

Assessment Through the Adoption/Guardianship Lens

1. Introduction and Objectives

1.1 Introduction

Welcome back to the National Adoption Competency Mental Health Training for Mental Health Professionals.

This module is: Assessment and Treatment Planning. This lesson is: Assessment Through the Adoption/Guardianship Lens.

In this lesson, we will review some widely used traditional assessment tools and propose additional questions related to adoption, foster, and kinship care that will guide a more tailored treatment plan for the child and family, and avoid misdiagnosis.

1.2 Section 1: Lesson Objectives

By the end of this lesson you will be able to:

- Understand and integrate an adoption competent assessment protocol into your clinical practice, and
- Determine applicability of standardized assessment tools in working with families

1.3 Adoption-Informed Assessment and Treatment Planning

This module will provide the opportunity to integrate all that you have learned to look at assessment and treatment planning through an adoption, guardianship, foster care, and kinship lens, understanding the importance of accurate assessment to formulate a treatment plan tailored to the child, adolescent, and family with whom you are working.

There is no one size fits all. The issues are complex, and while not all the underlying causes of behavior are related to adoption, these are issues that must be considered in concert with other factors.

Too many clinicians ignore adoption and guardianship issues for this population in collecting basic background information or fail to incorporate this information into an assessment of the issues facing the clients you serve.

We will address specific issues that need to be explored as you conduct your assessment, so that your treatment plan will reflect the full scope of the youth and family's history and experience.

2. Principles for Adoption-Informed Assessment

2.1 Principles for Adoption-Informed Assessment

If we are not asking about adoption in our work with families, we may miss a key element of case conceptualization and treatment recommendations as it is often overlooked or minimized in its role in the presenting problem. Additionally, developing a shared understanding of the problem and entering into a relationship helps the family feel understood, seen, and hopeful.

2.2 Four Principles

The primary principles for adoption-informed assessment include:

- Experiences of loss, separation, trauma, and adversity must be understood and addressed
- Providers work to facilitate open communication, addressing difficulties with missing, withheld, and/or inaccurate information
- The caregiver-child relationship is essential to recovery, and therefore, providers must attend to caregiver wellness.
- Identity formation is multifaceted and can be complex.

2.3 Dr. Brodzinsky

Let's listen to Dr. Brodzinsky speak about the differences to be aware of in the assessment of children and their families.

[Video Transcript]

DR. BRODZINSKY: Well, a clinical assessment involves collecting information about a child's history, as well as current life circumstances, the family dynamics; that's true for all clinical assessments. But adopted families present with some unique challenges. First of all, the child is connected to more than one family, not just the family that they are growing up in, but the family that they came from and foster families as well.

They also enter their families sometimes with information about the history that's not known, so sometimes there's information, key information, that we would like to have that simply isn't available, and that makes it difficult for the family, parenting them. It makes it difficult for the clinician who's going to be treating the child.

In addition, these are children, particularly the kids coming from foster care--and this is the dominant source of adoption today--these are children who come into their families, their adoptive families, with multiple adversities often. Histories of prenatal complications, birth complications. Histories of neglect, abuse of various sorts, multiple foster placements, exposure to domestic violence sometimes, exposure to parental psychopathology.

So there's a lot of adversity that can create trauma symptoms and other types of difficulties that the families who adopt them have to face. You have to be aware of that kind of a history in order to be able to have a good picture of who you're working with.

And these are also children who have histories of--some of them anyway--histories of contact, or desire for contact, with their birth families. And so working around those issues in adoptive families and helping them represent, I think, key assessment issues in these types of cases.

So a lot of times families say, "We simple don't know that information. We don't know what the child has experienced." And one of the things I always say is, "Let's take a look at the paperwork that you have in your possession." Sometimes families simple forget what a child has experienced. "Let's call the adoption agency or the facilitator," whoever helped the family in the adoption process.

Sometimes there's information that is there. Sometimes there's not, and that's when we begin to explore possibilities with the family without the child present, at least to give them some sense of what could be, not necessarily what was. But we want them to be curious about what happened to the child so that they don't approach this with a complete blank slate.

