Module #10

Working with Adoptive Parents on Managing Children’s Behaviors

Teaching Script
Module #10 Working with Adoptive Parents on Managing Children’s Behaviors

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Overview of Module

In this Module, students will review 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.

Materials Needed

- 2 Flip charts and markers
- LCD Projector and Screen
- Agenda
- Copy of PowerPoint Slides
- Candy for prizes for two quizzes in afternoon Modules
- Two copies of two role plays (found at the end of the Teaching Script)
- Handouts:

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Module #10 Working with Adoptive Parents on Managing Children’s Behaviors

- Handout #10.1 A Case Example: Using Our Knowledge of Early Brain Development
- Handout #10.2: Sweetpea
- Handout #10.3: Responses to Sweetpea’s Situation
- Handout #10.4: Danny
- Handout #10.5: Darla
- Handout #10.6: Checklist: Which are the “Top Ten” Most Concerning Child Behaviors for Adoptive Parents?
- Handout #10.7: Approaches in Working with Adoptive Parents who Report that Their Child is “Difficult” to Manage
- Handout #10.8: From HealthyChildren.org
- Handout #10.9: Mary and Sarah
- Handout #10.10: How to Find the Behavioral Triggers That Set Your Kid Off
- Handout #10.11: Trigger-Behavior-Response Checklist
- Handout #10.12: Setting a Calm and Consistent Routine: Zach
- Handout #10.13: Example of a Contract with a Teen
- Handout #10.14: A Quiz on Trauma and Self Regulation
- Handout #10.15: Specific Measures of Self-Regulation
- Handout #10.16: A Quiz on Genetics and Children
- Handout #10.17: Oppositional Defiant Disorder and Conduct Disorder
- Handout #10.18: Beth and Aaron
- Handout #10.19: Dottie and Angie
- Handout #10.20: Self Care for Adoptive Parents: Healing the Healer
Module #10: Working with Adoptive Parents on Managing Children’s Behaviors

Pre-Module Assignments

Students’ Assignments
None for this Module.

Pre-Module Assignment Checklist for Teachers
None for this Module.

Teacher 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 – 1:30AM 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

© 2012 The Center for Adoption Support and Education
Welcome to this Module on working with adoptive parents on managing children’s behaviors! The Center for Adoption Support and Education (C.A.S.E.) extends its thanks to Casey Family Services for its contribution to this training. C.A.S.E. thanks Casey Family Services for allowing C.A.S.E. to draw on Casey Family Services’ training, “Creating a Therapeutic Home,” in the development of this training. Special thanks go to Ms. Heather Lahti, Deputy Director of the Casey Family Services Maine Division, for her expertise and assistance in the development of this online training program.

Large Group Discussion: Before we begin our Module today that focuses on working with adoptive parents in managing their children’s behavior, what adoption issues have come up in your practice since our last Module together?

Introduction; Behavioral Consequences of Early Impacts on Brain Development, Childhood Trauma, and Attachment [Learning Objective #1]
In this Module today, we will be drawing on the work we have done in previous Modules that focused on the impact of trauma on the developing brain and the concepts of a Healthy Attachment Cycle and a Disturbed Attachment Cycle.

Our specific learning objectives for this Module are that you 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 and Dialectical Behavior Therapy (DBT) with adopted adolescents.

For some of you, this Module on working with adoptive parents on managing their children’s behaviors will be a review of information with which you are quite familiar; for others, this Module may provide new information on topics related to clinical work with adoptive families on children’s challenging behaviors. We have included this Module in the Training for Adoption Competency to assist you in sharpening and refreshing your skills in working with adoptive families when their children present challenging behaviors.

We know that in a great number of cases, adoptive parents seek out the help of adoption competent mental health professionals because of their children’s challenging behaviors.

Therapists who have longed worked with adoptive families are accustomed to helping families with problems in understanding and managing their adopted children’s challenging behaviors. In initial assessments with adoptive parents, therapists may hear such comments as:

"Sometimes we just look at each other and ask what we got ourselves into?"
"We knew this child would be different from us. But sometimes it seems we don’t know him at all."

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"It's narrowed down to keeping our marriage or this child, but not both."
"Every day I struggle with whether to give him back or not."
"I've lost control of my house and life to this child."
"Nothing I do or try seems like enough to help this child."
"We wonder how much longer we can stay committed to these children."

**Large Group Discussion:** What have been your experiences in working with adoptive parents who come to you because of their children’s challenging behaviors? Have you heard comments like these?

**Lecture**

It is important to note that these types of comments are made in a broader context that includes the benefits of having an adopted child. Most parents express that adopting their child is a life-changing event, with numerous rewards. What is often not taken into account, however, is the need to adequately prepare parents for the ways in which adopted children manifest with a variety of psychological characteristics and behaviors that may differ significantly from other children. Many parents embark on the task of raising an adopted child ill prepared for understanding or coping with the behavioral manifestations of a child with complex histories.

As we have learned in earlier Modules, adopted children’s and youth’s early life experiences have often involved parental separation, multiple caregivers, abuse, and neglect – experiences that can present challenges for both adoptive parents and their children. Even with these early life experiences, some children are simply more resilient than others. When considering these variables, however, one can see why adoptive parenting may end up involving much more than anticipated.

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Supporting adoptive parents in managing their children’s behaviors is important in helping families remain together. In a somewhat old – though still quite relevant – 1988 study, James Rosenthal and his colleagues matched pairs of children with special needs who had been successfully adopted with children with special needs whose adoptions had failed, in the hopes of finding out what differences existed between these two groups. They found that although attending to medical concerns or living with a child who is mentally low-functioning was difficult, it was seldom the greatest strain on the parent-child relationship. More significant were the child's emotional and behavioral difficulties--these predicted disruption at a much higher rate than did cognitive or physical disabilities. The article that provides the full findings of this study is on your Reading List.

As we have learned, adopted children who have histories of loss and trauma often exhibit behaviors that are coping strategies to help them defend against strong negative feelings like powerlessness, fear of closeness, and low self-worth. Adoption experts also refer to these negative behaviors as survival behaviors in that they have helped children to survive in their birth homes and in the foster care system. When these behaviors persist long after children are with permanent, safe families, however, families need specialized interventions to help children address underlying emotional issues and change destructive patterns.

**Brain Development: Emotional and Behavioral Consequences**

In your small groups, review the case scenario in Handout #10.1 and the highlights from our learning about early childhood brain development. Develop 3 or 4 talking points that you would use in helping these adoptive families understand the impact of early experiences on their child’s brain development and current behaviors.
Facilitate the groups’ reporting out of the talking points that they would use in working with this adoptive family.

Lecture: Behavioral Consequences of Trauma

As we see in Howie’s case and in other work that we have done:

- Trauma adversely influences the development of the brain.
- During trauma, the brain is in a state of fear-related activation.
- Persisting or chronic activation of this response can cause a persistence of the fear state.
- Children who are physiologically disorganized will rely on others to regulate their emotional state.

Large Group Discussion: What might you expect to be some of the behavioral consequences of early emotional trauma among: young children, school aged children and adolescents?

Facilitate the discussion for the three age groups. Add the following from the National Childhood Traumatic Stress Network and the National Institute of Mental Health as needed:

What might we see in young children?

- Passivity
- Easily alarmed
- Regression to earlier developmental behaviors
- Strong startle reactions
- Night terrors
- Aggressive outbursts
What might we see in school aged children?
• Intensive specific fears
• Alternating between shy or withdrawn behavior and unusually aggressive behavior
• Thoughts of revenge
• Disturbed sleep patterns
• Disruptive behavior
• Irrational fears
• Refusal to attend school
• Depression
• Emotional “flatness”
• Feelings of guilt
• Poor attention and concentration
• Physical complaints with no medical basis

What might we see in adolescents?
• Emotional numbing
• Depression
• Substance abuse
• Problems with peers
• Anti-social behavior
• Withdrawal and isolation
• Physical complaints
• Suicidal thoughts
• Confusion
• Guilt

Lecture: Behavioral Implications of Attachment

In a previous module, we focused on attachment and development. Let’s look at how children’s histories of disrupted attachment can impact their emotional and behavioral status.
Small Group Work

Handout #10.2

Return to your small groups and review the blog posting provided in Handout #10.2: Sweetpea, taken from the Internet. 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.

