C. By observing the behaviors of others around them
   
   D. Through behavior-specific management programs

2. Healthy self-regulation is related to the capacity to:
   
   A. Tolerate the sensations of distress that accompany an unmet need
   
   B. Use behavior to express internal working models
   
   C. Control the external environment
   
   D. Interact with others in ways that assure that one’s needs are met

3. When a child is experiencing overwhelming distress or when her caregivers are the source of the distress, the child experiences a breakdown in her ability to:
   
   A. Relate to her caregivers
   
   B. Express emotion
   
   C. Process and integrate what is happening
   
   D. Verbalize her distress

4. Many problems of traumatized children can be understood as efforts to:
   
   A. Seek revenge on others for what has happened to them
   
   B. Avoid responsibility for the negative consequences of their behaviors
   
   C. Gain mastery over their environments
D. Regulate their emotional distress

5. Children who have experienced chronic trauma are left with deficits in emotional self-regulation which is seen in (check all that are correct):

___ 1. A lack of continuous sense of self
___ 2. Poorly modulated affect
___ 3. Poor impulse control
___ 4. Uncertainty about the reliability and predictability of others

6. A child who has deficits in self-regulation can be expected to:

A. Openly discuss his fears and trauma
B. Seek new opportunities to reverse the earlier experiences and feel safer
C. Repeat their traumatic pasts
D. Use verbal rather than behavioral expression

7. The stress response systems of children who have difficulty with self-regulation are:

A. Organized but resulting in low levels of response
B. Over-organized resulting in difficulty in making any response
C. Poorly organized and hyper-reactive
D. Completely unorganized and not functioning

8. Children who have poor self-regulation often are (check all that are correct):

___ 1. Impulsive
___ 2. Hypersensitive to transitions
___ 3. Unable to relate to others
4. Over-reactive to minor challenges or stressors

5. Inattentive

6. Sluggish and nonresponsive

9. Which of the following are strategies that adoptive parents can use with their younger children who have poor self-regulation? (Check all that are correct).

__ 1. Model self-control in the parent’s own words and actions when frustrated

__ 2. Provide structure and predictability

__ 3. Calm the environment the parent senses that the child is becoming upset

__ 4. Do not try to talk with the child when he/she is having a “fit”; use firm, quiet actions

__ 5. Anticipate transitions and communicate changes in advance

__ 6. Provide children with opportunities to let off steam

__ 7. Be aware of one’s own flashpoints

10. **True or False**: Self regulation is extremely important in the teen years.
Handout # 10.15 Specific Measures of Self-Regulation

Assignments:

#1. Use the Questionnaire on Self-Regulation with your partner who is a 10 year boy, Danny, who was adopted from foster care two years ago. His parents report that he acts out at home and at school. Introduce the tool to him and work with him in completing the tool. When complete, join with your partner (now a fellow therapist) and calculate the scoring of the questionnaire. Reach some preliminary conclusions about Danny’s level of self-regulation.

#2. Use the Fast Track Project Child Behavior Questionnaire with your partner who is a 12 year girl, Dianna, who was adopted from Russia when she was four. Her parents report that she does not seem able to tolerate the slightest stress, going into “major melt downs” anytime things do not go her way or things unexpectedly change. When complete, join with your partner (now a fellow therapist) and calculate the scoring of the questionnaire. Reach some preliminary conclusions about Dianna’s level of self-regulation.

#3. Use the Adolescent Self-Regulatory Inventory with your partner who is a 15 year old boy, Akim, who was adopted from foster care at age 14. His parents report deepening concerns about his behavior which alternates between verbal aggressive with them and teachers and complete withdrawal. When complete, join with your partner (now a fellow therapist) and calculate the scoring of the questionnaire. Reach some preliminary conclusions about Akim’s level of self-regulation.
I. Questionnaire on Self-Regulation

This is a 13-item questionnaire used to assess children’s ability to regulate negative emotions and disruptive behavior, and to set and attain goals. Respondents rate how true each item is for them, ranging from 1 (never true) to 4 (always true). After reverse coding items 1, 2, 3, 4, 5, 8, 10, 11, 12, and 13, higher scores represent the child’s ability to regulate his/her emotions (items 1, 2, 3, 4, 5), behavior (items 9, 10, 11, 12), and cognitions (items 6, 7, 8).