[End of Video]

2.4 Additional Questions

If the child was adopted or in guardianship, a drop-down menu of additional questions should be included to supplement your standard assessment protocol.

Click on the arrow on the tablet to view the drop-down list of questions.

You can scroll through the questions by dragging the scroll button on the tablet.

You may also click on the link on the screen or in the Resources tab to see a handout of this list.

1. Why did you adopt or become your child's guardian or foster parent? What motivated you to embrace this child?
2. What were the circumstances that led you to choose building your family this way?
3. Whose decision was it to adopt, become the guardian, or foster?
4. What were the circumstances leading to the placement?
5. At what age did your child join your family?
6. How would you describe your child's adjustment to the family?
7. How does your child understand the circumstances of their removal from their birth family and their current placement?
8. What does your child know about their story?
9. What information was given to you at the time of placement that provides an understanding of the child's history?
10. Who is the key communicator about their history and how they came to your family?
11. What is the extended family's feelings toward the placement?
12. How many times did your child move before joining your family and who did they live with?
13. What do you know about where your child lived before joining your family?
14. What is your understanding of the types of losses your child experienced before joining your family?

15. Was there any history of abuse, neglect, or deprivation and what ages did this occur?
16. Do you have a comprehensive history of your child's life experiences before joining your family?
17. What do you know about your child's identity and heritage?
18. Does your child have biological siblings? If yes, do they live together? If not, do they have contact?
19. What relationships does your child have with their birth parents, siblings, birth family kinship network, community, or tribe?
20. For those children placed at an older age, with whom did or does your child have a close relationship?
21. What do you know about your child's birth history? Any complications or medical issues? Do you know if there were any exposures to toxic stress in utero and/or prenatal substance exposure?
22. What do you know about your child's medical history? Do they or you have contact with their birth family? If yes, tell us more about this experience?
23. If no contact, what does your child know about their birth family?
24. Do you know of any medical or mental health issues in their birth family?
25. What is the child's medical history, any chronic or acute issues? Did your child have any previous mental health treatment? For what? Is there a prior diagnosis and/or medication history for your child? Are they currently receiving any mental health care? If so, with whom?
26. For children placed internationally, what do you know about their foster care or orphanage experience? If in an orphanage, during what ages? What do you know about the conditions in the orphanage?
27. What precipitated you seeking support now?
28. What are your child's strengths, what do they enjoy doing or have skill/talent in?
29. What are the behaviors, challenges, or issues you are most concerned about and when did they start?
30. Can you tell me about any incidents that preceded your concerns? Consider possible triggers from the child's past history.

3. Enhancing Clinical Assessment

3.1 Enhancing Clinical Assessment

Let us now consider a framework developed by Murray and Sullivan focusing on 5 domains in clinical assessment that includes strategies for assessing each domain, and guidelines for using the results of the assessment for treatment planning.

3.2 Five Domains in Clinical Assessment

In their article, *Using Clinical Assessment to Enhance Adoption Success*, Kathryn J. Murray and Kelly M. Sullivan outline five domains to be covered in the clinical assessment:

- Child Trauma and Traumatic Stress
- Child and Adolescent Functioning
- Parent-Child Relationship and Attachment
- Parent Functioning, and
- Adoption-Specific Adjustment

Now let's explore the elements within each domain.

3.3 Child Trauma and Traumatic Stress

The first domain is child trauma and traumatic stress. Click on each number to hear the important elements to consider in regards to child trauma and traumatic stress.

1. Risk factors for children and youth in the child welfare system, as well as children and youth who are internationally adopted who experienced orphanage life, including multiple moves, multiple caregivers, broken attachments, neglect, and exposure to violence.
2. The importance of trauma screening for every child or youth, including exposure and symptoms of trauma. One example of a screening tool that has been validated for school-aged children and adolescents is the University of California Los Angeles Post Traumatic Stress Disorder Index. You will find an article on this Index in the Resources section.
3. Risk factors for children and youth subjected to trauma.
4. Complex trauma symptoms. Remember that complex trauma involves repeated exposure to traumatic events early in life or over time, or in prior generations, and may be the underlying cause for behaviors.

