Utilizing the Assessment in Goal Setting and Treatment Planning

1. Introduction and Objectives

1.1 Introduction

Welcome back to the National Adoption Competency Mental Health Training for Mental Health Professionals. This lesson is: Treatment Planning and Effective Practice Models.

1.2 Section 1: Lesson Objectives

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

- Formulate treatment plans that support secure attachments, resolution of grief and loss, self-regulation skills, and continued positive identity formation within a healing family environment
- Recognize the family as the core client and demonstrate a commitment to family systems work, and
- Understand the treatment implications regarding prenatal exposure to substances and Fetal Alcohol Spectrum Disorder for this population

2. Using Assessment to Formulate a Treatment Plan

2.1 Using Assessment to Formulate a Treatment Plan

Now that you have completed your assessment, you are ready to formulate your treatment plan, guided by the outcomes of the assessment tools you used.

2.2 DSM-5

As we have discussed earlier, the DSM-5 is not adequate to address the impact of trauma on development, leaving the clinician with formal diagnostic choices that may not address the complex nature of trauma and adoption issues.

Recognize that there will likely be several overlapping issues to be addressed at the same time. The diagnosis may be only a small part of the case formulation and is usually not indicative of the whole treatment plan needed.

2.3 Variety of Strategies

There is no one comprehensive evidence-based treatment for adoptive families, so treatment plans need to include a variety of strategies; sometimes including evidence-based or informed practices, as well as strategies specific to working with adoption issues, and simple tools for engaging children and parents.

Remember that foster, adoptive, and kinship families who seek mental health treatment present a range of issues, some which are relatively simple to address through psychoeducation, to those that are extremely complex, trauma-based, and require more in-depth interventions.

For instance, psychoeducation may be a part of your treatment plan to help parents or caregivers understand the underlying causes of behavior that you are seeing, while you work to employ strategies to address both the underlying causes of the targeted behaviors and the behaviors themselves.

2.4 Samuel Case Study

In many cases, interventions need to be focused on building attachments, helping the parent learn to be a therapeutic parent, and fostering healing from complex trauma. In other situations, psychoeducation can enhance the parent's understanding of their role in supporting the child's healing.

Let's look at a case study to illustrate how a treatment plan addressing adoption issues might be formulated. This is the case of Samuel, an 11-year-old boy with severe dysregulating and controlling behaviors. He was seen by two therapists.

Click each number to hear the case.

1. Samuel is an 11-year-old Caucasian boy who was referred by his single Caucasian mother, Susan, for attachment-focused therapy to address his pattern of dysregulated, impulsive, and aggressive behaviors. Samuel was placed with Susan for adoption at the age of 10 months. Susan reported that Samuel was challenging to soothe as an infant, and as he's grown, he has become more non-compliant and verbally and physically aggressive, especially after the adoption of his younger sister when he was 18 months old.

2. His biological mother reportedly used methamphetamines, alcohol, and cigarettes early in her pregnancy, however, Samuel did not test positive for substances at birth. He was removed from his biological mother at birth and separated from his older brother at the same time. He spent 3 weeks with a maternal aunt and then was moved to a foster home before adoption. He and his brother lived in separate homes and were adopted separately. No other biological family member came forward to take Samuel.

3. Susan reported that, as a young toddler, Samuel would tantrum for hours, including head-butting when changing diapers, kicking and hitting at her when she tried to calm him through hugs or containing his limbs. She also reported noticing a more distant attachment with Samuel when she compared it to the attachment she formed with her daughter.

4. At the time of the referral, Samuel's eating pattern was up and down. He would tantrum if he was not ready to eat and didn't get what he wanted. He would wake very early in the morning, but go to sleep quickly at night. His attention span for playing by himself was reported as 5 minutes if inside and 10 minutes if playing outside. When in the house, he constantly wanted his mother's attention. When playing with his sister, he would invade her space and push her down. Samuel was very bright and verbal, and at grade level.

