

# Issues in Diagnosis and Treatment of Adopted Children's Mental Health Needs

## 1. Introduction

### 1.1 Introduction

Welcome back to the National Adoption Competency Mental Health Training for Mental Health Professionals. This lesson is: Issues in Diagnosis and Treatment of Adoptee's Mental Health Needs.

### 1.2 Section 1: Lesson Objectives

At the end of this lesson, you will be able to:

- Identify and describe the core mental health issues that are addressed in adoption competent clinical interventions with children, youth, and their adoptive and guardianship families.
- Recognize limitations of current diagnostic assessment and medication practices commonly used with children and youth with foster and/or institutional care experiences.
- Identify and describe strategies for effective collaboration with child welfare and other professionals that promote information sharing, appropriate treatment planning and intervention, and parental involvement in the therapeutic process.

## 2. Significant Need for Mental Health Services

### 2.1 Significant Need for Mental Health Services

In previous lessons, we have discussed the increased likelihood that adoptees will access mental health services at a higher rate than their non-adopted peers.

### 2.2 Need for Mental Health Services

Based on several national studies, we can make several conclusions. Click on each number to hear them.

1. Children adopted from foster care have similar levels of mental health challenges as children still in foster care. One study shows very similar rates of depression, anxiety, behavior problems, and utilization of mental health services, but a higher rate of ADHD among the adopted group (Zill & Bramlett, 2014).

2. Youth in foster care are three times more likely to have ADD or ADHD and 7 times more likely to have depression relative to children not placed in foster care (Turney & Wildeman, 2016).
3. Among foster children and youth with mental health needs, approximately 30 percent receive no treatment. Several studies indicate that foster youth who do receive mental health treatment do not show significant improvement.
4. As noted earlier, in a meta-analysis of 85 studies on psychiatric disorders and treatments in adoptees and non-adoptees, the risk of adoptees experiencing psychiatric disorders, contact with mental health services, or treatment in a psychiatric hospital was twice as high as that of non-adoptees (Behle & Pinquart, 2016). One systematic review reported that social isolation and loneliness increased the risk of depression (and possibly anxiety) at the time at which loneliness was measured and between 0.25 and 9 years later. The duration of loneliness was more strongly correlated with mental health symptoms than intensity of loneliness. It is significant to note that these data were collected before the pandemic created conditions that contributed to loneliness, isolation, and exacerbated vulnerabilities that already existed in this population.

### ***2.3 Underlying Causes***

With most of these children and youth, it is difficult to isolate only one issue to work on or one diagnosis that captures the breadth of their mental health challenges, including concerns related to loss and identity.

When this is the case, conventional mental health assessments, diagnoses, treatments, and psychotropic medications may not address some underlying causes of these challenging behaviors, and may in fact be harmful, delaying targeted and effective treatment of important issues.

### ***2.4 Complexity of Challenges and Symptoms***

Children and youth with multiple risk factors often struggle with a range of challenging emotions, behaviors, and developmental deficits that frequently result in a string of diagnoses resembling alphabet soup.

- Conduct Disorder (CD)
- Oppositional Defiant Disorder (ODD)
- Reactive Attachment Disorder (RAD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Intellectual Disabilities (IDD)
- Post-Traumatic Stress Disorder (PTSD)
- Depressive Disorders, including Disruptive Mood Dysregulation Disorder (DMDD)
- Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE), and others

These diagnoses may be accurate or the result of a misdiagnosis by professionals who don't understand the impact of trauma and multiple losses. A meta-analysis of 85 studies on psychiatric disorders in adoptees and non-adoptees found that the risk of being diagnosed with a psychiatric disorder is significantly higher for adoptees. This elevated risk is greatest for conduct disorder and oppositional defiant disorder. Two other diagnoses that have risk ratios above 2.5 among adoptees are ADHD and psychosis (Behle and Pinquart, 2016).

## ***2.5 Implications of This Complexity for Assessment & Diagnosis Reflection***

In the video of Zoe's story, we witnessed the impact of many risk factors.

Zoe likely experienced prenatal exposure to elevated maternal stress and early interpersonal trauma from inadequate nurture, exposure to violence and physical abuse, disturbed and disrupted attachment relationships, traumatic grief, and other adversities.

One of the most positive relationships in her life was with her baby brother, and separation from him withdrew a primary protective factor in her life.