3.4 Child and Adolescent Functioning

The second domain is child and adolescent functioning. Click on each number to hear the important elements to consider in the area of child and adolescent functioning.

1. In addition to assessing trauma history, conducting a complete history must include factors such as number of moves, prenatal substance exposure, early deprivation, institutional care, and malnutrition. These all impact the child's brain development, ability to self-regulate, impulse control, cognitive and social functioning, and relational and attachment capacity.
2. When working with latency age or adolescent clients whose clinical presentation requires more in-depth neuropsychological evaluations, it will be important to integrate the youth's trauma history and its impact on development, as just discussed.

3. It is important to assess the child's and youth's strengths and resilience so that these can be used in formulating the treatment plan. Too often, when children and youth are presented for clinical assessment, parents and clinicians focus on problem areas and ignore strengths in the child, parent, and parent-child relationships. These may include their interest and talents, social functioning, identity, peer relationships, or school performance.
4. Remember that the underlying causes of behavior may relate to past experiences that may or may not be known, and it may take some time to establish enough of a relationship to uncover the experiences of the past.

3.5 Parent-Child Relationship and Attachment

The third domain relates to parent-child relationship and attachment. Click on each number to hear more.

1. The child's attachment and relationship with their parents is a critical protective factor. The stronger the attachment and more supportive the relationship is, the more it fosters family stability and child and family well-being.
2. Assess the child's and youth's ability to form and maintain positive relationships with peers, family members, teachers, coaches and others.
3. Use your observation skills to assess parent-child interactions, while asking questions designed to reveal the quality of the relationship. Join the parent and child or adolescent in an activity such as a board game, working on a craft project, or in a role play activity. Observing the interaction will give you information about the balance of the relationship and areas in which you need to help them.
4. Be sure to observe the relationship from the perspective of both the parent and the youth. Remember that each brings behaviors from their own experiences and that adults also carry the unresolved impact of trauma from their family of origin.
5. Recognize that some behaviors that the child brings to the family were once useful in a different circumstance but no longer are necessary in the current environment. Try to help the parent understand and create an environment where that behavior is no longer needed.

3.6 Focusing on Needs

Let's listen to Debbie Schugg talk about how the change in parenting style made room for her children to let go of behaviors that they no longer needed.

[Video Transcript]

DEBBIE: So we get a lot of pressure, and I know parents still get a lot of pressure from the outside: from neighbors to extended family, teachers, coaches, their faith community, anybody and everybody, the people in the grocery store that think they have a right to give you advice about your parenting. That you're indulging your child. You're spoiling

your child by coming in with empathy and compassion and trying to understand what they're feeling and tapping into some of these grief responses and stuff around losses that they have when they feel like you need to just really, you know, they should be in trouble for what they're doing.

And so I would get a lot of, "Really, you're going to let her go horseback riding after what she did at school yesterday?" And I would say, "Yes. Yes, because she needs it and that's helping her heal." Right. And so it's very counter-intuitive to switch up the way you're approaching behaviors, but the big win is that the behaviors start to dissipate because you're meeting the need.

And so, as parents, we try harder and harder and harder to extinguish these behaviors because the behaviors are a huge problem for us, for our kid, for everyone. And we want our kids to grow up to be good citizens and not behave that way. And we have a lot of our identity invested in it. But when we stop addressing the behaviors and start looking at the needs, and then we meet those needs, then the behaviors extinguish themselves because they're no longer needed.

[End of Video]

3.7 Helping Parents to Feel Heard and Understood

As part of assessing the parent-child relationship, consider the risk factors for parents developing Secondary Traumatic Stress, compassion fatigue, vicarious trauma and burnout. Also consider the possibility that the child's or youth's behavior may trigger a trauma response due to the parent's own history.

By the time families seek your help they may have worked with other therapists who were not helpful, experiencing failure and frustration. They may also have waited a long time to seek help and be exhausted by their own attempts to manage their family in crisis.