5. A few months prior to the new therapist meeting him, Samuel had a psychological evaluation done at a county behavioral health agency, where he was diagnosed with Anxiety, Depression, and ADHD. That therapist recommended Occupational Therapy, a behavioral specialist, and Parent Child Interaction Therapy (PCIT). Susan tried PCIT, and felt it was not effective.

6. At the time, the new therapist met Samuel and Susan. Susan was exhausted, fearful that her son's behaviors would never change and she had begun realizing how unprepared she was for this level of emotional disturbance. Susan was at a loss for new strategies. She had attended parenting classes for parenting children with trauma history and was seeking intensive therapeutic services.

7. In addition, she was struggling with finding any personal time for self-care, and had decreased her work hours to address her son's needs. She reported that Samuel would reject her attempts to give him affectionate hugs and his body would become rigid. However, Samuel would initiate hugs and his body would be more relaxed when he was in charge of the affection.

2.5 Samuel's Issues Reflection

What are the issues to be addressed in this case?

2.6 Diagnosis for Samuel Reflection

Thinking about his history, what diagnosis would you formulate for Samuel?

2.7 Treatment for Samuel Reflection

What course of treatment would you initially formulate?

2.8 Assessment and Treatment Plan

Now let's listen to Samuel's new therapist discuss their initial assessment and treatment plan for Samuel and his family. We will also hear about the progress Samuel has made.

2.9 Assessment

Based on my initial assessment, Samuel appeared to have Insecure Attachment, the Anxious/Avoidant type and exposure to in utero substances.

This exposure early in his gestation had probably contributed to his impulsivity, activity level, and inability to self-regulate age appropriately. This behavior could be indicative of Fetal Alcohol Spectrum Disorder (FASD).

However, the increase in aggression and anger, primarily directed towards his mother, coincided with the arrival of his younger sister, which took his mother's attention away from him.

It was my hypothesis that this decrease in mother's attention triggered anxiety and fear, which manifested in anger, physical aggression, and oppositional behaviors.

In addition, Samuel's controlling behaviors seemed to stem from a need to control his environment, which I believed made him feel less fearful and not forgotten by his mother.

His history of early separations and changes in caregivers confounded his felt safety and ability to attach.

2.10 Course of Treatment

Based on this assessment, the therapist's treatment plan included dyadic family therapy with Samuel and his mother engaging in attachment-focused activities designed to increase their connection, give Samuel the attention he was craving, and hopefully decrease his anxiety and fear.

Click on each number to hear the therapist describe the course of treatment.

1. *Initially, I directed most of my attention toward Samuel to develop rapport, establish rules and structure, and to model for Susan the language, attitude, and behaviors to use when responding to Samuel's oppositional and dysregulated behaviors. Samuel was given control in the therapy room to choose toys or games, within parameters and rules.*

2. *Each session followed this sequence:*
    - *Greeting and check-in with Samuel*
    - *His choosing an activity*
    - *Allowing him to lead the activity, bolstering his sense of mastery, but at the same time, reinforcing the rules and structure of the game*
    - *Transitioning into reciprocal play or attachment activities, such as playing a board game with Mom*
    - *Ending the session with a timer warning and connection with Mom before leaving*

3. *Reciprocal play activities included:*
    - *Throwing a soft Nerf ball back and forth*
    - *Playing the game "Mancala"*
    - *Copying each other's drawings*
    - *Playing "Simon Says"*
    - *Mirroring each other's body movements and emotions*

4. *Attachment activities included:*

- *Having Samuel and Mom thumb wrestle*
- *Playing "I Say/You Say"*
- *Playing a tactile game like "Finger to Elbow"*

2.11 Samuel's Response to Treatment

When Samuel had difficulty engaging in, or tried to control, the activity, he would be redirected.

Samuel struggled with transitions, such as our session endings, and would become aggressive, kicking the sofa legs.