Report Out

Facilitate the small groups’ reporting of how they might help this prospective adoptive mother think about Sweetpea’s behaviors and her decision about whether to adopt this child.

You may be interested in how other adoptive parents responded to this prospective adoptive mother’s questions. Look at Handout #10.3.

Large Group Discussion: What are your thoughts about these responses?

10:00AM – 10:30AM  Differential Diagnosis and Teaming [Learning Objective #2]

Lecture: Differential Diagnosis

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Differential diagnosis is the systematic method used to identify the condition, syndrome or disorder causing an individual’s signs and symptoms.

The term *differential* derives from the word *difference*: careful differential diagnosis involves first making a list of possible diagnoses, then attempting to remove diagnoses from the list until at most one diagnosis remains.

With emotional and behavioral conditions, there are very few diagnostic exams or tests to rule in or rule out a given diagnosis. Because of this, the skill level of the professionals involved is a vital component of the diagnosis. A team of professionals is often needed to determine what lies behind the signs, symptoms or behaviors of an adopted child.

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Small Group Work

Return to your small groups and review the case study of Danny. Discuss the questions and be prepared to report back to the larger group.

Report Out

*Facilitate the reporting out on the two questions. Make the following points (provided in italics) if not mentioned:*

1. **How might you respond to the question about whether Danny is suffering from RAD? Are there other possible explanations for his behavior?**
   
   • *The diagnostic complexities of RAD require a careful diagnostic evaluation.*
   
   • *Several other disorders, such as conduct disorders, oppositional defiant disorder, anxiety disorders, post traumatic stress disorder and social phobia share many symptoms and are often appear with or are confused with RAD, leading to over- and under-diagnosis.*

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RAD can also be confused with neuropsychiatric disorders such as autism spectrum disorders, pervasive developmental disorder, childhood schizophrenia and some genetic syndromes.

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

You might want assessments by the following before reaching a decision about the reasons for Danny’s behavior:

- Danny’s pediatrician
- A neurologist
- A psychologist (psychological testing)
- A psychiatrist
- An early education specialist

Return to your small groups and discuss Darla’s case provided for you on Handout #10.5. Take the quiz together and discuss together why are answering the way you are!

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”

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C. Janine’s moodiness

D. Janine’s history of neglect

E. Potentially, her birth mothers’ psychiatric history

Answer: A, B, and E. These factors might be strongly considered in making a differential diagnosis involving a possible mood disorder. Janine’s moodiness may be also being a factor related to the developmental stage of adolescence. Janine’s history of neglect, in and of itself, may or may not have a role in Janine’s current behavior.

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

Answer: A and C. Janine is showing some disorganized behavior and there is a history that might suggest parental mental schizophrenia. However, much more would need to be known in considering this diagnosis. Schizophrenia is characterized by the social-occupational dysfunction and at least 2 of the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms. It is not clear that two or more of these symptoms are present. There is concern that in the US, schizophrenia is over-diagnosed. The diagnosis of schizophrenia and other psychotic conditions is sometimes only clarified with certainty over time.

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

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E. Reproductive health issues

Answer: A, B, D and E. It is always important to consider the potential impact of alcohol or other drugs on an adolescent’s behavior. Post Traumatic Stress Disorder is also a possibility given Janine’s early childhood history. There also should be an assessment of the risk for suicide. A potential for suicide exists in all adolescents with psychotic disorders, but assessment of suicide risk should not be limited to adolescents who present with psychotic depression. Reproductive health issues are also important to consider in adolescents, particularly young women. There are no indications in this brief summary of Janine’s history and current status of a conduct disorder.

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

Answer: A, B, C, D, and E. The assessment of an adolescent with possible psychotic symptoms should include a thorough physical examination and appropriate medical work-up, including toxicologic screening or neurologic or other consultations as indicated. Involving Janine’s former and current teachers and/or guidance counselors and her former social work can help bring forth information about Janine’s behavior and emotional status in the past.
What are the behaviors that adoptive parents find to be the most common, persistent, and perhaps the most concerning behavior problems -- that they most want help with? Take a couple of minutes, go to Handout #10.6 and check the behaviors that you believe are the “top ten” most concerning child behaviors for adoptive parents. *Allow participants a few minutes to complete and then provide the following:*

According to a survey of training programs of adoptive parents, here are the top ten most unwanted child behaviors that adoptive families identify.

- Anger Outbursts
- Lying
- Stealing
- Eating Disorders and Food Issues
- Sexualized Behavior
- Fire-Setting
- Sleep Problems
- Self-Destructive Behavior
- Running Away
- Wetting and Soiling

**Large Group Discussion:** How many of these did you identify? Are these the behaviors that the adoptive families with whom you are working most often identify?

We will talk about managing many of these types of behaviors in this training.
Let’s think about what adoptive parents mean when they say that their adopted child is “difficult” to manage.

Let’s look at two ways to work with adoptive families in better understanding what they mean when they say that their child is “difficult” to manage.

In Handout #10.7, you will find two approaches to working with adoptive families on this issue. Among your group, choose one person to be the therapist and the other to be the adoptive parent for Approach #1. Role the scenario provided to you for Approach #1. The remaining group members will be observers. Then choose two different people to role play the therapist and adoptive parent for Approach #2. The remaining group members will be observers. I will call “time” to end the first role play and “time” to end the second role play. At the conclusion, discuss together the questions at the end of Handout #10.7. Allow 5 minutes for each role play and 5-6 minutes for the small group to debrief.

Facilitate the reporting out of the groups’ experience in using the two approaches.

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?
Small Group Work

Having worked with tools to help adoptive parents get clarity about the specific behaviors that they are finding “difficult,” brainstorm in your small groups about techniques or strategies that a therapist can use to help adoptive parents of children who may present as “difficult” to manage. Develop at least 5 strategies that a therapist can use.

Facilitate the reporting out of strategies/techniques, writing the strategies on a flip chart page. Refer participants to Handout #10.8, a list of parenting strategies with children who have “difficult” temperaments developed by HealthyChildren.org

11:30PM—12:30PM Helping Adoptive Parents Manage Their Children’s Behavior: Part 1 [Learning Objectives #4, #5]

Lecture

Freda D. Bemotavicz at the Edmund S. Muskie Institute of Public Affairs, University of Southern Maine, developed the following competencies for adoptive families with regard to behavior management (for more information, go to: http://muskie.usm.maine.edu/helpkids/rcpdfs/fostadopt.pdf)

Based on her model, adoptive parents who are effective in managing their children's non-severe behaviors:

- Understand why physical discipline is not appropriate
- Help children set limits on their behavior
- Follow through on discipline
• Forge agreements with other adult household members so that rules are applied consistently
• Discipline fairly and appropriately
• Encourage and reinforce positive behavior
• Use appropriate techniques to extinguish negative behavior

Large Group Discussion: One of the competencies is that the adoptive parent understands why physical discipline is not appropriate: In many cases, as a therapist, we need to help parents to understand why physical discipline is detrimental to their adopted children. How do we communicate this important point?

Facilitate a discussion and make the following points if needed:

• We may need to say that many of us were spanked and do not feel we were abused by any means. We may even feel that spanking is a positive form of discipline because we believe that it worked well for us as children.

• But, we need to point out that adopted children who have experienced physical abuse will experience spanking as a continuing form of abuse and danger.

• Spanking can trigger experiences of previous abuse and the child may confuse who is abusing them. Adopted children may see spanking as something their adopted parents do because they did not give birth to them and love them less.

• An adopted child may believe that if his adoptive parents were his birth parents, they would never spank him.

Lecture

The goal in our clinical work with adoptive parents is to help them create a structured, consistent, and nurturing home. Sometimes, this is called creating a “therapeutic home.”
Essential to creating a therapeutic home is recognition that the parent is the PRIMARY HEALER, just as we learned in the DDP model. This means that it is the parent, not the therapist, who plays the primary role in helping his or her child heal from past trauma.

Small Group Work

Key to helping parents in creating and sustaining a therapeutic home is assisting them in becoming aware of their own arousal levels – or emotional reactions – when their child behaves in ways that are upsetting or troubling. Develop in your small groups at least 3 ways that as a clinician, you can help parents become aware of and work with their own arousal levels – and especially their expressions of anger -- when they have adopted children who have experienced abuse or neglect.