Helping the parent to feel heard and understood, educating them about adoption issues and trauma, and their impact on the parent-child relationship can go a long way in establishing a supportive relationship with the parent.

3.8 Parent Functioning

The fourth domain is parent functioning.

Click on each button to hear the important elements to consider in this domain.

- **Parental History:** When assessing the parent's history of trauma, you may want to use the Adverse Childhood Experiences (ACEs) scale, covered in an earlier module. Parent's own triggers might get in the way of being able to clearly see their child's needs and support them.
- **Collective Trauma:** Be aware that collective trauma is passed from generation to generation. Helping parents understand these patterns can begin a healing process that interrupts the cycle.

- **Resilience and Strengths:** Assess the parent's resilience and strengths, as well as their natural supports. Involvement with their community, faith community, friends, neighbors, and family are important to developing a network of supports in tough times.
- **History of Loss:** Assessment of the parent's history of loss and how they manage grief can be helpful, especially if the parent has a history of infertility. This is an issue that is often overlooked, but can be a very powerful trigger for a parent. The loss of the child they dreamed of is often exacerbated by issues surrounding infertility.
- **Mental Health:** When indicated, a parent may need to be referred for further assessment or treatment to address their own mental health needs.

3.9 Adoption-Specific Adjustment

The final domain is adoption-specific adjustment.

The important elements to consider in this domain are:

- Many families do not seek therapy specifically related to adoption issues, it is always important to ask the questions which provide a deeper understanding as to the family's decision to adopt, the underpinnings of their child's removal or relinquishment, and the unique aspects to their adoption story.
- Both the parent and child may experience disappointment in that reality did not match their expectations. What did the parents think their child would be like? What did they think parenting would be like? What is the reality? For older placed children, what did the teen hope for, and what is the reality? Children and parents can be asked, *"What did you think adoption or foster/kinship placement would be like? What has been different or surprising?"* Adjusting expectations may be a key part of treatment planning.
- As we have discussed extensively, grief and loss are two of the most important core issues for both the parent and their child. It is important to remember that most children will have a grief reaction to their profound loss and this grief will become more pronounced and problematic as they mature. Exploring the history of losses through their lens as well as the parents' is essential to ameliorate the child and teen's and parents' symptomatology.

3.10 Acknowledge the Role of Loss

Too often, parents don't understand that challenging behaviors are often manifestations of unresolved loss and grief.

While the presenting behaviors may be concerning to you and the parents, it is critical that you acknowledge the role that loss has on the emotional well-being of children and adolescents, as well as facilitate communication between parents and their children about the losses they have experienced.

3.11 Communicative Openness

We have talked about the importance of communicative openness in previous modules, and the importance of honesty and truth telling in the relationship between adoptive parent and child.

In your assessment, it is important to explore what conversations have taken place with whom and what conversations still need to be had. A key aspect of the assessment is for you to ascertain the level of communicative openness between the child and parent around a myriad of issues, including but not limited to the child's history, understanding of how permanency decisions were made, and prior attachments the child had and the meaning or significance of those relationships.

3.12 Exploring What Adoption Means

Exploring what adoption means to the child or youth is another conversation to have.

Some children and youth do not understand what adoption really means and may mistakenly think that adoption ends at age 18 or 21, like foster care.

Perception of permanency changes over time, and it is important to continue to have this conversation, as well as help the child or youth correct misunderstandings or negative thinking about their history.

3.13 Sense of Permanence

Additionally, it is important to explore the child's or youth's sense of permanence in their family, along with feelings of safety, and connectedness. As teenagers move towards independence, the thoughts of leaving home compromise their sense of permanence. It is important to remember to consider the age of placement as this has an impact on their understanding of their story and triggers that might compromise their sense of permanency.

For therapists, it will be important to help parents understand these dynamics and engage in reclaiming behaviors to reinforce their commitment to their teen as being lifelong. For example, *"I can't wait until spring break when we can go to our favorite family place, camping at the lake."*

Parents could also create a family photo album or collage of family pictures to give to them for youth who are transitioning to their own independence. As discussed previously, parents also need to be aware that children placed at older ages may begin to fear separation and interpret it as abandonment.

