

Pathologizing Trauma: A Discourse Analysis of Diagnosis in Adoption

by

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Abstract

The purpose of this study is to look at the influence of diagnosis on the way in which the experiences of children who have been adopted are understood. The pathologizing of trauma is explored through a Critical Discourse Analysis of selections from the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), as well as an article on trauma as it relates to children who are in need of foster or adoptive homes.

A response-based perspective from the theories of Response-Based Practice is used for the Discourse Analysis to explore the ways in which language use highlights or silences the resistance shown by children who have experienced trauma. The results of the study show that language used in the discourse studied minimizes resistance shown by children who have been adopted. Through pathologizing language that focuses on symptoms of disorders, children's responses to trauma may not be fully recognized or understood.

The recommendations include the need for parents and adoption professionals to understand more about the responses children may be demonstrating to experiences of trauma. A part of this recommendation is the need to remain aware of the ways in which language contributes to understanding and making sense of the experiences and behaviours of children who have been adopted. The impact of not understanding the full context of behaviour related to trauma and adoption may lead to misdiagnosis, ineffective treatment or adoption disruption.

Keywords: adoption, trauma, discourse, language, Response-Based, DSM, ADHD, diagnosis, disruption, resistance

Table of Contents

CHAPTER 1: Exploring Diagnosis in Adoption	5
Purpose of the Study	5
Personal Connection	9
Purpose of Research.....	11
The Problem.....	12
Definitions.....	13
Process	17
LITERATURE REVIEW	19
Introduction.....	19
The Culture of the DSM	20
Behavioural and Emotional Dysregulation	22
Adoption Disruption	24
Attachment.....	25
Trauma and Adoption	26
Post-Traumatic Stress Disorder	28
Effects of Trauma	29
Diagnosis in Adoption	30
Resiliency versus Resistance	32
Literature Review Discussion.....	35
METHODOLOGY	37
Introduction.....	37
Discourse Analysis.....	38
Critical Discourse Analysis.....	40
Response-Based Practice	41
Understanding Language	43
Adoption and Discourse.....	45
Process	46
Design and Approach.....	49
Future Research	51
RESULTS	53
Process	53
Analysis.....	54
Context.....	54
Findings.....	55
Discrepancies	73
Summary of Results	75
DISCUSSION.....	77
Overview.....	77
Interpretations	78
Implications.....	81
Limitations	86
Further Research	87
Personal Experience.....	87
Conclusion	88

REFERENCES90
APPENDIX A.....105
APPENDIX B.....111
APPENDIX C.....112

Chapter 1: Exploring Diagnosis in Adoption

Purpose of the Study

This study analyzes language use, as it relates to understanding the trauma experiences of children who have been adopted. The analysis is conducted through a lens based on ideas from Response-Based Practice, as well as taking place within the context of the mental health diagnosis of symptomology. Prior to being adopted, children in foster care have often been victim to various forms of abuse and/or neglect (MCFD, n.d.). Due to this, children who have been adopted have unique needs that an adoptive family must be prepared to support throughout the lifetime of the child. With a child's experience of abuse, neglect or various forms of trauma, these experiences can be seen through the way the child behaves, the way in which they are able to regulate and express their emotions or the ways in which certain tasks in life may become more challenging for them, leading to possible delays in the child's development.

Behaviours that present as signs of what a child has been through are often viewed as "symptoms" that are demonstrative of the specific needs of the child (Rolon-Arroyo, Arnold, Harvey & Marshall, 2016), but can easily be grouped together and can quickly turn into a diagnosis or label related to a mental illness as outlined in the DSM-5 (American Psychiatric Association, 2013). While there are both benefits and challenges associated with receiving a mental health diagnosis, the potential serious implications for a child that was adopted cannot be overlooked. Questions arise that ask: what if the symptoms were reframed as justified responses to what the child has been through? In what way might this shift responses of others to the child and their needs? In looking at this further, I begin by exploring more about the needs of children who were adopted, the connection between children who were adopted and diagnosis and the culture in which all of these occur.