1. I have a hard time controlling my temper.
2. I get so frustrated I feel ready to explode.
3. I get upset easily.
4. I am afraid I will lose control over my feelings.
5. I slam doors when I am mad.
6. I develop a plan for all my important goals.
7. I think about the future consequences of my actions.
8. Once I have a goal, I make a plan to reach it.
9. I get distracted by little things.
10. As soon as I see things that are not working, I do something about it.
11. I get fidgety after a few minutes if I am supposed to sit still.
12. I have a hard time sitting still during important tasks.
13. I find that I bounce my legs or wiggle with objects.
II. Fast Track Project Child Behavior Questionnaire

This 20-item questionnaire is designed to measure the self-regulation skills of children and adolescents. After reverse coding items 4, 5, 7 and 19, lower scores indicate ability to self-regulate.

How often does each of the following statements describe you? Would you say?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

1. I wait my turn during activities.
2. I cope well with disappointment or frustration.
3. I accept it when things do not go my way.
4. My feelings get hurt.
5. When I get upset, I whine or complain.
6. I control my temper when there is a disagreement.
7. I stop and calm down when I am frustrated or upset
8. I think before I act.
9. I do what I am told to do.
10. When I want something, I am patient when waiting.
11. I follow the rules.
12. I stick with an activity until it is finished.
13. I can concentrate and focus on one activity at a time.
14. I ignore kids who are fooling around in class.
15. I fight or argue with adults.
16. I tell new kids my name without being asked to tell it.
17. When people are angry with me, I control my anger.
18. When someone tells me a rule that I think is unfair, I ask about the rule in a nice way.
19. When I disagree with my parents, I yell and scream.
20. I ask friends for help with my problems.
III. Adolescent Self-Regulatory Inventory

This is a 36-item questionnaire used to measure the self-regulation of teens. Respondents rate how true each item is for them, ranging from 1 (not at all true for me) to 5 (really true for me). A sum or average of the items should be calculated. After reverse coding items 1, 2, 5, 6, 7, 8, 12, 14, 15, 16, 18, 19, 21, 34, and 35, higher scores indicate the ability to self-regulate.

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tr>
<td>Not at all true for me</td>
<td>Not very true for me</td>
<td>Neither true nor untrue for me</td>
<td>Somewhat true for me</td>
<td>Really true for me</td>
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</table>

1. It’s hard for me to notice when I’ve — had enough! (sweets, food, etc.).
2. When I’m sad, I can usually start doing something that will make me feel better.
3. If something isn’t going according to my plans, I change my actions to try and reach my goal.
4. I can find ways to make myself study even when my friends want to go out.
5. I lose track of the time when I’m doing something fun.
6. When I’m bored I fidget or can’t sit still.
7. It’s hard for me to get started on big projects that require planning in advance.
8. I can usually act normal around everybody if I’m upset with someone.
9. I am good at keeping track of lots of things going on around me, even when I’m feeling stressed.
10. When I’m having a tough day, I stop myself from whining about it to my family or friends.
11. I can start a new task even if I’m already tired.
12. I lose control whenever I don’t get my way.
13. Little problems detract me from my long-term plans.
14. I forget about whatever else I need to do when I’m doing something really fun.
15. If I really want something, I have to have it right away.
16. During a dull class, I have trouble forcing myself to start paying attention.
17. After I’m interrupted or distracted, I can easily continue working where I left off.
18. If there are other things going on around me, I find it hard to keep my attention focused on whatever I’m doing.
19. I never know how much more work I have to do.
20. When I have a serious disagreement with someone, I can talk calmly about it without losing control.
21. It’s hard to start making plans to deal with a big project or problem, especially when I’m feeling stressed.
22. I can calm myself down when I’m excited or all wound up.
23. I can stay focused on my work even when it’s dull.
24. I usually know when I’m going to start crying.
25. I can stop myself from doing things like throwing objects when I’m mad.
26. I work carefully when I know something will be tricky.
27. I am usually aware of my feelings before I let them out.
28. In class, I can concentrate on my work even if my friends are talking.
29. When I’m excited about reaching a goal (e.g., getting my driver’s license, going to college), it’s easy to start working toward it.
30. I can find a way to stick with my plans and goals, even when it’s tough.
31. When I have a big project, I can keep working on it.
32. I can usually tell when I’m getting tired or frustrated.
33. I get carried away emotionally when I get excited about something.
34. I have trouble getting excited about something that’s really special when I’m tired.
35. It’s hard for me to keep focused on something I find unpleasant or upsetting.
36. I can resist doing something when I know I shouldn’t do it.
Handout #10.16 A Quiz on Genetics and Children