Report Out

Facilitate the groups’ reporting out of their ideas. Make the following points if not mentioned:

- If an adoptive parent is stressed or anxious in response to their child’s behavior, threat messages will be transferred to their child through body language and tone of voice. Children who have experienced abuse or neglect or other trauma will be especially sensitive to the parent’s verbal and non-verbal behavior.
- Adoptive parents can be helped to assess different expressions of their own arousal levels: body language, eye contact with the child, facial expression and tone of voice.
- We can help adoptive parents think about how they react in stressful situations and how those reactions might impact their child.
- We can help adoptive parents recognize and deal with their own anger in difficult moments with their children. We can help them understand that it is not helpful to pretend to be okay when they are really angry.
- We can help adoptive parents talk about their feelings with their children as they feel their anger mounting. If the adoptive parent feels that he might be too angry to make a good decision, the parent can wait a few minutes and think it over before he responds.
If the other parent or another caring adult is present, the adoptive parent might want to ask this person to step in for a time so that the adoptive parent can take a break.

Lecture

Some key principles that we can share with adoptive parents to help them create the structure and consistency necessary for a therapeutic home for their children are:

1. The child is doing the best he/she can.

   In the book, *Parenting a Child with Intense Emotions*, the authors write:
   
   “Accepting and reminding yourself that a child is doing the best he can help you feel less angry, less disappointed, and less frustrated with your child. In turn, your child is less angry, less frustrated, and more able to hear what you say to him. Remembering the assumption that your child is “doing the best he/she can” will prove quite helpful when your child has strong emotions.”

2. The child may have a temperament that is very different than the parent(s).

   • It is not uncommon that parents who have several children recognize differences in persistence, distractibility, and energy levels, and are aware that one child may be typically outgoing and enthusiastic, while his brother is shy and "low-key."

   • One child may be temperamentally the same as his or her parents while another child is quite different. In adoptive families, it is equally true that a child may have a temperament that is like his or her parents or quite different.

   • The mix or the "goodness of fit" between parent and child matters. The match or mismatch between a child and parent determines the harmony between them. Temperament, however, is not set in stone. Although temperament has been shown to be consistent over time, family environment and life experiences
can make a difference. Parents who are sensitive to their child's temperamental style and can recognize the child's unique strengths can make family life smoother.

3. The child’s psychological and chronological ages are important.

**Large Group Discussion:** What is the difference between psychological and chronological age and why is it important to pay attention to both?

*Make the following points if not mentioned:*

- Chronological age is the child’s actual age from birth regardless of development level. Chronological age is a measure of the time a person has spent out of the womb interacting with the environment.
- It is inseparably associated with biological growth and experience. Individual growth rates vary widely, and, as a result, children of the same chronological age show marked differences in strength, motor proficiency, and other qualities.
- Psychological age refers to the child’s emotional and social maturation. Psychological age can be impacted by early experiences of abuse, neglect or abandonment.
- Some children function at a much younger psychological age than their chronological age because of experiences of early deprivation.

4. It is important to pay attention to stimulation and stress levels for children.

- Children are exposed to stress on a daily basis. There are times they need help to cope with stress. If they do not have a release, they can become overwhelmed – which can lead to melt downs or inappropriate behavior.
- Stress in children varies, depending on the child's life experience and his/her development level. Children under the age of six, and those with learning disabilities and developmental disorders are less cable of coping with stress than older children.
• A child can learn from a small amount of stress in daily life. However, if a child is exposed to situations that cause him/her excessive stress, the negative impact can be profound. As an example, if an adopted child was repeatedly exposed to domestic violence involving hitting and screaming when she was with her birth family, she will likely react strongly if her adoptive parents raise their voices with one another.

• Negative stress affects children in every walk of life and in many different ways. It is especially difficult for children under ten to cope. Those who are male, have social disorders, are "difficult," or who were born premature are also more vulnerable. Children with histories of exposure to domestic violence, extreme poverty, or exposure to street violence, and children who have been bullied have been exposed to extremely high levels of stress on a continuous basis.

• High stress levels can have many detrimental effects on young children, including, but not limited to, a change in brain chemistry and function and a higher risk of disease. Stress can lower a child's immune system, making him/her susceptible to colds, flu and childhood diseases.

• Stress in children is almost always released by physical reaction. Excessive sweating, clammy palms, rocking, crying for no reason, temper tantrums or melt downs, stomachaches, headaches, nervousness, hair chewing, thumb sucking, bed wetting, fingernail biting, hair twisting and sleep disorders are all signs a child is overwhelmed. Depression, shyness, worrying, appetite change, and clinging are also signs of excessive stress levels in children.

What are some environmental strategies that we can help parents learn in order to create a therapeutic home for their adopted children? We will look specifically at these strategies:

• Supervision
• Forecasting difficult times
• Calm, consistent routine
First, let’s consider supervision. In your small groups, read the case scenario of Mary and Sarah (Handout # 10.9). Discuss the questions that follow the case scenario and be ready to report out to the larger group.

**Report Out**

Facilitate the reporting out of each question. Add the points listed below each question if not raised in the discussion.

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

   We know from research and clinical experience that teens who were sexually abused as children are at greater risk in adolescence of:

   - Pregnancy
   - Multiple sexual partnerships
   - Sexually transmitted disease
   - Sexual re-victimization

   We also know that when children are exposed to the sexual advances and acts of adults, they are at risk for later sexual problems. The more extreme and persistent forms of abuse produce greater disruption of the child’s developing sexuality.

   When the sexual abuse has been particularly gross (in terms of physical intrusiveness, frequency, duration or closeness of relationship to abuser), there is an increased risk of precocious sexual activity in adolescence -- with the attendant risks of teenage pregnancy and social ostracism.

   More information on the longer term impact of child sexual abuse on teens and adults can be found on your reading list.

2. **What types of supervision would you help Mary develop to ensure Sarah’s physical and psychological safety?**

   Develop an attentive supervision plan to protect Sarah:

   - Guide her in the proper attire
   - Help her develop other ways to talk with male adults
• Watch her behaviors with adult males to protect her from possible harm

In addition, Mary could be helped to establish guidelines in the home:

• Help Sarah learn the importance of privacy – for herself and for others in the home.
• Keep adult sexuality private.
• Be aware of and limit sexual messages received through the media. Teens who have experienced sexual abuse can find sexual content overstimulating or disturbing. Mary might want to monitor music and music videos, as well as television programs, video games, and movies containing nudity, sexual activity, or sexual language and limit access to adult magazines. She may want to monitor Sarah’s Internet use. Information on protecting children and teens from media harm is on your reading list.

Lecture: Forecasting Difficult Times

As therapists, we can help adoptive parents anticipate problems, plan ahead and be prepared. We can help adoptive parents learn to recognize their child’s triggers, anticipate what settings and contexts elicit difficult behaviors and develop a plan to manage the behavior before it occurs or identify strategies to reduce the likelihood of the problem arising.

• Children who are adopted may have specific “triggers”—words, images, or sounds -- that signal danger or disruption to their feelings of safety and security. The triggers are specific to each child but they come from past experiences or are associated with trauma.

• Children tend to develop their own “cues” in response to these trigger events -- warning signals that adults can “read” to understand that the child is having difficulty. These cues may include facial expressions or nervous tics, changes in speech patterns, sweating, feeling ill, becoming quiet or withdrawn, complaining or getting irritable, or exhibiting a fear or avoidance response.
• If adoptive parents miss these cues, children may escalate their behavior to a point where they completely lose control.

To focus more on “triggers”, look at Handout # 10.10. This Handout provides information from Empowering Parents for parents in identifying triggers and helping their children become more aware of their triggers. Review this Handout later and consider it a resource in your work with adoptive parents.

In your small groups, review Handout # 10.11 Trigger-Behavior-Response Checklist developed by Lehigh University as homework for its Parent Education Program. This is a tool is designed to help parents be aware of the triggers for their child, the child’s resulting behavior, and how they as parents responded. Review this tool and discuss with your group how you might use it with adoptive parents with whom you are working.

Report Out: What are your thoughts on this tool? Do you see it having value in your work with adoptive parents?

Lecture: Calm and Consistent Routine

The third strategy – in addition to supervision and forecasting difficult times – is establishing a calm and consistent routine. We often think about routines for infants and younger children. But, what about establishing a calm and consistent routine for teens? As we discussed in an earlier Module, young people’s emotions and behaviors can shift into overdrive during adolescence, sending them potentially off into risky territory. These issues may be intensified when a young person has experienced earlier trauma.
Small Group Work

In your small groups, read the case example in Handout #10.12 about Lynn and Howard and their son Zach. Answer the questions that follow the case example and be ready to report to the larger group.