What diagnoses do you think could be given to Zoe based on her behaviors? Please check any of the following that you think might be given:

- CD
- ODD
- ADHD
- PTSD
- Depression
- RAD
- PDD
- Persistent, Complex Grief

## ***2.6 Implications of This Complexity for Assessment & Diagnosis Response***

Reflecting on this list, most of these diagnoses might apply.

Within this complex context, it is difficult to isolate only one or two diagnoses that capture the breadth of Zoe's or many other adoptee's mental health challenges.

## ***2.7 Trauma Lens Reflection***

Looking through a trauma lens, how might your diagnoses change?

## ***2.8 Trauma Lens Response***

It is important that the focus of your work with children and youth like Zoe be on trauma and grief and not the externalizing behavioral manifestations.

With a focus on trauma and grief, we would hope to see a reduction in diagnoses such as Conduct Disorder, Oppositional Defiant Disorder, and Reactive Attachment Disorder among others.

When we shift the focus to trauma and grief, we also shift the type of treatment plan we develop to one that addresses the full range of clinical complexities.

## ***2.9 Implications of This Complexity for Assessment & Diagnosis***

Traditional assessment tools may miss the fact that a child's behaviors are adaptive responses to traumatic experiences, and may serve the child or youth in surviving untenable circumstances, as seen with Zoe.

The diagnoses given may not always be adequate to indicate the best treatment options for children or address the underlying causes of Zoe's behavior problems.

## ***2.10 Other Considerations in Assessment***

Click on each circle to hear about other considerations in assessment.

1. **Assessing the Cause:** Assessing the causes of child and family problems can be extremely complex, and there is a high potential for misdiagnoses and missed diagnoses among this population. When trying to assess children and youth, it is very hard to unravel the specific nature and causes of problems, since they may have experienced multiple known risk factors, as well as suspected or unknown ones.
2. **Sparse Information:** Often there is sparse, if any, information available on children's and youth's genetic histories and prenatal or early-life experiences which is particularly true for those who are adopted intercountry. An earlier lesson in this module stressed the importance of understanding the child's unique story and felt experience along with systemic influences like the decisions made in the child welfare system for Zoe.
3. **Standardized Assessment Challenges:** Many difficulties are not measured by standardized assessment instruments, such as the Child Behavior Checklist (CBCL) and the Strengths and Difficulties Questionnaire (SDQ). This is particularly true for a range of attachment and trauma-related difficulties, abnormal responses to pain, hoarding food, self-injury, and others. The Assessment Checklists for Children (ACC) and for Adolescents (ACA) were developed to capture more of these challenges (Tarren-Sweeney, 2013). A copy of the Brief Assessment Checklist for Children and a link to the website describing the other two measures are in the Resources.

### **3. Additional Challenges with Elevated Risk in Adopted Youth**

#### ***3.1 Additional Challenges With Elevated Risk in Adopted Youth***

There are additional health and mental health challenges, which are overrepresented in this population and often are not accurately assessed.

The symptoms of some of these conditions overlap with trauma symptoms and developmental delays.

We will briefly review some of these conditions.

#### ***3.2 Statistics Regarding Disorders Associated with Prenatal Alcohol Exposure***

Children and youth in foster care and adoptees have an elevated risk for neurodevelopmental disorders, particularly Prenatal Alcohol Exposure.

There are other toxic substances that also may impact development, but alcohol is the most common and the most developmentally devastating.

The lifelong neurodevelopmental disability, which is labeled ND-PAE (Neurobehavioral Disorder-Associated with Prenatal Alcohol Exposure) in the DSM-5, was previously known as Fetal Alcohol Spectrum Disorder.

#### ***3.3 Domains of Impact***

Children and youth affected by prenatal alcohol exposure demonstrate some of the same symptoms as those with other developmental disorders, but there is no other medical or genetic condition that explains their symptoms, and there is more than minimal exposure to alcohol during prenatal development.

There are four primary domains that can be impacted by prenatal alcohol exposure.

1. Neurocognitive functioning: impairment in 1 or more of the following - IQ (below 70), executive functioning, learning, memory, or visual-spatial abilities. A child with FASD has trouble with remembering, understanding, and following directions.
2. Sensory and motor functioning: deficits in sensory processing, delays in gross and fine motor development, problems with coordination and balance.
3. Emotional regulation: controlling emotions and impulsivity.
4. Social communication: difficulty understanding others or communicating with them; difficulty reading social cues or social immaturity.