To address this, Samuel was given a 10, 5, and 2-minute warning. Also, to ease the transition, I acknowledged how hard it was for him to stop the playing time with mom and empathized with those feelings.

After I modeled this approach, Susan took my lead in saying these transitional words, giving Samuel a hug, and helping him to clean up and get ready to leave.

This routine was followed at the end of each session. At first, Samuel was resistant to this routine and required a lot of re-direction and hands-on attention by Susan and me to lessen his aggressive behavior. With consistency and repetition over time, session endings became calmer.

2.12 Psychoeducation and Support of the Parent

The other focus of therapy was providing psychoeducation and support to Susan on ways to manage Samuel's behaviors at home and accept her role as a therapeutic parent.

Click each button on the left to hear the therapist describe more about the psychoeducation Susan received.

Educate: *Significant time was spent educating Susan about the impact of trauma on Samuel's nervous system and his underlying fear and need for control which drove his oppositional and angry behaviors. Education on how attachment is formed and how to create attachment opportunities with an older child was provided.*

Validate: *Validating Susan's feelings, even her feelings of regret for adopting, and normalizing her experience, without any judgment or criticism, was key to giving her a sense of hope and decreasing her sense of helplessness and failure.*

Age: *Susan was encouraged to see Samuel's developmental age (age 7) as opposed to his chronological age (age 11) when parenting him in his dysregulated or non-compliant state. "Parenting the stage and not the age" was a slogan she was encouraged to embrace.*

Regulate: *Susan was encouraged to follow Dr. Bruce Perry's framework for supporting youth exposed to trauma, "Regulate, Relate, Reason" when Samuel was dysregulated in any way and to focus first on helping Samuel regulate and feel connected before trying to talk to him about his behavior. This framework was designed to help vulnerable youth to "learn, think and reflect." She was encouraged to identify the strategies and techniques that helped him feel calm, such as letting him choose his favorite toy or to watch a favorite TV program, and to integrate use of these techniques during the day before his anxiety escalated.*

Plan*: In addition, Susan was educated to identify situations that could be stressful and anxiety provoking to Samuel, even if they were intended to be fun, and to proactively plan how she was going to manage his behaviors should he be triggered in those situations. Suggestions included:*

- *Giving him forewarning about the event and discussing expectations and triggers, or*
- *Listening to music before experiencing something new.*

For example, if they are going to a bowling alley, forewarning may include discussing with Samuel that it will be noisy there, that there will be a lot of people, and that he will have to change his shoes.

Services*: In addition to family therapy, and to further support Samuel, he received occupational therapy (OT) to address his sensory issues, and intensive, in-home behavioral services for 6 months. The in-home behavioral services were designed to reinforce the strategies modeled in therapy with him and his mom. At the direction of the therapist, the in-home work followed the same formula of playing a game with Samuel and Susan, giving him the 10-, 5-, and 2-minute warnings when the play time would end, and helping Susan to practice all the techniques they learned in therapy sessions so that she would feel confident in using them going forward.*

2.13 Regulate, Relate, Reason

To learn more about Dr. Perry's "Regulate, Relate, Reason" framework, click on each word.

Regulate: Help the child regulate and calm their flight, fight, freeze responses. This can be done in a number of ways including using soothing language and fewer words, providing a safe place for the child to go and time to process before moving on. The parent should remain calm and not hover over the child.

Relate: Connect with and relate to the child focusing on how the child feels. You can acknowledge how they feel and how these feelings can be hard for them.

Reason: Support the child in reflecting, learning, and articulating their emotions. You can help them begin to understand and differentiate their feelings in a nonjudgemental way. You can teach them the language of emotions and help them use the strategies they have identified.

2.14 Progress

It's important to remember when working with families with similar histories the progress may be slow and will include setbacks. This is important for you to acknowledge and educate the parents about, so they don't become discouraged.