Report Out

Facilitate the reporting out of the groups’ work on each question.

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

Have the groups report on their strategies. Cover the following as needed:

Some strategies that the therapist can recommend are:

- **Help Lynn and Howard recognize that balanced limits build trust between parents and teens.**

Lots of parents are afraid to set limits and Lynn and Howard may have special fears because of Zach’s comments about searching for and going to live with his birth parents. Lynn and Howard worry that limits will build a wall between them and Zach. In truth, limits actually show a teen that his parents care. The tricky part is finding a balance between parents’ need for control and the teen’s need for independence.

A University of California (Berkeley) study found that parents who set clear, consistent rules but also give their teens some freedom are definitely doing something right. Their teens score higher on tests; are more mature, positive, and skilled in social situations; and are much less likely to use alcohol and drugs than other teens. Here is the study: Diana Baumrind, "The Influence of Parenting
Style on Adolescent Competence and Substance Use," *Journal of Early Adolescence* 11(1), 1991, 56-95

• *Every teen is different. It is important for Lynn and Howard to be clear about where Zach needs limits.*

Zach appears to need a good deal of structure right now. Lynn and Howard may consider setting boundaries that spell out:

- What he can and can't do during after school.
- When he has to do homework.
- When he needs be home at night on weekends.
- What kinds of parties he can go to and who he can go with.
- When and why he can use a car and ride in one.

• *Work with Lynn and Howard to join with Zach on setting the rules.*

Teens are much more likely to obey rules and limits that they help to create. Lynn and Howard can be supported in working with Zach to figure out what they both can live with. They can be encouraged to be open-minded about Zach’s goals and needs — and crystal clear about theirs. Two guidelines:

- **Work for both parents and teen.** Find middle ground.
- **Make the parent’s expectations clear.** Saying "Be responsible" is vague. Saying "Do your homework before you ask to go out" spells out what you expect.

• *Work with Lynn and Howard in joining with Zach on the consequences as well.*

Lynn and Howard need support in establishing the price to be paid for stepping over the line. They can engage Zach in helping define the consequences. Some questions that they might keep in mind:

- **Does the punishment fit the crime?** Grounding him for a week may be too harsh when Zach 20 minutes late for dinner, but reasonable when he misses curfew by two hours.
- **Can you enforce the consequence?**
• **Is the consequence clear?** Saying, "If you miss curfew, you can't use the car." is vague. Saying, "For every 30 minutes you're late, you lose your right to use the car for one day." makes the cost clear.

• **Ask Lynn and Howard to consider making a contract with Zach.** It is important that Lynn and Howard and Zach be on the same page. They might ask Zach to say each limit and consequence out loud. They may choose to put the details in writing. An example of contract specifically addressing drug and alcohol use is on Handout #10.13.

  Handout #10.13

2. **How would you work with them about their fears of losing Zach if they take these steps?**

   *Have the groups report out on their ideas. Make the following points if not mentioned:*

   • It is not uncommon for teens to express rejection of their parents. Teens who are not adopted may threaten to run away. Teens of separated or divorced parents may threaten to go to leave with the other parent. Teens who are adopted, depending on their level of contact with and knowledge about their birth parents, may threaten to find a “better” place with their birth parents.
   
   • Zach is attempting to solve the struggles with his adoptive parents through ignoring them and letting them know that he could “vote with his feet.” By addressing these struggles in a constructive way, both issues can be resolved.
   
   • If Zach has no or little information about his birth family, he may be signaling a desire to know more and that desire should be respected to the extent it may be possible. We will talk more about openness in adoption in the next Module.
   
   • If Zach has information about his birth parents or is in contact with them, it would be important to address his statements with the therapist to determine what is behind this behavior.
Lecture: Self Regulation

Self-regulation can be thought of as having two parts: cognitive regulation and social-emotional regulation. Self-regulation is a combination of the two.

Cognitive self-regulation is the degree to which children can regulate their own behaviors, are reflective, and can plan and think ahead. They have control of their thinking. They plan, they monitor, they evaluate thinking strategies, and they can attend and remember on purpose.

It is not to say that children without self-regulation cannot attend or remember at all -- some children can remember remarkable things like the numbers of all the players on their favorite team. What children need to learn to do is to "remember on purpose" – that is, to remember things they must know and remember how to act in a given situation.

Social-emotional self-regulation means that the child is able to inhibit and delay gratification. The child can control his emotions. As an example, if someone bumps into 8-year-old Henry on the playground, he doesn’t erupt into anger. With social-emotional self-regulation, the child knows when he’s talking too loud, when he’s irritating other people, or when he needs to stop a behavior. Social-emotional regulation also means the child can internalize standards of behavior and apply these standards without being reminded. As an example, four year old Sally shows social-emotional regulation when she sees a friend building a block house and walks around it instead of into it.

Dr. Bruce Perry and Dr. Bessel van der Kolk have written extensively on the impact of trauma on a child’s ability to self regulate.
Return to your small groups and together take the quiz on Handout #10.14. When we return to our small groups, we will check everyone’s answers. The team with the most correct answers wins a prize!

Report Out

Review each question and have the groups call out their answers. Confirm the correct answer and provide the information included below for each correct answer.

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

   Answer: B. By anticipating their caregivers’ responses to them. Children’s interactions with their caregivers allows them to construct what Bowlby calls their “internal working models”. These internal working models are defined by their internalizing the affective and cognitive characteristics of their relationships with their caregivers.

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

   Answer: A. Tolerate the sensations of distress that accommodate an unmet need. The first time an infant feels hunger, she feel discomfort, then distress and then she cries. An attuned adult
responds. And after thousands of cycles of hunger, discomfort, distress, response, and satisfaction, the child learns that this feeling of discomfort, even distress, will soon pass. An adult will come. As young children learn to read and respond appropriately to these inner cues, they become much more capable of tolerating the early signs of discomfort and distress that are related to stress, hunger, fatigue, and frustration. When a child learns to tolerate some anxiety, he will be much less reactive and impulsive. This allows the child to feel more comfortable and act more "mature" when faced with the inevitable emotional, social, and cognitive challenges of development. With the capacity to put a moment between a feeling and an action, the child can take time to think, plan, and usually come up with an appropriate response to the current challenge.

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

*Answer:* C. Process and integrate what is happening. At the core of traumatic stress is a breakdown in the capacity to regulate internal states. If the distress does not let up, children cannot comprehend what is happening or devise and execute appropriate plans of action.

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

*Answer:* D. Regulate their emotional distress. When children are exposed to reminders of a trauma, they tend to behave as if they were traumatized all over again. Their problems can be
understood as efforts to minimize objective threat and regulate their emotional distress. Unless parents understand the nature of such re-enactments, they are likely to label the child as ‘oppositional,’ ‘rebellious,’ ‘unmotivated,’ and ‘antisocial.’

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

Answer: All choices should be checked. Children who are chronically traumatized are literally “out of touch” with their feelings and often have no language to describe internal states.

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

Answer: C. Repeat their traumatic pasts. These children tend to communicate their traumatic past by repeating it in the form of interpersonal enactments, in their play and in the fantasy lives. The other three responses are incorrect: (A) Children who are chronically traumatized rarely spontaneously discuss their fears and trauma and they have little insight into the relationship between what they do, what they feel, and what has happened to them. (B) These children have difficulty appreciating novelty; without a map to compare and contrast, anything new is potentially threatening. What is familiar tends to be experienced as safer even if it is predictable source of terror. (D) These children lack internal maps to guide them and they tend to act, instead of plan and they show their wishes in behavior rather than discussing what they want.
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

Answer: C. Poorly organized and hyper-reactive. The reasons for the poor organization and hyper-reactivity of these children’s stress response system are varied but include genetic predisposition, developmental insults (such as lack of oxygen in utero), or exposure to chaos, threats, and violence.

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

Answer: 1, 2, 4, 5. Children with poor self-regulation are often impulsive, hypersensitive to transitions, and tend to overreact to minor challenges or stressors. They may be inattentive or physically hyperactive.