The needs of adopted children are often classified as “special needs” and children with these particular designations may be classified by adoption workers as “hard to place” (Creamer, 2008; Gornall, 2007; Tickle, 2015). This then has the potential to turn a response into a symptom or into a special need with far reaching implications, such as a child not finding a permanent adoptive home. Although this may be the common experience of adopted children around the world, the focus in this paper will be on the experiences of children being adopted through the foster care systems of North America, with a lens that stems from the way in which the North American mental health system relates to symptomology and trauma.

In British Columbia (BC), prospective adoptive parents are required to take specific education that prepares them for adoption, with a focus on the special needs of adopted children, regardless of where they are adopting from, or the age of the child they are adopting (Adoption Act of BC, 1996). In BC, the majority of prospective adoptive families, however, are hoping to adopt young children who are considered healthy and who have minimal special needs (L. Carin, personal communication, September 20, 2016). Although many prospective adoptive parents understand that children coming to adoption have often experienced trauma, along with significant loss, the belief is often that with love, care and attention, the child has the potential for normal development and health. Due to this belief, parents may be interested in adopting children who are younger and/or classified as having fewer special needs. Amongst perspective adoptive parents, there seems to be a common belief that a younger child will have fewer issues than an older child who will be impacted by higher special needs due to a potentially longer exposure to trauma and adverse living conditions (L. Carin, personal communication, September 20, 2016).

Many of the behaviours that are displayed by adopted children can be described as symptoms of disorders as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013). It is common to have a DSM-5 disorder referenced in connection to a child available for adoption, particularly in a written profile of a child where their placement needs are outlined in terms of what their specific challenges may be. This may relate directly with the common belief that adopted children have more special needs, learning difficulties and more behaviour challenges than their non-adopted peers (Pitula, Thomas, Armstrong, Essex, & Crick, 2014; Psik, Psik, & Gencoz, 2014; Wiik, Loman, Van Ryzin, Armstrong, Essex, Pollak, & Gunnar, 2011).

Throughout the Literature Review, I will discuss the commonly diagnosed behavioural and emotional challenges of adopted children and how those are presented and understood within the literature. Through this, it is relevant to explore the connection between the child's experiences that have led them to be in need of an adoptive home and the resulting behaviours. From there, an exploration can take place of the impact of such descriptions, labels or diagnoses on adopted children and how this connects to their experience, identity development and stability in terms of permanence in an adoptive home. Due to the significant role played by adoptive parents and adoption professionals, it also seems relevant to explore how the understanding of an adopted child's experience impacts decisions made by them. Having an increased understanding of what a child has been through and how they may be responding to their social environment can help those involved in an adopted child's life to better be able to support the unique needs of each individual child.

Throughout this study, I explore children's responses to trauma through the language of Response-Based Practice. Response-Based Practice provides perspective from which to view

responses as a way of understanding a person's behaviours as adaptive and directly related to life experiences (Wade, 2002). Resistance is used to describe the ways in which a person consciously or unconsciously responds when faced with trauma or oppression, such as when they fight back an attacker, or equally, remain still while being attacked, creating safety through whatever form of resistance seems adaptive and responsive in the moment (Wade, 2002). Response-Based Practice uses language to shift responsibility from the victim or person experiencing oppression to the perpetrator of violence and/or the event/system creating the oppression (Wade, 2002). In the context of adoption, the use of response-based language shifts the blame for the behaviours of the child from the child to the people and event(s) that led to the child's experiences of trauma.

Instead of looking at whether or not a child has the capacity for resiliency, it might be more helpful to attend to children's acts of resistance. This highlights what is known as the child's "directional response" instead of the "*effect of or impact*" of what has occurred in their life (Wade, 2007, p. 64). "When open defiance is impractical or too dangerous, resistance is expressed indirectly and on the micro-level of social interaction" (Wade, 2007, p. 64).

Resistance does not have to be a physical action, such as fighting back, but instead is inclusive of any effort to fight against oppression or protect oneself from harm (Wade, 1997). This includes what others may see as "doing nothing," such as a child who does not run away from an abusive situation or does not cry out when being abused. When looking at this on the surface level, it may seem that the child missed many opportunities to fight back, when in actuality, they may have been silent because it protected their sibling, or chose not to run away because they knew someone would get hurt if they did, or any other number of possibilities for why these decisions were made in the moment. By assuming that an assessment was made, even if unconsciously,

resistance differs from resilience in that the strength does not have to be displayed outwardly and includes a wider range of possibilities for the child's responses and actions. "Alongside each history of violence and oppression, there runs a parallel history of prudent, creative, and determined resistance" (Wade, 1997, p. 23). Children that demonstrate resilience in the context of adoption, are also showing resistance to oppression, such as a child who acts in a certain way to get adopted as a means of protection, without allowing themselves to act in the way that is most comfortable to them. Recognizing and bringing attention to resistance can highlight a person's strengths.