First: Two conditions in which genetics are involved that principally affect a child’s cognitive development: Down Syndrome and Fragile X Syndrome.

1. Individuals with Down Syndrome are at risk of which of the following health conditions?
   - A. Poor hearing
   - B. Thyroid difficulties
   - C. Pulmonary disease
   - D. Both a and b
   - E. Both a and c

2. When children have Down Syndrome, what are some common behavior concerns reported by parents and teachers?
   - A. Wandering/running off
   - B. Stubborn/oppositional behavior
   - C. Attention problems
   - D. Obsessive compulsive behavior
   - E. Autism spectrum disorder
   - F. All of the above
   - G. All of the above except for E

3. Check off which of the following are appropriate steps for the adoptive parent of a child with Down Syndrome to take when their child has behavior problems?
   - ___ 1. Rule out a medical problem that could be related to the behavior
   - ___ 2. Consider emotional stresses at home/school/work that may impact behavior
3. Develop a behavior treatment plan using the ABC’s of behavior (Antecedent, Behavior, Consequence of the behavior)

4. If behavioral problems are chronic, consult with a behavior specialist

Fragile X Syndrome

1. **True or False**: Fragile X syndrome is the most common cause of mental retardation.

2. What of the following is not a behavioral issue that may be present when a boy has been diagnosed with Fragile X syndrome?

   - A. Distractibility
   - B. Whining and crying when in new situations
   - C. Violent outbursts
   - D. Poor eye contact

3. Are there particular areas of behavioral concerns for girls with the full mutation of Fragile X syndrome?

   - Yes
   - No

**Second**: Several psychiatric childhood diagnoses that are believed to have some genetic basis:

- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Obsessive compulsive disorder
- Schizophrenia
- Manic depressive illness
• Early onset depression

1. Which of the following is not a symptom of ADD and ADHD?
   
   A. Distractibility
   
   B. Hyperactivity
   
   C. Depression
   
   D. Impulsivity
   
   E. Inattention

2. In addition to genetics, ADD/ADHD may be caused by:
   
   A. The child’s lack of exercise
   
   B. Environmental factors such as lead or maternal smoking during pregnancy
   
   C. Inadequate limit setting by parents and teachers
   
   D. The presence of other psychiatric disorders

3. True or False: Adoptive parents often need assistance in identifying parenting patterns that are contributing to their children’s attention disorder problems.
1. **True or False:** Autism is a highly variable neurodevelopmental disorder that first appears during infancy or childhood, and generally follows a steady course without remission.

2. Which of the following is **not** a part of the characteristic triad of symptoms of autism?

   - A. Impairments in social interaction
   - B. Impairments in communication
   - C. Impairments in cognition and memory

3. Children with autism experience developmental problems in all but which of these areas?

   - A. Behavior
   - B. Language
   - C. Social Skills
   - D. Creativity

---

**Obsessive-Compulsive Disorder**

1. **True or False:** Obsessive compulsive disorder has been found to run in families.

2. Symptoms of obsessive compulsive disorder in children include:

   - A. Anxiety
   - B. Worry that things are not “just right”
   - C. Worry about losing items
   - D. Repetitive behavior
   - E. All of the above
3. **True or False**: Children are easily diagnosed with obsessive compulsive disorder.

4. When a child has been diagnosed with OCD, the most important changes for the adoptive family to make are:

   A. Environmental changes
   
   B. Behavioral changes
   
   C. Both A and B
   
   D. There are no proven changes that adoptive families can make to help a child with OCD.

1. **True or False**: Genetics are thought to be the primary factor in schizophrenia.