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

**Answer:** All are correct (1-7).

**10. True or False:** Self regulation is extremely important in the teen years.

**Answer:** True. Self-regulation remains perhaps even more important in the teen years, which are often marked by an increased vulnerability to risks such as truancy, peer victimization, and substance use. Adolescents who do not regulate their emotions and behavior are more likely to engage in risk-taking and unhealthy behaviors. Being able to suppress impulsive behavior and to adjust behavior as appropriate has been linked to positive outcomes for children and adolescents. Some of these positive outcomes include:

- **Higher academic achievement.** Children who are self-regulated are more likely to perform well in school.
- **School engagement.** Adolescents who delay gratification and adjust their behavior are more likely to be engaged in school. Moreover, such students tend to work harder than do their peers who lack self-regulatory abilities.
- **Peer social acceptance.** Self-regulation is also linked with favorable perceptions by others. Children and adolescents who are able to control impulses and reflect on their actions are more likely to have friends and to get along with others.
- **Avoidance of negative behaviors.** Self-regulated adolescents are less likely to engage in substance abuse, truancy, and violence.
- **Healthy eating patterns.** Adolescents who are able to regulate their behavior are more likely to have healthy eating habits.
Lecture

In our work with adopted children and teens, we can work with them in assessing their levels of self regulation. Several assessment tools for self regulation in children and youth have been developed and are provided in Handout #10.15.

Small Group Work

Divide into pairs. I will assign each pair one of the three assignments. Use the assigned questionnaire with your assigned child and youth and role play the use of the questionnaire with the child/youth assigned to you. Complete the scoring and discuss your preliminary conclusions about the child’s/youth’s level of self regulation.

*Give each pair an assignment, attempting to assign an equal number of pairs to each assignment. Allow about 12 minutes for the activity.*

Report Out

*Facilitate the reporting out of the pairs for each assignment. Ask:*

- For therapists: How well do you believe you introduced the questionnaire and the reasons for using it to the child/youth?
- For children/youth: How did you feel about using the tool?
- How did the process go in using the tool?
- How did you conclude the session?
- What were the scores? [Note to Trainer: Allow the [pairs to discuss any differences scores]
• What were your preliminary conclusions about the child‘s/youth‘s level 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.

Lecture: Research on Children’s Self-Regulation

In our work with adoptive parents around their children’s self regulation issues, there is limited research on which we can draw that focuses on children who have been abused or neglected. Here are some of the few studies on these issues:

• One study, Longitudinal Study of Self-Regulation, Positive Parenting, and Adjustment Among Physically Abused Children by Kim-Spoon and colleagues (see Reading List), found that in physically abused children ages 4 to 7 with low level of self regulation, positive parental behaviors act as a protective factor to reduce externalizing
symptomatology. This study found that physically abused children with low levels of self regulation suffer detrimental effects resulting from negative parental behaviors.

- A study by Schatz and colleagues (see Reading List) found that self-regulation is a key process variable in the relationship between maltreatment risk and children's development. The findings suppored targeting self-regulatory abilities to halt the progression of developmental difficulties often found in maltreated children. The researchers suggested that because self-regulation is a mechanism for transmitting the effects of maltreatment risk to multiple domains of children’s functioning, intervention programs that focus on fostering self-regulation in home and preschool settings should enhance developmental outcomes. Another study by Cleary and colleagues (see Reading List) found that showed that adolescents with histories of maltreatment regulate themselves best when their family functions well as a group.

**Large Group Discussion:** What are your thoughts about these research findings?

**2:30PM – 2:55PM  Genetics and the Impact on Behavior [Learning Objective #7]**

Let’s look now at the potential role of genetics in specific child behaviors. We know that genetics play a significant role in a child’s growth, learning, behavior, and personality. Understanding the effect of genetics on child development and behavior can help adoptive parents give their children the best possible opportunities. Some conditions for which genetics play at least a partial role are:

- Down's Syndrome
- Fragile X syndrome
- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)
• Autism
• Obsessive compulsive disorder
• Schizophrenia
• Bi-polar illness
• Early onset depression

How much do you know about each of these conditions? Return to your small groups and do an additional quiz with one more chance to win prizes! Complete the quiz on Handout #10.16. 
Allow about 10 minutes for teams to complete the quiz.

Let’s see how you did! Prizes for the team that gets the most correct answers! Work through the following questions. Answers are in italics below each question.

**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
Answer: D. Both a and b. Individuals with Down Syndrome are susceptible to many health conditions in addition to poor hearing and thyroid difficulties, including: cataracts, celiac disease, congenital heart disease, dementia and intestinal and skeletal problems.

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

Answer: F. All of the above.

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

Answer: All should be checked. Intervention strategies for treatment of behavior problems are variable and dependent on the child’s age, severity of the problem and the setting in which the behavior is most commonly seen.
1. **True or False:** Fragile X syndrome is the most common cause of mental retardation.

*Answer:* True. Some symptoms of this childhood health disorder are: intellectual problems ranging from mild learning disabilities to severe mental retardation; loose flexible joints and flat feet; social and emotional problems including possible aggression, attention difficulties or shyness; and speech and language difficulties.

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

*Answer:* C. Violent outbursts. Boys with Fragile X are often described as distractible and impulsive, with symptoms of attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD). Many boys have unusual, stereotypic behaviors, such as hand flapping and chewing on skin, clothing, or objects, which may be connected to sensory processing problems and anxiety. Sensory processing problems may manifest themselves as tactile defensiveness, such as oral motor defensiveness, sensitivity to sound or light, and poor eye contact. Some children with fragile X become very worried about changes in routine or upcoming stressful events (e.g., fire drills, assemblies). This is often referred to as "hyper-vigilance." Parents often report that their children stiffen up when angry or upset and become rigid and very tense. Sometimes, they simply tighten up their hands. Tantrums may be a result of anxiety and a
feeling of being overwhelmed. Crowds and new situations may cause boys to whine, cry, or misbehave, in attempts to get out of the overwhelming settings.

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

   ___ Yes

   ___ No

Answer: Yes. Girls with the full mutation of the fragile X gene appear to have some specific areas of concern in the area of behavioral and emotional difficulties. Shyness, anxiety, depression and difficulties with social contacts are most often mentioned as characteristics of girls with fragile X.

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
Answer: C. Depression. *Distractibility, impulsivity and inattention are symptoms of ADD and ADHD and hyperactivity is a symptom of ADHD.*

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

   Answer: B. *Environmental factors such as lead or maternal smoking during pregnancy. Other possible causes of ADD/ADHD are: brain injury before or after birth and nutrition and food (sugar, food additives and/or lack of omega-3 fatty acids have an adverse affect on some children.)*

3. **True or False:** Adoptive parents often need assistance in identifying parenting patterns that are contributing to their children’s attention disorder problems.

   Answer: False. *Adoptive parents should be assured that no sort of bad parenting is a cause of 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.

   Answer: True. *Overt symptoms of autism gradually begin after the age of six months, become established by age two or three years, and tend to continue through adulthood, although often in more muted form.*
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
   
   D. Restricted interests and repetitive behavior

   Answer: **C. Impairments in cognition and memory.** *A, B, and D describe the triad of symptoms of autism and the autism spectrum disorders.*

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

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

   Answer: **D. Creativity.** *Children with autism experience developmental problems in behavior, language and social skills.*

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### Obsessive-Compulsive Disorder

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

   Answer: True. *Close relatives of those with obsessive compulsive disorder are up to nine times more likely to develop it than the general population.*

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

Answer: E. All of the above. Obsessive compulsive disorder (OCD) is a type of anxiety disorder. Children with OCD become preoccupied with whether something could be harmful, dangerous, or wrong, — or with thoughts that bad things may happen. With OCD, upsetting or scary thoughts or images pop into the child’s mind and are hard to shake. Children with OCD may also worry about things being out of "order" or not "just right." They may worry about losing "useless" items, sometimes feeling the need to collect these items. A child with OCD feels strong urges to do certain things repeatedly in order to banish scary thoughts, ward off something dreaded, or make extra sure that things are safe or clean or right. Children may have a difficult time explaining a reason for their rituals and say they do them "just because."

3. **True or False**: Children are easily diagnosed with obsessive compulsive disorder.

Answer: False. The onset of obsessive-compulsive disorder (OCD) usually occurs during adolescence or young adulthood, but younger children sometimes have symptoms that look like OCD. However, the symptoms of other disorders, such as ADD, autism, and Tourette’s syndrome can also look like obsessive-compulsive disorder, so a thorough medical and psychological exam is essential before any diagnosis is made.