Personal Connection

My personal connection to adoption began many years ago when I started work as an adoption social worker. Throughout the years, I began to realize that I wasn't actually working much with children, as the majority of the work happened outside of a direct connection. It was this awareness that led me to see the importance of the work being done on behalf of the children and the necessity to find ways to include their voice when not meeting with them face-to-face. This needed to be done carefully, but also consciously as it is easy to get caught up in the paperwork and view a child by how they are described on paper, when they are not standing in front of you. Prospective parents can easily get discouraged through the preparation phase as well. As an adoption social worker, it can be tricky to find the balance between making sure the prospective parents are as prepared as they can be, but not scared into thinking solely of the worst case scenario, taking away all aspects of the hope they carry. Adoption education is intended to help prospective families prepare for the unique challenges and joys of adoptive parenting and also for the sake of the child so that their family understands why they might be responding in certain ways, as represented through their behaviours, emotions and actions.

At the same time as I was working in the adoption field, I also began to learn about the theories and principles of Response-Based Practice. Through my studies, I began to wonder about the ways that children respond to their experiences and how this is reflected in the language used in adoption and diagnosis. Although already aware of the areas of oppression that adopted children face, through the incorporation of Response-Based Practice into my thinking, I wondered how the language being used contributed to the understanding of children's experiences and whether this understanding was in some way furthering the oppression that they faced. In my experience adopted children continually show resistance, both prior to and after an adoption. As an example, I have seen children who protect themselves by not attaching to their new adoptive family members right away and I have also seen children who will pick one new adoptive family member to attach to quickly and desperately. While quite different responses, both are equally adaptive and resourceful in the way they offer some protection and safety for the child as they adjust to their new home.

I have also seen children who have recently joined their adoptive family refuse to eat or children who overeat and hoard food. Both situations are likely learned from their previous experiences, but on top of this, food is one thing they can control in a world where all other areas of control have been taken away from them. The child who refuses to eat or the child who overeats is not responding in a less adaptive way than the other, both are living within their realm of experience and making decisions based on their own safety and protection. In these examples, an eating disorder diagnosis may not address what is actually going on, which is that the child has not had the opportunity to learn that food is plentiful or in the case of undereating, the child may not yet trust that there are possibilities for other areas of control in their life. This takes time and jumping in too soon with a diagnosis may mean that the treatment is not focused on the root

cause of what is going on. Support and resources need to be focused towards the current situation of the child by parents and professionals who have strong backgrounds and understanding in adoption. This is why it is so important that there are professionals who specialize in adoption and have this basis for understanding the issues that may present. If a mental health practitioner did not have an understanding of adoption, in these situations they may look to their DSM for answers and make conclusions that risk being inaccurate or unhelpful.

Purpose of Research

The purpose of this research is to explore how the culture created by such commonly used resources as the DSM, has changed the way that society may relate to and understand an adopted child's resistance, as highlighted through a response-based lens. Through a Discourse Analysis, the language used to describe experiences of trauma (both through the lens of diagnosis and education about trauma) will be explored to begin to look further into how meaning is made regarding the experiences of an adopted child. It is of particular importance to delve into as the exploration takes place in the context of how others make meaning of an adopted child's experience, not how the children themselves make meaning of their own experience. By exploring the impact of how others make meaning of these children's behaviours, it may be possible to reinterpret this behaviour in a way that better supports children who have been adopted to make a more positive meaning of their own actions and experiences as they develop their self-identity.

A Discourse Analysis examines what the language is saying and how it is being said, but also what is not being said or what is left silenced. Through this, an exploration can occur on how meaning is made through assumptions, bias and interpretation as it exists within the culture in which the discourse was created.