All of these impairments result in problems in daily life skills.

#### ***3.4 Missed Diagnosis & Misdiagnosis of PD-NAE***

The impact of alcohol exposure during pregnancy is often not assessed, which greatly impacts clinical outcomes.

Ira Chasnoff and his colleagues at a specialized mental health clinic analyzed the comprehensive, multidisciplinary diagnostic evaluations of 547 foster and adopted children who were randomly selected from over 3,000 who had been patients at the clinic. They found that 29 percent met the criteria for a diagnosis within the fetal alcohol spectrum. In this group, 80 percent had never been diagnosed as affected by prenatal alcohol exposure prior to their referral. Other children had received this diagnosis, but did not meet the criteria (Chasnoff, Wells, & King, 2015).

An in-depth protocol for treatment of these children is in the Resources tab.

### ***3.5 Sensory Processing Disorder (SPD)***

One problem frequently found among children experiencing institutionalization and deprivation or neglect is Sensory Processing Disorder or SPD. This is a condition that may be genetic in which the brain cannot analyze, organize, and integrate sensory messages efficiently. Click each letter to learn more.

S: Children with SPD may demonstrate a range of atypical behaviors, including oversensitivity to tactile sensations such as shirt labels rubbing their necks or defensiveness to being touched, hypersensitivity to noises, and aversion to many tastes or food textures, odors, distractibility, clumsiness, and others. SPD also may be caused by prenatal substance exposure or premature or traumatic birth.

P: SPD is not currently recognized as a distinct medical or psychiatric diagnosis, and its symptoms overlap with those of Autism Spectrum Disorder, and ADHD. It is treatable with the support of occupational therapy.

D: The STAR Institute for Sensory Processing Disorders offers many resources for both professionals and parents. For more information, see the link to their website in the Resources tab, as well as a symptom checklist for SPD symptoms in children of different ages.

### ***3.6 Chronic Health Needs***

Many adoptees and children in guardianship experience prenatal and early life conditions that predispose them to chronic health problems, such as asthma, or a special need, such as traumatic brain injury or deafness.

These challenges frequently increase economic, parenting, and social-emotional stresses for them and their families. The National Survey of Adoptive Parents reports that 26 percent of adopted children have moderate or severe health difficulties, and many have more than one health problem.

### ***3.7 Issues Presented In Children With Attachment Challenges***

Also, attachment challenges in both children and parents may pose risks for adjustment. Adverse early life experiences can impact attachment patterns for many children. One study found that when an adoptive mother perceives a lack of attachment by the child, there is an eightfold increase in adoption disruption.

Adopted children may have many attachment challenges that do not fit either Reactive Attachment Disorder (RAD) or Disinhibited Social Engagement Disorder (DSED) diagnoses. Therapists in a clinical post-adoption counseling program rated separation and attachment conflicts as underlying emotional issues in three-fourths of adopted children served (Smith, Howard, & Monroe, 2000). While these issues may not fit a diagnosis, they are central to addressing the child's challenges. Click on each number to learn some of these issues.

1. Grieving a former foster family's failure to adopt and fear of attaching again
2. Fantasizing birth mother will return and resisting attachment to adoptive parents
3. Unresolved grief reaction precipitated by adoptive parents' divorce
4. Death in the family precipitates child's fear of losing adoptive mom
5. Sadness and worry related to not being related to a birth sibling
6. Pervasive fear of losing the adoptive family
7. Loyalty conflicts related to birth and adoptive families

While these issues may not fit a diagnosis, they are central to addressing the child's challenges.

### ***3.8 Evie Example***

Let's consider this example. Click on each photo to learn the example of Evie.

1. Evie is a 10-year-old girl adopted from foster care at age 5. She was removed from her birth family at 18 months because of neglect and maternal alcoholism. Her father had abandoned the family soon after her birth.
2. Evie lived in three different foster homes before being placed for adoption. She was in the third home for nearly three years. She was quite distressed to leave this foster home, especially because she was being separated from another child who had become her best friend.
3. Her adoptive parents sought treatment for Evie within a year of placement because of withdrawn behavior, low frustration tolerance, frequent tantrums, and difficulty accepting caregiving from the parents. Evie reported missing her previous foster siblings.
4. Efforts were made to maintain Evie's relationship with the previous foster family, but when they visited with them, Evie got into a physical fight with the former foster sibling and it was decided to curtail future contact. Evie's reaction to her parents' decision was to withdraw even more.