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.

Answer: False. Studies indicate schizophrenia is influenced by genetics, but genetics alone cannot be considered the root cause of schizophrenia. Many individuals experiencing schizophrenia have no family history of the illness. Instead, genetics are thought to make certain people more susceptible to schizophrenia. Other considerations, such as environmental factors, may combine with genetics to trigger 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

Answer: D. Cruelty to animals. The other choices are possible indicators of childhood schizophrenia.

3. **True or False**: A proper assessment is crucial to diagnosing childhood schizophrenia and finding effective treatment.

Answer: True. Diagnosing childhood schizophrenia is challenging because children are often unable to verbalize thoughts and feelings. A proper assessment is crucial. The assessment should consist of gathering information from several sources: parents, child, teachers, and the
child’s pediatrician. Signs and symptoms should also be gathered to see if the child meets DSM-IV criteria for the disorder.

Bi-polar illness

1. Individuals who are risk for developing manic depressive (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

Answer: B. Between 14 and 18 years of age.

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

Answer: B. Irrational feelings of guilt and sadness. These feelings are warning signs of a depressive episode. Warning signs of a manic episode include increasing feelings of euphoria, impulses toward reckless or risky behavior, lack of self control with finances, severe agitation and a decrease in the need for sleep or food. Racing thoughts and flights of creativity also are signs.
3. **True or False**: Behavioral warning signs of a depressive episode include sleeping up to 20 hours a day.

*Answer: True. Depressive episodes are marked by a significant lack of energy, sleeping up to 20 hours a day, and a craving for sweet or bready foods.*

![Early onset depression](image)

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

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

*Answer: C. Genetic, social and familial factors. Children of parents who experienced an early onset depression are at greater risk of a pre-adolescent depression; genetics very likely play a role in the transference of the disorder*

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

*Answer: E. All of above. In addition, the following are signs of early onset depression: persistent sadness and hopelessness; increased irritability or agitation; poor self-esteem or guilt; frequent
physical complaints, such as headaches and stomachaches; lack of enthusiasm, low energy, or low motivation; and drug and/or alcohol abuse.

Large Group Discussion: How well did your team do? Note to Trainer: Award candy to the winning team(s).

2:55PM – 3:10PM  Break
3:10PM – 4:20PM  Helping Adoptive Parents Manage Severe Behavioral Issues  [Learning Objectives #8, #9, #10]

The conditions that we just discussed are believed to have at least some genetic basis and can involve severe behavioral issues. There are other conditions that adopted children may have that can result in severe behavior problems. Today, we will focus on two of these conditions: Oppositional Defiant Disorder (ODD) and Conduct Disorders. Take a minute or two to look at Handout #10.17.

What are the competencies that we can help adoptive parents to develop in managing their children’s severe behavioral problems? Let’s look at A Competency Model for Foster and Adoptive Parents developed by Freda D. Bemotavicz.

Competency #1: With the therapist, adoptive parents develop a strategy for intervening when a child exhibits severe behaviors. The adoptive parent has a plan tailored to the child's needs as to how the parents and other household members will handle severe behavioral problems. The adoptive parents value the plan as a means to stay grounded in emergencies.
Large Group Discussion: What are some of the characteristics of a plan for adoptive parents to manage severe behaviors?

Raise the following if not mentioned:

1. The plan is written down.

2. The plan has behavioral goals written in specific language that the child can understand.

3. The goals are age appropriate.

4. There are only a few goals. Inclusion in a behavioral plan should be limited to behaviors involving safety, socialization, personal hygiene (including sleeping and eating behavior), and other core living skills, and only if the child does not seem to be acquiring them through modeling, instruction, or normal maturation. Too many target behaviors confuse the child and make success unlikely.

5. The plan is fair.

**Competency #2:** The adoptive parents protect people and pets in the household when a child is behaving destructively. The adoptive parent acts quickly to get everyone out of harm's way.

**Competency #3:** The adoptive parent projects calm and control when a child is out of control.

**Competency #4:** The adoptive parent uses appropriate techniques to calm children who are exhibiting out of control behavior or behavior that is self-destructive or destructive to people, pets, and property. The adoptive parent works closely with children to help them learn how to bring themselves under control.

When adoptive parents stop an unsafe, out-of-control act in a gentle manner, they send the child three reassuring messages:

1) "I can count on my parents to help me when I lose control."
2) "When I grow up I will be able to control myself and act with compassion like my parents do."

3) "My parents see my need. I am not bad; it is my action that is wrong. I am loved and lovable - and, like them, I will learn to express myself freely but safely."

As therapists, we can help adoptive parents strengthen their skills in stopping unsafe acts gently and clearly. Here are some ways that adoptive parents can be helped to respond to their children’s unsafe acts:

- Remind the child that feelings can be expressed but not acted on.
- Lovingly remove the aggressive child from the act, hugging the child (when receptive), and telling the child: "I see you are very upset, (angry, scared). I'll help you vent your feelings safely and resolve your needs".
- When there is a victim, immediately tend to this person without scolding the aggressor. The aggressor will benefit from watching the parent’s compassion toward the hurt child and is likely to feel remorse.
- Scolding or punishing the aggressor takes the opportunity for developing remorse away from him. Instead, the child may feel rage and self-hatred.

In your small groups, read the case scenario about Beth and Aaron in Handout #10.18. Discuss your answers to the questions and be prepared to report back to the larger group.

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

Some possible things that Amanda and Hank could say to their daughter are:
• “I am so lucky to share life with you.”
• “You are so important to me.”
• “I love you.”
• “What an awesome person you are.”

2. How can you help Amanda and Tom respond when Beth hurts Aaron?

When Beth hurts Aaron, Amanda and Hank can:

• Gently stop her
• Give love
• Say: “Daddy and I love you, and we love Aaron. Remember, we cannot hurt each other. I will help you not to hurt him. Daddy and I will make sure we are all safe at home. Please use your words and tell me why you want to hurt Aaron.”

Lecture

Competency #5: The adoptive parent understands and accepts the fact that severe behavioral problems are not easily or quickly resolved.

When adopted children’s behavior problems are severe, it is important to help adoptive parents understand that they will not be quickly or easily resolved. Look at a case drawn from an adoptive parent’s letter asking for help . . .

Small Group Work

In your small groups, read the case of Dottie and Angie in Handout #10.19. Discuss together the questions that follow the case scenario and be ready to report back to the larger group.
Facilitate the reporting out on the two questions. Cover the material after each question.

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

Lecture

Angie’s Temperament. As we discussed earlier, temperament is the “emotional style” of a child. A temperamentally difficult child may behave in ways that are impulsive, insensitive to others, easily threatened, aggressive or withdrawn. Except in the most severe cases, however, temperament alone cannot indicate that a child may become dangerous or violent.

Problems in Attachment. What in Angie’s history and behavior might lead to believe that attachment might be an issue?

Here are two possible indicators:

- Unstable and inconsistent caregiving in the first year of life
- Current indiscriminate affection for strangers

Emotional Trauma. Emotional trauma has a negative impact on a child’s emotional style profoundly affecting their relationships and how they view the world. Physical, emotional and mental abuse damages a child’s basic sense of safety. Children who are physically abused and treated violently often become violent. A child who is neglected, which appears to be Angie’s history, often has difficulty forming relationships and caring about others.

Prenatal and/or environmental exposure to drugs and/or alcohol.
Studies have shown that school age children who were perinatally exposed to meth and other drugs are at greater risk of:

- Attention Deficit Hyperactivity Disorder
- Social maladjustment possibly caused by sensory integration problems, development disorders, and environmental deprivation
- Learning disabilities leading to academic failure.

We know that Angie’s birth mother used drugs. We may need more information on whether Angie was prenatally or environmentally exposed to meth or other drugs. Resources on meth exposure on children are on your reading list.

We also know that Angie’s birth mother drank heavily. There has been much research on Alcohol-Related Neurodevelopment Disorder (ARND) that shows that children who are exposed pre-natally to alcohol can experience a complex pattern of behavioral and learning problems, including difficulties with memory, attention and judgment. Some of Angie’s behaviors might suggest the possibility of ARND. Resources on FAS and ARND are on your reading list.