Using a response-based theoretical lens, the research question is: How does the language of diagnosis contribute to the meaning made in relation to adopted children's experiences of trauma? The intent of this study is to provide insight into how discourse related to adoption can influence the way in which the experiences and behaviours of adopted children are understood. It is my belief that the more that adoption and mental health professionals, as well as adoptive parents, understand the potential impact of the language being used and the unique responses that children can display to their situation, the more conscious the parents and professionals can be in making decisions for children and working in the best interests of the child. While this may not change the system that is designed around the diagnosis of disorders through the categorization of symptoms, it might allow space for different questions to be asked and perhaps due to that, different results or a clearer understanding of the existing process.

The Problem

The medical model involves the clinical description of symptoms in order to classify them into a condition that can best describe and treat those symptoms (Fink & Taylor, 2008). While this can be helpful in terms of working from an evidence-based perspective, there are also potential long-term implications for the person receiving the diagnosis. This may include others focusing on the deficits of a disorder, instead of seeing a person as separate from their diagnosis (Barsky, 2015). While diagnosis can be helpful as the person receiving the diagnosis may now have access to resources and a specific treatment plan, the focus of this paper is on the ways that a diagnosis may not be helpful and the risks that may be involved in providing a diagnosis without all of the information or understanding of the situation. In terms of working with children, there are many factors to consider in looking at DSM diagnoses as there is the potential for life-long implications. In the case of adopted children, there are also additional factors to

consider, such as the child's experiences leading to the adoption, the transition period, the sense of security or attachment within a new home and others depending on the situation. Some of these will be explored in further detail throughout this research paper. For example, the adjustment period of an adopted child may factor into how their behaviours are presenting, as could their age at the time of the adoption. The focus of the paper is to reframe adopted children's behaviours as responses to trauma, to see if their behaviours can be more accurately described and understood, leading to a more helpful response from adults. This is not to say that a diagnosis is not helpful or does not accurately describe the symptoms for the child, but in order to determine this, the full picture of the child's experiences and responses should be considered.

Adopted children have a unique experience that separates them from the experience of children who have not been adopted (Wiik et al., 2011; Mahmood & Visser, 2015). Mental health professionals and others interacting with adopted children may not have the specific understanding of how the adoption experience has contributed to the child's presentation, or how it may be factored into treatment plans. While there is a fine line between taking the adoption into consideration when looking at all that is going on for the child and using the adoption as an overarching explanation of behaviour, a balance of all relevant considerations is the goal.

Definitions

In this research paper, the term "adopted children" is used in a general sense to include not only children who have already been adopted, but also those who are in need of an adoptive family. This includes children in the foster care system that are available for adoption, where the plan for reunification with birth family is not currently an option and they are in permanent custody of the government. Under this term are also the children who have been relinquished by their birth family and placed into an adoptive home. Through the government, children are

usually removed from their parents care, whereas in a relinquishment adoption, the parent(s) make the adoption plan for the child (BC Adoption Act, 1996). Both types of adoption lead to a break in attachments for the child and a need for a transition to a new family and new attachments to develop. I recognize and understand that each adopted child is unique and that no two experiences will be the same and would not normally use the phrase adopted children as it has the potential to define a child by their adoption and separates them from other children. However, I am using the term adopted child in this paper as a phrase chosen to encompass children in various stages of foster care or adoption, including children who have been adopted and children who will be adopted. This is being used in a general sense to represent the belief that all adopted children have experienced some kind of abuse, neglect and/or trauma that has led to their need for an adoptive home. In situations where physical, sexual or emotional abuse has not occurred prior to the adoption, the separation from the birth family may still be considered a trauma in itself. More about this is explained and explored throughout the study.

Response Based Practice is a theory based on the idea that people experience oppression and in many ways demonstrate intentional resistance to that oppression, instead of being passive victims (Wade, 1997). Oppression is understood as being present when there is an unequal access to both power and privilege (David, 2013). Adopted children fit this category for many reasons, not only from possibly being victims of acts of abuse and parental neglect, but from a break in attachment from their birth family and also from the child's inequitable status of power in making decisions regarding their future (Douglas & Philpot, 2003).