3.14 Assessment through an Adoption Lens Reflection

In thinking about these five domains, list three questions not included in your current assessment that would be essential in an adoption competent clinical assessment.

3.15 Assessment through an Adoption Lens Response

You may have thought of several questions. As a starting place, it is essential to ask every parent if the child was adopted, in a guardianship, currently or previously in foster care, or currently or previously living in a kinship arrangement.

This is not a question that is routinely asked, and parents may feel it is not important information or not related to the problem they are presenting. However, it is essential since this type of permanency has far reaching implications for the treatment plan.

To ensure your clinical work at inception is embedded in adoption competency, we are providing you with an assessment tool in the Resources tab that can be incorporated into your existing assessment/intake process.

3.16 Adoption-Specific Adjustment

With this structure for assessment in mind, let's listen now to Michelle Buchanan-Tyler, LCSW-C, an adoption competent therapist, talk about how assessment changes with an adoption lens.

[Video Transcript]

MICHELE BUCHANAN-TYLER, LCSW-C: My practice has changed dramatically in terms of my initial meetings with the family, my initial assessment. I am spending more time thinking through questions now with an adoption lens than I would have in the past. Before, I might have attributed certain behaviors to just one thing and then kind of started developing a treatment plan based on that.

Now I'm trying to tease out or by asking adoption-specific questions, to try to see if maybe there's a different track I can take that might help this family feel more competent, because all of us want to feel competent and we want to feel that--the kids want to be able to feel that they're making their parents happy. And when you're failing, it's just not a good feeling.

[End of Video]

4. Standardized Assessment Tools

4.1 Standardized Assessment Tools

As part of a comprehensive assessment, mental health professionals may often include standardized assessment tools, to determine a baseline diagnosis that can be matched to the DSM-5. Let's discuss some of these now.

4.2 Tool Types

Common tools like the Child and Adolescent Needs and Strengths Comprehensive Assessment (CANS), Treatment Outcome Package (TOP), Child Behavior Check List (CBCL), Youth Self Report (YSR), the Parenting Stress Index (PSI), and the Traumatic Symptoms Checklist for Children (TSDD) are a few standardized tools that can be very helpful in measuring changes in behavior, levels of stress, and progress in measurable outcomes for children and adolescents.

Although these tools have not been specifically studied with this population, they can support your clinical assessment by providing additional insights in key areas. This information can guide treatment planning, enhance client engagement, clarify the course of treatment, and help monitor progress or identify lack of progress.

These tools provide a checklist of symptoms to be rated but do not indicate any underlying causes for the symptoms. Integrating tools like this or others you may have found helpful should be used in conjunction with the Adoption Competent Clinical Assessment.

Many of the clients you will be working with have prior treatment histories. It is important that you request from the family, placement agency, or previous treatment providers any prior evaluations that can support your understanding of the child and family.

Let's take a brief look at a few of these tools.

4.3 CANS

The use of the CANS in initial diagnosis and periodic reassessment is helpful in establishing a baseline and indicating where services are needed to address behaviors and problems.

Periodic screening reveals where improvement or other changes occur. The CANS provides a linkage between the assessment process and the individualized service or treatment plan.

4.4 Core Areas of CANS

There are two versions of CANS, one for children ages 0-4, and one for children ages 5-17. The basic structure of the Comprehensive Tool for Youth 5-17 includes core items to be rated for the youth and caregiver.

The core areas addressed are the child's:

- Functioning
- Strengths
- Acculturation
- Behavioral Health Needs
- Risk Behaviors, and
- Caregiver Strengths and Needs

Each of these have individual items.

For example, under Risk Behaviors, the items include:

- Suicide Risk
- Self-Harming Behaviors
- Danger to Others
- Sexual Aggression
- Running Away
- Delinquency
- Fire Setting
- Risky Social Behavior, and
- Bullying

4.5 CANS Administration

The CANS is easy to administer, is widely used in both child welfare and mental health and is easily understood by the child and parent.