2. What might be some interventions that you would talk with Dottie about?

**Lecture**

Here is where a multidisciplinary assessment and differential diagnosis will be key. The following would likely be indicated:

- A neuropsychological evaluation that looks at the relationship between the functioning of Angie’s brain and her behavior
- A psychiatric assessment for any underlying psychiatric disorders that may be present
- A behavioral/environmental assessment
- A sensory integration assessment
- A special education assessment that includes special classroom management for behavior modification and special education program needs
Lecture: Interventions with Teenagers with Severe Behavior Problems

We have looked at Cognitive Behavioral Therapy (CBT) previously but today we will focus on CBT as an approach that has proven effective in helping teens with severe behavior problems. This module is not intended to teach CBT but instead to introduce CBT as a treatment approach that therapists can learn or know enough about to appropriately refer their adoptive family clients. Let’s look specifically CBT with adopted teens with foster care histories. We are drawing here from an excellent article by Pamela Lowell that is on your reading list.

The inability to manage strong feelings can cause adopted teens to act out in inappropriate ways. These young people have experienced trauma and multiple losses. As we discussed earlier, they display difficult behaviors when memories are re-triggered by circumstances that remind them of the trauma and loss that they have experienced. They may not even be aware of the exact memory.

Cognitive Behavioral Therapy (CBT) is based on an understanding that feelings trigger thoughts and those thoughts influence behaviors. While we cannot control feelings because feelings are neither good nor bad, we can control the meaning that we assign to our feelings. By getting a handle on our thoughts, we can manage our behaviors.

Here are the questions that we might ask an adopted teen after a difficult incident – using the principles of CBT:

1. What were you FEELING before you acted out? Mad? Jealous? Scared? Frustrated? What signals were you getting from your body that you were feeling that way? Heart beating fast? Clenched fist?
2. What THOUGHT was connected to the feeling? OR What were you saying to yourself at the time? For example: “Hitting makes me feel better?” or “Lying will get me out of this situation?” We can help the teen find the thought that was there.
3. What "BEHAVIOR" was connected to the thought? What did you do? Actually hit the person? Throw something? Scream? Lie? Did it get you what you wanted?
4. If not, what could you have told yourself about that feeling to change your behavior and not get you into trouble? In other words: what would be a more positive thing for you to think?

**Demonstrated Role Play**

We will apply these questions to a situation in which a teen, Brad, adopted at age 14 and now age 16, hurled his cell phone at the wall, in the general direction of his adoptive dad. Brad routinely throws things when he is frustrated or angry. May I have a volunteer to read the part of the therapist?

*Note to Trainer: Two copies of the Role Play at the end of this Teaching Script.*

Here is how the conversation between Brad and his therapist might go – in extremely oversimplified form:

Therapist: What were you FEELING when you threw the cell phone?

Brad: I was angry. My dad was yelling at me to get off the phone and get to my chores. My heart was beating fast.

Therapist: What were you saying to yourself at the time? (THOUGHT)

Brad: I have to throw things--it calms me down.

Therapist: So, what did you do?

Brad: Well, I threw my phone against the wall.

Therapist: Did that get you what you wanted?

Brad: Well, no. I don’t have a phone now and I was grounded for a week. I guess if I keep throwing things, I am going to keep getting into trouble.

Therapist: What could you have told yourself when you get angry -- to change your behavior and not get you into trouble?
Module #10 Working with Adoptive Parents on Managing Children’s Behaviors

Brad: When my heart is beating fast I know I’m getting angry.

Therapist: So when you feel your heart beating fast, what could you do instead of throwing things – things that would calm you down but not get you in trouble?

Brad: I don’t know.

Therapist: Let’s brainstorm some ideas.

[Eventually Brad and Therapist come up with six ideas: shoot baskets, listen to music, tell his parents he is mad, take a few deep breaths, go for a run, watch a sports program]

Therapist: So, how can these ideas help you?

Brad: Okay, I know that I am going to get angry sometimes. I guess that I can do some of things instead of throwing stuff.

END OF ROLE PLAY

Large Group Discussion: What are your thoughts about using this approach with adopted teens?

Lecture

Dialectical Behavior Therapy (DBT), which was developed by Marsha Linehan, PhD, at the University of Washington, is a type of psychotherapy for borderline personality disorder (BPD). DBT is a cognitive behavioral therapy that focuses on the role of cognition and behaviors in the development and the treatment of BPD. DBT includes some changes to the traditional cognitive behavioral elements of therapy in order to help specifically reduce the symptoms of BPD.
**Research Support for Dialectical Behavior Therapy.** DBT was the first psychotherapy shown to be effective in treating BPD in controlled clinical trials -- the most rigorous type of clinical research. While DBT is no longer the only therapy to have shown effectiveness in controlled trials, it has grown a large evidence base and is considered one of the best treatments for BPD in terms of documented success rates.

**Theoretical Basis for Dialectical Behavior Therapy.** DBT is based on Dr. Linehan's theory that the core problem in BPD is emotion dysregulation, resulting from mixing biology (e.g., genetic and other biological risk factors) and an emotionally unstable childhood environment (e.g., where caregivers punish, trivialize or respond erratically to the child's expression of emotion) together. The focus of DBT is on helping the client learn and apply skills that will decrease emotion dysregulation and unhealthful attempts to cope with strong emotions.

**What to Expect in Dialectical Behavior Therapy.** Usually, DBT includes a combination of group skills training, individual psychotherapy and phone coaching, although there are exceptions. Patients in DBT are asked to monitor their symptoms and use of learned skills daily, while their progress is tracked throughout therapy.

There are four main types of skills that are covered in DBT skills training. These are:

- **Mindfulness Meditation Skills.** These skills center on learning to observe, describe and participate in all experiences (including thoughts, sensations, emotions and things happening externally in the environment) without judging these experiences as "good" or "bad." These are considered "core" skills that are necessary in order to implement the other DBT skills successfully.

- **Interpersonal Effectiveness Skills.** The focus of this skill session is on learning to successfully assert your needs and to manage conflict in relationships.

- **Distress Tolerance Skills.** The distress tolerance skills session promotes learning ways to accept and tolerate distress without doing anything that will make the distress worse in the long run (e.g., engaging in self-harm).

- **Emotion Regulation Skills.** In this session, patients learn to identify and manage emotional reactions.
Dialectical Behavior Therapy for Adolescents (DBT-A) is a clinical program targeted at high risk, multi-problem adolescents that focuses on identifying and treating depression and risky behavior in adolescents, including self injury, suicidal ideation and suicide attempts, substance use, binging and purging, risky sexual behavior, physical fighting, and other forms of risk-taking. DBT-A has been adapted by Alec Miller and Jill Rathus from Marsha Linehan’s initial conceptualization of DBT which was developed for adults diagnosed with Borderline Personality Disorder. DBT-A targets five areas:

- confusion about self
- impulsivity
- emotional instability
- interpersonal problems
- parent-teen problems

The treatment has been shown to be effective in treating self-harming adolescents with depression who demonstrate some traits of borderline personality disorder that are beyond that expected of typical adolescent development (unstable sense of self, unstable interpersonal relationships, inappropriate or uncontrollable anger or other emotions, serious mood swings, recurrent self-harm or and/or suicide attempts, chronic feelings of emptiness, and impulsivity that puts the teen at risk).

More information about DBT is found in the Reading List.

4:20PM – 4:25PM  Healing the Healer

Lecture: Self Care for Adoptive Parents: Healing the Healer

Handout #10.20
We can provide adoptive parents with suggestions about how to take care of themselves as they are healing their children. Handout #10.20 provides a list of suggestions that you may wish to share with adoptive parents.

4:25PM – 4:30PM Summary and Closing

We are reaching the end of our Module today. Please ask yourselves the following questions:

- Can I describe two impacts on a child’s later behavior as a result of trauma and two impacts as a result of attachment disruption?
- Can I define differential diagnosis?
- Can I describe two methods that a clinician can use to better understand what parents mean when they say that their child is “difficult”?
- Can I list four behavior management competencies for adoptive parents?
- Can I list four key principles that adoptive parents can use to help them create structure and consistency for their children?
- Can I effectively use self-regulation assessment tools with children/adolescents?
- Can I name four mental health conditions for which genetics are believed to play at least a partial role?
- Can I describe 5 features of a behavioral management plan?
- Can I describe the use of Cognitive Behavioral Therapy and Dialectical Behavior Therapy with adopted adolescents?