Samuel's course of treatment lasted over 12 months with increasing positive interactions, affirmed by Samuel and Mom.

2.15 Course of Treatment Reflection

Think back to your responses to the earlier questions about diagnosis, needs, and treatment planning. Did his therapist's course of treatment align with yours?

2.16 Aspects of Treatment Reflection

Were there aspects of treatment that you had not considered?

2.17 Treatment Reflection Response

As you can see, the course of treatment provided by the therapist was effective in addressing the initial diagnostic formulation, building a strong foundation for attachment between mother and son, as well as reducing concerning behaviors as initially presented.

This case validates the notion that you must go beyond the presenting problem by integrating the child's early history and your understanding of permanency-related issues in your diagnosis, assessment, and treatment. This is why it is so important to use the adoption competent clinical assessment from the beginning.

One area not addressed in this treatment plan was Samuel's in utero substance exposure. We will discuss this further in the next section.

3. Special Considerations: Fetal Alcohol Spectrum Disorder

3.1 Special Considerations: Fetal Alcohol Spectrum Disorder

As in Samuel's case, you are likely to see families who come to you because of their child's behavior, without understanding the connection to prenatal substance exposure and Fetal Alcohol Spectrum Disorder (FASD).

It is important for clinicians working with this population, at a minimum, to assess for this exposure and understand the behaviors that may be related.

3.2 Fetal Alcohol Syndrome: The Dilemma for Adoptive Families

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term encompassing a range of birth defects and developmental disabilities that can occur in individuals exposed to alcohol before birth. These disorders can result in various physical, behavioral, and cognitive impairments, some of which can persist throughout a person's life.

Fetal Alcohol Syndrome (FAS) is a permanent condition that results in brain damage and developmental delays due to prenatal alcohol exposure and is the most severe fetal alcohol spectrum disorder (FASD) diagnosis. The Centers for Disease Control and Prevention (CDC) estimates that up to 1 in 20 US school-age children may have Fetal Alcohol Spectrum Disorder.

Children in foster care are more likely to be affected by FASD than the general population. In a scoping review in 2024 analyzing studies from 2012 to 2023, authors estimated that approximately 18.8% of children in care have FASD. Additionally, about 30% of children diagnosed with FASD are placed into foster care, indicating a strong association between PAE and subsequent foster care placement.

Engesether B., Hoffner M., Johnson E., Klug M.G., Popova S., Burd L.. Prevalence of fetal alcohol spectrum disorder in foster care: A scoping review. Alcohol Clin Exp Res (Hoboken). 2024 Aug;48(8):1443-1450. doi: 10.1111/acer.15394. Epub 2024 Jun 20. PMID: 39031634.

3.3 Fetal Alcohol Spectrum Disorder (FASD)

Three areas of information processing affected by fetal exposure to alcohol are neurocognitive functioning, adaptive functioning, and self-regulation.

Click on each number to learn more.

1. It is important for you to know and to help parents understand that children with FASD are not purposefully choosing not to remember, respond, self-regulate, or participate reciprocally. Due to the impact of alcohol on their brain, they are not able to perform these functions .

2. They may have difficulty reading and responding to social cues, which can cause serious problems throughout their life. They may have difficulty with abstract thinking, memory, and regulation of emotions and moods.

3. They may shut down or become dyregulated when parents attempt to discipline them or confront them about behaviors that may cause harm to them.

3.4 FASD Assessment Reflection

Think back to the case of Samuel. The record indicated that Samuel’s mother was known to use alcohol and methamphetamine during pregnancy.

Which of Samuel’s behaviors might indicate to you to pursue a more in-depth FASD assessment? List them here.

3.5 FASD Assessment Response

Possible answers include: short attention span, dysregulation, impulsiveness, and Samuel being challenging to soothe as an infant.

It is also important to make sure that the assessment and diagnosis of FASD is conducted by someone with this expertise. Diagnosis of FASD is based largely on history and on behavioral observation. Because we often don't have prenatal history for children, behavior may be the only indicator.