As an example of reframing through a response-based lens, a child who experienced sexual abuse prior to being adopted may be described as showing symptoms of Post-Traumatic Stress Disorder (PTSD) (Hebert, Langevin, & Daigneault, 2016). From a response-based lens,

instead of categorizing these symptoms through a diagnosis of PTSD, the behaviours that the child is demonstrating could instead be viewed as a response to the trauma and resistance to the abuse that occurred. For example, if the child is dissociating, this can be seen as separate from a PTSD diagnosis, and instead as a strategy used by the child to protect themselves from the emotional and physical pain that occurred from the sexual abuse. This reframing changes the interpretation of behaviour from a child who has displayed symptoms of being “damaged,” to a child that has drawn on an innate ability to do what is needed to protect themselves. This is a strength-based perspective. This frame does not mean that a PTSD diagnosis may not be relevant or useful, but instead provides more context for the explanation of the symptoms and behaviours. Through this response-based lens, the exploration includes an analysis of various discourses that relate to a child’s experiences of trauma. From this, the context in which the behaviours or symptoms occur can be examined for the ways in which language use contributes to the way the child’s experience is understood.

Although children are often victims of abuse or are witness to abuse that is occurring in the family home, historically they have been seen as passive participants in the events that occurred, both too young to understand what is occurring and too young to do anything other than be there (Richardson & Bonnah, 2015; Stainton, 2016). Response-Based Practice aims to highlight the ways in which all people (including children) demonstrate agency and therefore are actively involved in what is going on around them. For adopted children, this means that they were actively participating in the events that led up to their adoption (often traumatic experiences) and, through their current behaviours, are demonstrating ways that they are protecting themselves from those events occurring again.

A strength-based perspective is explored and used throughout this paper. This perspective is collaborative in that the person is usually involved in making plans and accessing services with the understanding that they best know and understand their own situation (Hammond, 2010). While a strength-based perspective does not ignore challenges that may exist, it instead uses the existing strengths of a person to understand and work with those challenges (Pattoni, 2012). An approach that focuses solely on a person's deficits may fail to recognize all of the strengths and positive attributes that exist alongside any challenges.

Within this paper, the terms "pathologized" or "disordered" are used to describe language that speaks from a deficit-view, focusing solely on the diagnosis or symptoms a person may display. Pathologizing something means viewing symptoms as abnormal which can then lead to assumptions that it must be changed or fixed, as is the definition of a disorder (Merriam Webster, n.d.). "Pathologizing and medicalized conversations can limit possibilities for change, particularly when these conversations are privileged above other possible conversations one can engage in" (Kindsvatter, 2005, p. 503). Through an exploration of language that pathologizes, and its potential impact on adopted children, the hope in this research is to highlight the risks that are inherent in such language use and to suggest alternatives.

The term "emotional and behavioural challenges" is used throughout this paper to describe what the child may be experiencing and/or displaying. While I would prefer the use of language that does not have negative connotations as to the child's responsibility in their behaviour, this is the term that is used throughout the literature as explained further in the Literature Review. Due to this, this term is used to describe the behaviours and emotional dysregulation often seen in adopted children. While the challenges seem to be described as challenging behaviours for the child to have, one could also argue that the behaviour is actually

challenging for others, such as the parents who must learn to respond to these behaviours.

However, in the way this term is used within the literature, the challenge appears to be described in terms of how the child behaves differently than expected for their developmental and biological age and that is the context from which the term is used in this research.

Process

In order to conduct this research, I have chosen two sections of the DSM-5 that seem most relevant to the experiences of adopted children. The first is the section on ADHD (see Appendix A), as adopted children are approximately four times as likely to receive an ADHD diagnosis than their non-adopted peers (Simmel, Brooks, Barth, & Hinshaw, 2001; Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007). Through this discussion, I explore the descriptions of the symptoms of this disorder in order to look at the ways in which meaning has been made from the behaviours of adopted children. The second selection I include in the Discourse Analysis is the section of the DSM-5 that addresses Trauma and Stressor-Related Disorders (see Appendix B), as it speaks directly to the responses of adopted children to traumatic experiences. My goal in including this section is to see how the description was provided in terms of responses and/or symptomology and if there is room within that description for an alternate explanation and therefore response to children that have been traumatized through the adoption process. The third text selection I include is an information sheet on trauma (see Appendix C) that was designed to educate prospective adoptive and foster parents so that they can understand the impacts of trauma experienced by the children joining their family. I include this document as it describes the experiences of trauma outside of the lens of diagnosis and I want to see if this changes how language is used and the way in which language contributes to the meaning made about the child's experiences. As noted, and further explored, adoptive parent education is a

vital part of the success of adoption placements and gaining some insight into how the information is shared seems relevant to the context in which trauma is understood in relation to children who have been adopted. The way language is used contributes significantly to the interpretation and understanding of what is being shared and due to this, language holds power in how information is presented and received.