As a result of this Module, you should be able to answer “yes” to each of these questions. If not, please feel free to talk with me after the Module and please review the Module materials.

In your email inbox, you will find a message with a link to a brief online survey for you to provided feedback on today’s workshop. It will ask you to rate the quality and relevance of the workshop content and the effectiveness of the learning activities, to identify the strengths of the training Module, and to recommend ways that the training can be improved. Please follow the link in the email and provide the feedback right ways while the Module experience is fresh in your memory.

In our next Module, we will focus on issues related to openness in adoption. Download your student packets from the C.A.S.E. website.
Thank you for your attention. See you next [week/month]!
Module #10 Working with Adoptive Parents on Managing Children’s Behaviors

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


Demonstrated Role Play: Therapist and Brad (Copy #1)

Therapist: What were you FEELING when you threw the cell phone?

Brad: I was angry. My dad was yelling at me to get off the phone and get to my chores. My heart was beating fast.

Therapist: What were you saying to yourself at the time? (THOUGHT)

Brad: I have to throw things--it calms me down.

Therapist: So, what did you do?

Brad: Well, I threw my phone against the wall.

Therapist: Did that get you what you wanted?

Brad: Well, no. I don’t have a phone now and I was grounded for a week. I guess if I keep throwing things, I am going to keep getting into trouble.

Therapist: What could you have told yourself when you get angry -- to change your behavior and not get you into trouble?

Brad: When my heart is beating fast I know I'm getting angry.

Therapist: So when you feel your heart beating fast, what could you do instead of throwing things – things that would calm you down but not get you in trouble?

Brad: I don’t know.

Therapist: Let’s brainstorm some ideas. [Read: Eventually Brad and Therapist come up with six ideas: shoot baskets, listen to music, tell his parents he is mad, take a few deep breaths, go for a run, watch a sports program]

Therapist: So, how can these ideas help you?

Brad: Okay, I know that I am going to get angry sometimes. I guess that I can do some of things instead of throwing stuff.
Demonstrated Role Play: Therapist and Brad (Copy #2)

Therapist: What were you FEELING when you threw the cell phone?

Brad: I was angry. My dad was yelling at me to get off the phone and get to my chores. My heart was beating fast.

Therapist: What were you saying to yourself at the time? (THOUGHT)

Brad: I have to throw things--it calms me down.

Therapist: So, what did you do?

Brad: Well, I threw my phone against the wall.

Therapist: Did that get you what you wanted?

Brad: Well, no. I don’t have a phone now and I was grounded for a week. I guess if I keep throwing things, I am going to keep getting into trouble.

Therapist: What could you have told yourself when you get angry -- to change your behavior and not get you into trouble?

Brad: When my heart is beating fast I know I'm getting angry.

Therapist: So when you feel your heart beating fast, what could you do instead of throwing things – things that would calm you down but not get you in trouble?

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Therapist: Let’s brainstorm some ideas. [Read: Eventually Brad and Therapist come up with six ideas: shoot baskets, listen to music, tell his parents he is mad, take a few deep breaths, go for a run, watch a sports program]

Therapist: So, how can these ideas help you?

Brad: Okay, I know that I am going to get angry sometimes. I guess that I can do some of things instead of throwing stuff.
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
Module #10 Working with Adoptive Parents on Managing Children’s Behaviors

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
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.
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.

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.

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.
Handout # 10.9 Mary and Sarah

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:

... 

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

(\url{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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What Happened Before?</td>
<td></td>
<td></td>
<td></td>
<td>What Happened After?</td>
</tr>
<tr>
<td></td>
<td>☐ Asked to do something</td>
<td></td>
<td></td>
<td></td>
<td>☐ Discussed problem behavior</td>
</tr>
<tr>
<td></td>
<td>☐ Bored – no materials or activities</td>
<td></td>
<td></td>
<td></td>
<td>☐ Nothing/ignored</td>
</tr>
<tr>
<td></td>
<td>☐ Could not get something he/she wanted</td>
<td></td>
<td></td>
<td></td>
<td>☐ InterruptedBlocked</td>
</tr>
<tr>
<td></td>
<td>☐ Stopped from doing a like activity</td>
<td></td>
<td></td>
<td></td>
<td>☐ Verbal redirection to activity</td>
</tr>
<tr>
<td></td>
<td>☐ Loud environment</td>
<td></td>
<td></td>
<td></td>
<td>☐ Physical redirection to activity</td>
</tr>
<tr>
<td></td>
<td>☐ Another person provoked the child</td>
<td></td>
<td></td>
<td></td>
<td>☐ Physical restraint</td>
</tr>
<tr>
<td></td>
<td>☐ Child needed to move from one activity ________ to another ---</td>
<td></td>
<td></td>
<td></td>
<td>☐ Removed from room/area</td>
</tr>
<tr>
<td></td>
<td>☐ Attention being given to others</td>
<td></td>
<td></td>
<td></td>
<td>☐ Required to continue activity</td>
</tr>
<tr>
<td></td>
<td>☐ Nothing – the behavior was “out of the blue”</td>
<td></td>
<td></td>
<td></td>
<td>☐ Time-out (duration: ________)</td>
</tr>
<tr>
<td></td>
<td>☐ Other: (specify: ____________________</td>
<td></td>
<td></td>
<td></td>
<td>☐ Other (specify: __________)</td>
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</table>

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<tr>
<th>Location:</th>
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<th>Time:</th>
<th>Behavior</th>
<th>Response:</th>
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<tr>
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<td>What Happened Before?</td>
<td></td>
<td></td>
<td></td>
<td>What Happened After?</td>
</tr>
<tr>
<td></td>
<td>☐ Asked to do something</td>
<td></td>
<td></td>
<td></td>
<td>☐ Given reinforcement</td>
</tr>
<tr>
<td></td>
<td>☐ Receiving attention (parents/siblings)</td>
<td></td>
<td></td>
<td></td>
<td>☐ Received attention from others</td>
</tr>
<tr>
<td></td>
<td>☐ Alone</td>
<td></td>
<td></td>
<td></td>
<td>☐ Ignored</td>
</tr>
<tr>
<td></td>
<td>☐ Preferred toys/activities available</td>
<td></td>
<td></td>
<td></td>
<td>☐ Play continued</td>
</tr>
<tr>
<td></td>
<td>☐ Another child initiated play</td>
<td></td>
<td></td>
<td></td>
<td>☐ Other continued: ______________</td>
</tr>
<tr>
<td></td>
<td>☐ Playing with another child</td>
<td></td>
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<td></td>
<td>☐ Given transition warning (e.g. in 5 minutes you will need to turn off the TV)</td>
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<td></td>
<td>☐ Other: (specify: ________)</td>
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<thead>
<tr>
<th>Location:</th>
<th>Trigger</th>
<th>Date:</th>
<th>Time:</th>
<th>Behavior</th>
<th>Response:</th>
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<tbody>
<tr>
<td></td>
<td>What Happened Before?</td>
<td></td>
<td></td>
<td></td>
<td>What Happened After?</td>
</tr>
<tr>
<td></td>
<td>☐ Following directions</td>
<td></td>
<td></td>
<td></td>
<td>☐ Given reinforcement</td>
</tr>
<tr>
<td></td>
<td>☐ Sitting quietly</td>
<td></td>
<td></td>
<td></td>
<td>☐ Received attention from others</td>
</tr>
<tr>
<td></td>
<td>☐ Staying on-task</td>
<td></td>
<td></td>
<td></td>
<td>☐ Ignored</td>
</tr>
<tr>
<td></td>
<td>☐ Waiting for turn</td>
<td></td>
<td></td>
<td></td>
<td>☐ Play continued</td>
</tr>
<tr>
<td></td>
<td>☐ Cleaning up</td>
<td></td>
<td></td>
<td></td>
<td>☐ Other continued: ______________</td>
</tr>
<tr>
<td></td>
<td>☐ Sharing</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>☐ Waiting</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>☐ Being kind to other</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>☐ Transitioning smoothly</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>☐ Playing nicely with other children</td>
<td></td>
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<td></td>
<td>☐ Other (specify: ____________)</td>
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</table>
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>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>Most of the time</td>
<td>Some of the time</td>
<td>None of the time</td>
</tr>
</tbody>
</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.

<table>
<thead>
<tr>
<th>1</th>
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<tbody>
<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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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

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**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

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
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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.

Schizophrenia

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.

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”.