3.6 FASD Video

Now take a look at the following video to see the experiences of a mother advocating for her son who was diagnosed with FASD at age five.

[Video Transcript]

NARRATOR: Lived experiences with fetal alcohol spectrum disorders. Jen.

JEN: I am Jen and I am an incredibly fierce advocate. When you hear about mama bear, that is me and I very proudly wear the title of that "mom" when it comes to doing what needs to be done for my kiddos. I have a son, Jay, and he is nine years old. He is an amazing kid.

He's so funny. He is the comedian when he gets out of the car during drop off line. He always has a joke for whoever's helping to open up the door for him.

We finalized his adoption right before his first birthday. I was wheeled out of the hospital with him. So I'm the only mom he's ever had contact with.

So we knew going home from the hospital that he had alcohol, tobacco, and meth exposure. He had spent 15 days in the NICU. We had no idea that the alcohol exposure was a factor. He has lots of behavior struggles.

He is smart as a whip, but his impulse control definitely is a thing, and that impacts the way that he is able to function in everyday life. It wasn't until he was five that a friend of mine who happens to work in child welfare, she says "Jen, I really think that you need to look into this FASD piece." And so me being the mom that I am, I'm like, done.

I go home that night, I start Googling "FASD Florida," which is where we are, and I came up with our diagnostic clinic that we happen to have. But other than that, I didn't even know to be looking for something prior to having that conversation with her. I even made an appointment with our pediatrician when we were in the middle of big struggles and I just said "I need help."

And I was told I wasn't stern enough as a parent and I was told to go read a book. I left that appointment in tears. The center is able to offer diagnostic evaluations for kiddos who have confirmed alcohol exposure for free, but the moment that they told me he had fetal alcohol syndrome, it was kicked to the gut because I knew that, that meant he was going to have lifelong challenges.

But it was also very validating because I knew there was something off, I just couldn't pinpoint what it was. So again, I didn't know what I didn't know, but I knew something was off and I just really wanted to be able to help him. So as hard as it was to get his diagnosis, it was also very freeing because then we had a direction.

They came with a plan in the form of their reports that we got from the assessment team. It is a wonderful, very thorough. This is the information that we found, here's our observations from the day, and then here's what you can do for going forward. So a wonderful list of recommendations of books of different providers to reach out to, of ways that we can start supporting his needs.

So one of the things that was really supportive for Jay that I learned about was occupational therapy and sensory needs. I didn't know what I didn't know about sensory and all of these behavioral symptoms that I was seeing. So that was one of the supports that we were able to get pointed in the right direction of. I was able to shift my thinking.

Before we had his diagnosis, his trajectory was very unknown. I didn't know if we were looking at significant behavior needs. I didn't know if he would be able to be successful in a classroom. Once we got his diagnosis, we were able to flip the script on that.

We were able to put him in a place where he could be successful. I call it name it to tame it, so I can label and identify what his needs are, then I can help tame those behaviors. If I were talking to another caregiver who either knew or suspected that their kiddo has FASD, I would tell them that it's tough in the beginning because we don't know.

It's tough because we may be sad about what we envision for our children might not be possible, but our children are going to show us how amazing they are. Our children are going to show us how successful they can be. And when we find those other caregivers, when we know we don't have to do it alone, we can truly accomplish anything.

Some of the things that Jay has been able to progress through are when he went from a nonsupportive school environment to an environment where his needs are being met. He went from having struggles every day to not having struggles, being his version of successful. He then graduated from those needs to have less supports and continues to just knock it out of the ballpark.

He is going from the EBD school that he was in initially to transfer over into a self-contained classroom, and every time we up the bar for him, he meets it, he meets it and says, "I got you, Mom." Jay is able to be in a regular classroom in a school that is meeting his needs. Jay is able to learn.