5. Soon thereafter, the maternal grandmother moved in with the family. She gave Evie a great deal of attention and Evie responded positively. Unfortunately, the grandmother had a stroke and was transferred to a nursing home.
6. With parental attention being directed toward the grandmother, Evie's behavior deteriorated quickly. She reverted to tantrums when she didn't get her way, became oppositional, periodically refused to go to school, and refused care by her parents.

### ***3.9 Evie Reflection***

If you were her therapist, what treatment strategies would you consider?

### ***3.10 Evie Response***

Some possible considerations and interventions could be:

- Educate parents as to the impact of unresolved loss, share how children grieve, for example, behavioral manifestations, low frustration, emotional withdrawal, tantrums
- Use a loss box with Evie to acknowledge and honor her losses
- Teach parents parenting techniques that build attachment with Evie
- Validate the importance of Evie's relationships with her previous foster siblings and her sense of loss in being separated from them, as well as her fear of losing her grandmother. This may be a means by which the adoptive parents can connect with her and begin building trust.
- Develop a lifebook with Evie, with an emphasis on tracking her placements, her experiences in different homes, her reactions to being separated from significant others, and her experiences with, and feelings about, her current family.
- Focus on validating and normalizing her reactions, including her difficulty in trusting and feeling secure.
- Encourage visitations with her grandmother, with whom she had a positive relationship.
- Revisit the issue of contact with the previous foster siblings; explore in more detail the reasons for the fight during a previous visitation and explore options for reconnecting Evie with them.
- Focus on parent-child interventions in therapy, with an emphasis on relationship building and reframing Evie's negative behaviors in the context of her previous adversities.

### ***3.11 Issues Related to Complex Trauma***

Many trauma and child welfare scholars have recognized the limitations of current diagnostic and treatment approaches to adequately address the complex range of challenges present in children and youth who have experienced multiple interpersonal traumas, defined as complex trauma.

A new diagnostic category, Complex PTSD, was added to the 11th International Classification of Diseases published by the World Health Organization.

Complex PTSD expands the core PTSD symptoms to include dysregulation in three domains:

1. Emotion processing
2. Self-organization, and
3. Relational functioning

Links to articles in the Resources section delineate differences between PTSD and Complex PTSD and their implications for treatment.

Experts are also proposing a new classification, "Developmental Trauma Disorder." This characterizes children who have been exposed to multiple or chronic interpersonal traumas, usually in a caregiving relationship.

This was not included in the DSM 5, but research is continuing to make the case for its inclusion in the future, and these issues will be examined further in the module on trauma.

### ***3.12 Issues Related to Infant Mental Health***

Close to one-fourth of children in foster care are 0 to 3 years of age. Infant mental health is a very important, specialized field, with modes of treatment that differ from that of older children.

Click on each photo to hear about infant mental health.

1. Research on very young children involved with child welfare services indicates that at least one-third demonstrate mental health and developmental problems, but only 2 percent receive mental health services. Also, many infants adopted from other countries have significant challenges at placement. As we move into the next modules you will learn more about brain development and attachment and the critical role that addressing trauma at the earliest age affects the mental health of the child.
2. It is important to be observant of the behavior of infants and toddlers who come into foster, adoptive, or guardianship families. Some may show signs of intrauterine substance exposure, poor nutrition, failure to thrive, and other signs of distress. It is important if you observe these signs, to make a referral to a developmental pediatrician.
3. Treatment most often involves working with caregivers and babies together, emphasizing relationship, interaction, emotions and knowledge of babies' needs. Home visiting programs, attachment-focused approaches, infant-parent psychotherapy, psychoeducational and family support services, are among the well-researched and effective treatments.

### ***3.13 Considerations in Diagnosis***

As we have discussed already, mental health professionals specializing in working with children and youth experiencing foster care and adoption stress the importance of assessing and addressing the impact of trauma and other risk factors before diagnosing youth with mental illness.

## 4. Use of Medication in Mental Health Treatment of Adoptees

### 4.1 Use of Medication in Mental Health Treatment of Adopted Children

Let's turn now to a discussion of the use of medication in the mental health treatment of adoptees.