This paper will include a description of how the culture as created through the DSM came to be, what the research says about adopted children, a close look at meaning made through language use in adoption literature, the potential impacts of this language use and the hope for change in moving forward. In the Literature Review, the current research regarding adoption, trauma and diagnosis will be explored, along with further information on the DSM-5, as it relates to how symptoms are categorized and understood within western culture. As this research is conducted from a lens of Response-Based Practice, throughout the paper more information on the context of this lens is included and discussed.

LITERATURE REVIEW

Introduction

Much research is available on various aspects of adoption; from statistics to personal accounts of adoption; to studies of mental health throughout an adopted child's life. For the purpose of this research paper, the Literature Review is focused on the experiences of trauma as it relates to adoption, commonly identified behavioural challenges of adopted children, common diagnoses for adopted children and how the research explains the trends as they relate to adopted children. Through this, the link between trauma and symptomology/diagnosis will be explored.

Throughout the literature there seems to be an understanding that a child in foster care or a child in need an of adoptive family has experienced trauma; whether through various forms of abuse or neglect, or through the adoption experience itself with the trauma being related to the separation of the child from their birth family and the related break in attachments (Post, 2013). The assumption for this paper is that the adopted children that are referred to, have experienced trauma of some kind. Due to this, the Literature Review will focus on the definitions of trauma in this context and the culture of diagnosis in which this unfolds and is understood. A Critical Discourse Analysis will be conducted to further explore the connections between trauma, behaviours/symptoms and diagnosis through language use.

Within related literature, a common theme is the idea of "resiliency" with a focus on the importance of building resiliency in children in order to support the child in working through their experiences of trauma (Ager, 2013). Due to this noticeable theme, it seems relevant to devote a section of the Literature Review to comparing and contrasting the notion of resiliency with the idea of "resistance" to examine the differences of how these two terms are used and referenced, specifically in terms of meaning through language use.

As this research is conducted through a qualitative research method, its aim is to examine existing research and in particular, the way in which language use may be influencing the implications of that research and in turn, how parents and other professionals respond to children who have been adopted. To do this I use Critical Discourse Analysis through a lens based on the theories and perspectives of Response-Based Practice. The Discussion section of this paper will incorporate information from the Literature Review and the Results section to explore the ways in which language use interprets and makes meaning of children's experiences of trauma. Through this, an exploration of the ways in which a child's voice and lived experiences are translated into the written word will be conducted.

The Culture of the DSM

In order to understand the culture of diagnosis created by the Diagnostic and Statistical Manual of Mental Disorders (DSM), it is important to understand the history of the DSM and how the classification system was developed. The first edition of the DSM, developed by the American Psychiatric Association (APA), came out in 1952, after a post-World War 2 move from biological explanations for symptoms to psychologically based explanations (Clegg, 2012). The 127 diagnoses listed in the DSM-I (Cooper & Blashfield, 2016), have expanded to 297 diagnoses listed in the DSM-5 (Rosenberg, 2013). By the time the third edition of the DSM came out in 1980, a clear system seemed to have been developed through the DSM, with a goal of providing diagnoses to disorders, similar to the medical model of diagnosing illness, through the classification of signs and symptoms (Guze as cited in Clegg, 2012; Decker, 2013). The development of the DSM-III has been identified as a turning point in the understanding and treatment of mental illness, with a shift from broad descriptions of disorders, to a specific and symptom-based classification system (Mayes & Horwitz, 2005). This was potentially influenced

by a number of factors, including pharmaceutical companies, politics that were present amongst mental health professionals, health insurance companies and increasing government involvement in issues of mental health (Mayes & Horwitz, 2005). The DSM-3 also represented a move away from understanding unique responses to an experience or event, into the grouping of responses as symptoms that allowed a classification system to be developed (Clegg, 2012; Romelli, Frigerio, & Colombo, 2016).