Some states are adopting the CANS as their preferred assessment tool.

To learn more about the CANS tool, you can find information at the CANS website in the Resources tab.

4.6 TOP

Another assessment tool is the Treatment Outcome Package (TOP). Click on each number to hear more.

1. TOP was developed by The Annie E. Casey Foundation's Child Welfare Strategy Group in partnership with the Duke Endowment and Kids Insight and the Outcome Referrals Inc.
2. There are three versions of the TOP assessment tool; for the child, adolescent, and adult. The TOP is written at a fifth grade reading level and takes an average of 8 minutes to complete.
3. The goal of this tool is to assess the social and emotional well-being of children especially those in, or coming from, the child welfare system. It is easy to use and helpful in uncovering information that might be difficult to share in conversation.
4. It tracks two things: How children are doing using well-being indicators, and whether there is improvement through treatment. Some states are adopting this measure as their standard.

You can learn more at the outcome referrals website in the Resources tab.

4.7 Child Behavior Checklist (CBCL) and Youth Self Report (YSL)

The Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR) are intended to detect emotional and behavioral problems in children and youth.

The CBCL is completed by the parent and the YSL is completed by the child or adolescent ages 6-18. Repeating these periodically can give a good indication of progress in treatment in those areas covered by the tool.

You can access more information at The Achenbach System of Empirically Based Assessment (ASEBA) website.

4.8 Parenting Stress Index (PSI)

The Parenting Stress Index (PSI) is a simple questionnaire that quickly screens for parental stress and stress in the parent-child relationship.

It is primarily used for parents with children under age 12 and takes 20-25 minutes for the parent to complete. There are short and long forms, with subscales for both parent and child.

The PSI is useful in designing a treatment plan, for setting priorities for intervention, or for follow-up evaluation. It can be used over time to measure changes in the stress level and changes that have come about as a result of treatment.

For more information visit the APA website linked in the Resources tab.

4.9 Traumatic Symptoms Checklist for Children (TSCC)

The TSCC measures posttraumatic stress and related psychological symptomatology in children ages 8-16 years who have experienced traumatic events, such as physical or sexual abuse, major loss, being a victim of, or witness to, violence.

It was developed by Dr. John Briere. It is a 54-item self-report checklist that can be administered in 15-20 minutes. It is also available in Spanish.

More information is available on the Psychological Assessment Resources (PAR) website listed in the Resources tab.

4.10 Motivational Interviewing Model

As you are thinking about assessment tools, to use you may want to consider use of Motivational Interviewing, or MI, strategies as well. MI is becoming a popular communication technique that can be used to elicit and strengthen motivation for change. This technique is based on three key elements:

1. Collaboration between the therapist and the client
2. Evoking or drawing out the client's ideas about change, and
3. Emphasizing the autonomy of the client

Some core skills include expressing reflective empathy, having the client define the problem, and "rolling with resistance" or inviting clients to examine new points of view rather than head- on arguments, particularly in the early phase of treatment.

Other important therapeutic skills include using open-ended questions, affirmations, reflections, and summarizing.

A key technique of MI is called the "Readiness for Change Ruler," where the therapist asks a client to rate on a scale from 1 to 10 their readiness to change or learn new ways to resolve problems.

This technique can be paired with other assessment and treatment interventions used in your practice. Check out the Resources tab for more information

5. Conclusion

5.1 Wrapping Up

A comprehensive adoption competent clinical assessment through an adoption lens that looks at the whole child and family is essential to both diagnosis and formulation of treatment goals and intervention.

5.2 Learning Journal

Please click on the journal page to write down your reflections on this lesson.

5.3 Journal Reflection

Reflecting on this lesson, what are your key takeaways and how might you apply these in your practice?

5.4 Journal Response

Click the "Print Results" button to print and save your answers.

5.5 Conclusion

Congratulations! You have completed Assessment Through the Adoption/Guardianship Lens

In the next lesson, we will cover unique assessment issues in your work with relative caregivers.