### 4.2 Use of Psychotropic Medications

In addition to limitations in assessment and diagnosis of children's mental health issues, another concern today for children in foster, adoptive, or guardianship families is the overutilization of psychotropic medication.

Let's watch one more clip from Zoe's story related to her mental health treatment. Zoe is again separated from her brother Benaniah after having been reunited for a time in the same foster home. She is deeply affected by this and lashes out at those around her, particularly her foster mother. When she is taken for mental health treatment, the first strategy tried is medication.

[Video Transcript]

*[ZOE AND YOUNG BOY PLAYING IN WATER]*

*[ZOE AT SCHOOL]*

ZOE: *Oh, where's Kyra?*

TEACHER: *Hi. She had to leave early.*

ZOE: *Oh.*

*[ZOE RUNNING HOME]*

*[ZOE RUNNING FRANTICALLY THROUGH HOUSE]*

ZOE: *Benaniah. Benaniah. Benaniah. Benaniah!*

FOSTER MOTHER: *Zoe.*

ZOE: *Benaniah?*

FOSTER MOTHER: *Zoe, wait. Zoe--no, listen. Zoe, it happened so quickly, they wouldn't let me tell you.*

*[ZOE WITH SMALL BOY BY WATER]*

ZOE: *When I finally come close, it starts all over again.*

*[ZOE SITTING ON THE FLOOR]*

*[ZOE, A WOMAN AND A MAN SITTING ON A COUCH]*

*PSYCHIATRIST: She may have some negative side effects to it, but this will help with moments of uncontrollable anger. I really believe this will make life easier.*

*FOSTER MOTHER: Zoe doesn't need meds; she needs more therapy. She needs more interaction with her mom.*

*ZOE: You see what I do, but forget why.*

*[ZOE TALKING WITH WOMAN AT HOME]*

*FOSTER MOTHER: You'll still get a chance to see him. Hopefully twice a month, maybe even more. I've already set up a playdate for this weekend.*

*ZOE: Why do they think they can just have him? They aren't his parents.*

*[ZOE, WOMAN AND MAN SITTING ON A COUCH]*

*PSYCHIATRIST: If it doesn't work, we can always up the dosage or add a second medicine to it, to help you feel a little less sad or angry.*

*FOSTER MOTHER: But why wouldn't you--*

*ZOE: You forget what I've heard. You forget my pain.*

*[End of Video]*

### **4.3 Use of Psychotropic Medication for Zoe Reflection**

There are times when medication is indicated and can be beneficial. In this situation, why might medication be contraindicated?

### **4.4 Use of Psychotropic Medication for Zoe Response**

In Zoe's situation, her aggression is directly a result of the abrupt separation and powerful feelings of loss, helplessness, breach of trust, and uncertainty about maintaining her relationship with her brother.

Additionally, this episode triggered the trauma of past experiences of separation and loss.

### **4.5 Primary Medication Concerns**

A research brief in your Resources, Handout: *Psychotropic Medication Use by Children in Child Welfare*, explores the use of psychotropic medication by children and youth in foster and congregate care.

Click each image to learn some concerns that have been raised by this study and the federal government related to possible inappropriate use of psychotropic medications.

- Use of psychotropic medication with children under age 6 without real understanding of the impact on physical and brain development
- Use of 3 or more types of psychotropic medications simultaneously
- Inappropriate use of antipsychotic drugs, with long term, harmful side effects for children
- Prescribing psychotropic medications without also assuring that children are engaged in ongoing psychosocial mental health treatment

#### ***4.6 Study Results Related to Prevalent Use of Psychotropic Medication***

According to the National Center for Health Statistics, 7.5 percent of U.S. children, ages 6 to 17, take medication for “emotional or behavioral difficulties.” An Illinois study, assessing the needs of close to 2,000 adopted children, found that parents of all types of adopted children reported a high rate of psychotropic medication usage: 28 percent for private domestic infant adoptees, 29 percent for those adopted from another country, and 31 percent for those adopted from the child welfare system (Howard, Smith & Ryan, 2004).

In addition, research findings have raised other concerns, such as the fact that nearly 40 percent of foster and adoptive parents do not receive information about the purpose or side effects of psychotropic medications, and prescribers not monitoring important side effects in their oversight of this treatment.