2. Which of the following is NOT a behavior that may be an indicator of childhood schizophrenia?

   A. Trouble telling dreams from reality
   
   B. Confused thinking
   
   C. Extreme moodiness
   
   D. Cruelty to animals

3. **True or False**: A proper assessment is crucial to diagnosing childhood schizophrenia and finding effective treatment.
1. Individuals who are risk for developing bipolar illness generally experience an onset of symptoms:

   A. Between 10 and 14 years of age
   B. Between 14 and 18 years of age
   C. Between 18 and 25 years of age
   D. In middle adulthood

2. Which of the following is NOT a warning sign that a child may be entering a manic episode?

   A. Impulses toward reckless or risky behavior
   B. Irrational feelings of guilt and sadness
   C. Severe agitation
   D. Decrease in the need for sleep or food

3. **True or False**: Behavioral warning signs of a depressive episode include sleeping up to 20 hours a day.

   ![Early onset depression](image)

1. Childhood depression very likely occurs through an interaction effect of:

   A. Genetic and familial factors
   B. Social and familial factors
   C. Genetic, social and familial factors

2. Which of the following are behavioral indicators of early onset depression in children?

   A. Withdrawal from friends and from activities once enjoyed
B. Changes in eating and sleeping habits

C. Forgetfulness and lack of concentration

D. Poor school performance

E. All of the above
Handout #10.17  Oppositional Defiant Disorder and Conduct Disorder

The Symptoms of Oppositional Defiant Disorder (ODD)

Here is what the DSM-IV says are the symptoms of ODD. The child:

- Often loses her temper
- Often argues with adults
- Often actively defies or refuses to comply with adult requests or rules
- Often deliberately annoys people
- Often blames others for mistakes or misbehavior
- Is often touchy or easily annoyed by others
- Is often angry and resentful
- Is often spiteful and vindictive

The Difference between ODD and ADHD

An important difference is that none of the ADHD symptoms involve behavior that is considered to be deliberate and willful. Although children with ADHD often engage in behavior that annoy others and fail to follow through on requests, their behavior is generally not deliberately and willfully initiated.

Important information to share with adoptive parents of a child who has been diagnosed with ODD

A therapist would want to share with adoptive parents that the kinds of difficulties that are associated with ODD are critically important to bring under control as soon as possible because such behavior becomes more entrenched and difficult to change the longer it persists.

A therapist also would want to share with adoptive parents that children with ODD are at significant risk for the development of the more severe kinds of behavioral disturbances that are characteristic of Conduct Disorder.

Conduct Disorder

A Conduct Disorder (CD) is a more severe type of behavioral disorder than ODD that is also more likely to develop in children with ADHD.
According to DSM-IV, the essential feature of CD is "...a repetitive and persistent pattern of behavior in which the basic rights of others or age appropriate social norms or rules are violated."

The DSM-IV states that the behaviors associated with Conduct Disorders fall into 4 main groupings:

1. **Aggressive behavior that causes or threatens to cause harm**
   Examples: initiating fights; cruelty to people or animals

2. **Conduct that causes property loss or damage**
   Examples: fire setting with intent to cause damage; deliberate destruction of property

3. **Deceitfulness or theft**
   Examples: shoplifting; breaking into someone's house; frequent lying to obtain goods or avoid obligations

4. **Serious violation of rules**
   Examples: truancy from school; running away from home; staying out at night prior to age 13

**More information about Conduct Disorders . . .**

- Although a Conduct Disorder may occur in children as young as 5 or 6, its onset is usually in late childhood or early adolescence.

- The course of CD is variable: in a majority of individuals, the disorder remits by adulthood.