He is an A, honor roll student, and he has gone from a place where you could see how hard it was for him, and how he was internalizing so much of his struggle to a flourishing, happy kid. What keeps me positive is knowing that there are others on this journey with me, and we will not stop.

In the future, I see my son proud of himself, reaching his potential, and being the amazing kiddo that I know he is.

NARRATOR: For more information, visit cdc.gov/fasd.

Video obtained from: https://youtu.be/Y7Gl7r7fBVA.

3.7 Impacts of FASD

FASD presents unique challenges due to the complexities of the diagnosis and the permanent damage that has occurred to brain functioning.

As the children get older, and the implications of compromised executive functioning are apparent, adolescents with this type of exposure will present with increased risk-taking, coupled with inability to comprehend cause and effect.

These behaviors may include substance abuse, association with negative peer group, sexual promiscuity, inappropriate use of technology, poor academic performance, and impulsivity.

Collaboration with multiple systems is essential. FASD is a lifelong disorder that requires accommodations in parenting, education, health care, vocational preparation, independent living, and interpersonal interactions.

3.8 Strategies for Managing FASD Video

Let's listen to an adoptive father describe the strategies he uses to help his daughter to manage FASD. Beyond the strategies that you heard Sienna's father use, check out the Resources tab for a list of strategies for parents.

[Video Transcript]

[HELPING YOUR TEEN WITH FASD]

MALE: We took Sienna in when she was eight. She's my sister's child, but she isn't really fit to mother her properly. After about a year together, I found a program that specialized in adopted kids. She was diagnosed with Fetal Alcohol Syndrome. She was also diagnosed with ADHD. The psychiatrist recommended putting her on meds to try to help with the attention issues. This worked quite well. It took a few tries with different types and we need to up the dose sometimes, but it did work. It makes life a little easier, but I still have to fight tooth and nail for any help in school.

Sienna can't really retain basic information either. Like I'll think she's learned something, something simple, but the next day it's like she has no memory of it. For example, every morning Sienna has trouble getting ready for school. When she goes to her room to get dressed, she needs to be called several times to hurry up. She forgets to brush her teeth and wash her face. And then she can't find her school bag. The more I try to hurry her along the more stressed and upset she gets. She just can't understand all the steps needed to get her organized and out the door. She shows her confusion and frustration by

becoming loud or angry, even aggressive. Or she'll completely shut down because she feels so overwhelmed.

Our counselor gave us ideas for behavior strategies. He suggested we adjust the environment to make it easy to follow the rules. So we made a plan of what needs to be done to get ready for school and it's very detailed and easy to follow. A toaster on the counter with bread, butter and jam beside it or a cereal bowl and spoon on the table reminds her to eat breakfast. Pictures of her bathroom routine help her to leave home clean and neat. I'll even lay her clothes out in the order that the clothes go on. This helps her stay on track when she's getting dressed.

This has helped a lot, but again, still be so tiring and disheartening. It can feel so isolating. It's hard to know who to share details with. It can be a really lonely road. I went to a counselor myself, who was the first person I felt understood what we were going through. The stress can really weigh you down. It was nice to have someone to talk to about how I feel.

[End of Video]

Video obtained from: https://www.youtube.com/watch?v=MLKL4FpU49o.

3.9 Therapist's Role with FASD

Given the prevalence of FASD in the population of children experiencing foster care and adoption, it is critical that we as therapists are able to identify signs and symptoms and make appropriate referrals for a comprehensive assessment, diagnosis and treatment planning.

4. Conclusion

4.1 Wrapping Up

In this lesson, we addressed important considerations in assessment and treatment planning, with specific attention to helping parents to parent children with FASD.

4.2 Learning Journal

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

4.3 Journal Reflection

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

4.4 Journal Response

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

4.5 Conclusion

Congratulations! You have completed Treatment Planning and Effective Practice Models. In the next lesson, we will explore clinical considerations in working with Native American families.