#### ***4.7 Best Practices Related to Psychotropic Medication Use***

During your assessment, include questions for youth and their parents regarding current medications prescribed and their positive and/or negative side effects.

Help parents find knowledgeable psychiatrists and pediatricians who work with this population for initial assessments or reassessments of youth.

Build collaborations in your community with psychiatrists who can work closely with you and the families to assess the need for, and effectiveness of, medication as part of the overall treatment plan.

## **5. Mental Health Treatment**

### ***5.1 Mental Health Treatment***

Let us now turn to a discussion of mental health treatment approaches for this population of children and youth, including evidence-based, evidence-informed, and promising practices.

## ***5.2 Evidence Based and Evidence Informed***

In recent years, there has been a growing emphasis on using and funding practices that have been shown to be effective.

There are many terms used to describe the continuum of evidence-based practices, with a lack of consensus on definitions across disciplines.

This graphic reflects the continuum of practices moving from evidence-informed to evidenced-based.

Click on each box to hear more about that category.

**Emerging:** Emerging practices have weaker evidence of effectiveness and may be newer practices that have not yet been rigorously studied.

**Promising:** Promising practices have research evidence supporting them, but the research may not be replicated and sufficiently rigorous for a higher rating.

**Supported:** Supported practices are moving toward evidence-based, however, have been used with fewer randomized trials.

**Well-supported:** Well-supported practices are the highest rated and have a foundation of rigorous research.

Reference: California Evidence-Based Clearinghouse for Child Welfare

## ***5.3 Considerations for New Therapeutic Approaches***

In considering incorporating a new therapeutic approach, clinicians should assess the extent to which it is evidence-based, and equally important, has been studied with adoptive, foster, and guardianship families.

There are several websites that evaluate the scientific foundation of practice models, such as the California Evidence-Based Clearinghouse for Child Welfare, the National Traumatic Stress Network, and The Society of Clinical Psychology.

## **5.4 Limits of EBPs With Adopted Children**

While it is important to use practices that are evidence-based, there are limitations. Some of these limitations include:

- Very few practice interventions address issues that stem from loss, attachment, and identity among adopted children, who also may have other coexisting developmental challenges.
- Most EBPs have not been researched with children and youth who are in adoptive or guardianship families, limiting the knowledge about their impact on this population.
- EBPs usually address a single diagnosis. Very few address the complex mix of symptoms and pervasive developmental impact that are common for many of these children and youth.
- Finally, some EBPs lack community-based considerations, and have been shown to be effective with one group, but not effective with others.

## **6. Exploration of Mental Health Treatment Practices**

### **6.1 Exploration of Mental Health Treatment Practices**

As a mental health professional, you can benefit from knowledge about a broad range of treatment approaches that address the mental health needs of the children, youth, and families with whom you work.

### **6.2 Practices**

Understanding the practices available allows you to interact more effectively with children and their parents, use clinical assessments with a critical eye, and make appropriate treatment decisions. You will need to monitor the child's progress as well, with an understanding of the intervention and outcomes that can be expected.

### **6.3 Program Directory**

Please review the resource on your screen, *"Evidence-Based and Evidence-Informed Treatment Models Most Commonly Used with Foster & Adopted Children."*

A PDF version can also be downloaded from the Resources tab. Please check out the models you are interested in by clicking on their associated websites.

During this course, we will explore a few models in more depth, particularly those that have been created for children and youth experiencing complex trauma. Our goal is not to train you in specific practice models, but to help you learn more about some models that are tailored to the needs of this population.

## **6.4 Helpful Ancillary Interventions**

You can also review this resource, *“Ancillary Interventions for Working with Foster and Adopted Children and Youth”* available for download in the Resources tab.

## **7. Conclusion**

### **7.1 Wrapping Up**

This lesson provided a foundation for understanding a range of treatment issues and interventions to address the mental health needs of children and youth.

We hope that providing you with information about a range of interventions will help you to consider enhancing your use of these practices to more effectively meet the complex mental health needs of the youth and families you serve.

### **7.2 Your Journal**

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

### **7.3 Journal Reflection**

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

### **7.4 Journal Response**

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

### **7.5 Conclusion**

Congratulations! You have now completed Issues in Diagnosis and Treatment of Adopted Children’s Mental Health Needs.

The next module will focus on attachment, child development, and mental health.