- Nonetheless, a substantial percentage of individuals continue to display sufficient behaviors into adulthood to warrant the diagnosis of antisocial personality disorder as young adults. This is most likely to be true for individuals whose Conduct Disorder begins early in life and is marked by aggressive behavior.
Handout # 10.18 Beth and Aaron

Case Scenario

When Beth (adopted at age 2) was 4 1/2, she became very annoying and sometimes aggressive toward her 18-month-old brother, Aaron, who is also adopted. She would pull Aaron’s arm hard or pinch him. It was a new behavior for Beth. At first, her adoptive parents, Tom and Amanda, simply ordered her to stop it, using a stern voice. Two weeks later, when alone with Beth, Amanda expressed her love for her and told her what a wonderful person she was. Amanda was shaken by Beth’s response: "You don't love me. I am terrible." "Why?" she asked anxiously, and Beth answered: "Because I hurt Aaron." She was pained to see that Beth, a child who previously never had to be punished and had always had a fun disposition, was wilting in front of her eyes. She recognized that Beth was feeling jealous and her self-image was taking a nose dive. That day, Amanda started hugging Beth several times a day. She explains:

“A child who hurts is not experiencing herself as being bad. She is experiencing a deep pain, loneliness, lovelessness and loss of control. I responded to Beth’s cry for help and love by giving her what she needed. My initial reaction was based on fear and was therefore counter-productive. When I ordered Beth to stop disturbing her brother - then and only then were her feelings of being "bad" internalized and reinforced. If I had continued scolding her, she may have turned into a bitter bully. Instead, I changed my behavior and responded to her plea for love.”

1. How might you work with Amanda and Tom as to what they might say to Beth?

2. How can you help Amanda and Tom respond when Beth hurts Aaron?
Handout # 10.19 Dottie and Angie

Dottie, a single adoptive mother, tells you that her 5-year-old, Angie, has severe behavior problems, especially at school. Dottie adopted Angie from foster care. Angie’s birth mother drank heavily and used drugs. Angie’s father left the family when Angie was about 12 months old. At that point, Angie entered foster care. She tested positive for methamphetamines and amphetamines and displayed behavior problems especially in social settings.

The foster family worked with Angie to help calm her but at age 2, when Dottie adopted her, Angie continued to have severe behavior problems. She would scream if left alone in a room; she would flail around during bath time as if she were being drowned; in public, she would yell, scream, and throw herself on the ground crying. She continues to do this on occasion. She approaches any stranger as if she has known the person her entire life. Sometimes, she will go up and sit on an unsuspecting stranger or run up and hug them. Dottie tells you that she has told Angie not to do this, but she still does.

When Angie was first adopted, she ate “like there was no tomorrow,” and three years later, she continues to do this. Dottie says that it is as if Angie does not know when she is full. As Angie is getting older, some of her behaviors are more extreme. Recently, when Dottie put her down for a nap in order to make some phone calls and talk with friends, Angie purposely urinated in her room, even though she is fully potty trained and has full access to the bathroom. On three occasions when something has made her mad during the day, she has pooped in her pants and smeared it all over the walls, carpet, blankets, her face, and her clothes and toys.

At school, Angie refuses to do anything she is told to do; she will not share toys; and she will not participate in activities. She hits other children and runs through the halls yelling and screaming. If the teachers try to stop her, she will do a “fake cry” which will continue for hours or until they cater to her. She is now in a behavior disorder class, but it is not helping. She has been to many doctors and is on medication. Dottie tells you, “I love her dearly and want to help her, but nothing seems to have helped thus far, nobody has ever given us a clear explanation as to why she behaves this way. Has anyone ever dealt with a child like this before? What can I do to help it stop?”

1. What issues would you explore with Dottie to help her understand what may be behind Angie’s behaviors?

2. What might be some interventions that you would talk with Dottie about?
Handout # 10.20 Self Care for Adoptive Parents: Healing the Healer

Understand your own need for kindness and compassion.

Recognize the important of self care as replenishment for your family: a night out, exercise, classes, hobbies, or massage – as some examples

Create nurturing relationships with your partners, friends and family

Remember that you are not the source of your children’s problems

Acknowledge your own feelings of grief, rage and despair

Maintain a sense of humor

Maintain a support network with other parents of children with behavioral issues and/or poor attachment

Maintain trust and openness with a professional for support

Avoid splitting with your spouse or partner

From Daniel Hughes, Facilitating Developmental Attachments:

“Remember that if you become like your child, you lose. If your child becomes more like you, you both win.”

“Remember if your child is able to form an attachment with you, you have participated in a psychological birth”.