One criticism of the DSM is that the cluster of symptoms that are applied to a label of a mental disorder are arbitrary and based on what is occurring at the time in history in which each edition of the manual is created and the decisions of the mental health professionals at that time (Watters, 2013; Romelli et al., 2016). This means that the existence of certain disorders and the creation of symptom classifications in the DSM influence each other and shift how the culture responds to mental illness. While the symptoms of certain disorders have perhaps always existed, the way in which these are categorized into illness have changed, meaning that the same symptoms could have a vastly different diagnosis or label at different periods of time (Watters, 2013). One way of looking at this, is understanding the context of the culture that is created by the current DSM. This classification system can take away the individual experiences or unique responses that people have and instead classify these responses as symptoms that are representative of a mental health disorder. The interpretation and use of the DSM is in itself subjective in nature as an understanding of the presentation of symptoms will never be completely without bias or influence (Clegg, 2012; Watters, 2013; Romelli et al., 2016).

Culture does not only shape our understanding of the diagnosis of mental illness, but also our understanding of the treatment of mental illness, including the recent influence of pharmaceutical companies into categorization and treatment of mental health conditions

(Watters, 2013). While there are some disadvantages that can be identified for the current system of classifying mental disorders, this system has also been noted to be beneficial for research, prevention, treatment assessment and many other areas where a classification system is a useful way to study disorders (Kraemer, 2007).

Behaviours and Emotional Dysregulation

When reviewing the literature on children that have been adopted or are in need of an adoptive family, the topic of common behavioural and emotional challenges is predominant. Aspects such as the age of the child at placement has been shown to be a contributing factor in potential behavioural and/or emotional challenges for the child (Brand & Brinich, 1999). In British Columbia, there are approximately 1000 children available for adoption, with almost 80% of those children age six or older (Culbert & Sherlock, 2015). The children who are currently in the foster care system and able to be placed in adoptive homes are considered to have more special needs and behavioural challenges than foster children had in the past (Simmons, Allphin & Barth, 2000). It is not clear whether this is due to an actual increase in the special needs of the children or if it is due to a new understanding or perspective on the impacts of trauma and therefore a higher level of labelling. Regardless of the reason for this increase, it points to the need for adoptive parents and professionals working with adoptive families to develop skills and training to work with these needs in a way that is congruent with the experiences of the specific child rather than responding to children in a general way as described below.

While there are specific conditions that seem to be commonly diagnosed with adopted children (ADHD, attachment disorders), there are also more generalized terms that are used to describe a series of behaviours or presenting symptoms, such as the term “adopted child syndrome.” This is an over-arching term that describes the likelihood of an adopted child’s

behaviour, including “defiance of authority, and acts of violence” (Smith, 2001, p. 491). This terminology demonstrates how wide-spread the belief is that emotional and behavioural challenges are present in adopted children. In the following section I will review some commonly used terms within the literature on adoption.

Adoption literature references children with varying levels of behavioural or emotional challenges and attributes these challenges to different causes, speculating as to whether or not these challenges are long term. Often, adopted children with severe behavioural and emotional challenges are described as being “problematic” (Fisher, 2015; Raaska, Elovainio, Lapinleimu, Matomaki, & Sinkkonen, 2015; Wiik et al., 2011). The same literature focuses on ways to change the problematic behaviours, rather than focusing on understanding why the behaviours exist in the first place, which might change how these behaviours are perceived by caring adults, and therefore, how parents, therapists and social workers are implicitly expected to respond. Most often, the information on children’s challenging behaviours, as noted in the research, is directly correlated to the child’s experience of trauma that occurred prior to their adoption placement (Brand & Brinich, 1999; Gray, 2012; Howard, Parris, Nielsen, Lusk, Bush, Purvis, & Cross, 2014). This leads to acknowledgement that the context of how the child developed these behaviours is important. It is also noted that when looking at the behavioural differences between adopted and non-adopted children, it is important to account for factors such as the age of child at the time of adoption and the stage at which the behaviours are being looked at, such as whether this is during the adjustment period when new attachments are not yet formed (Brand & Brinich, 1999).

Within the adoption literature, emotional issues of the adopted child are described as being in the form of dysregulation or displays of emotions that seem to fall outside of what is

considered age appropriate (Rice, Jones, & Thaper, 2007; Rosnati, Montirosso, & Barni, 2008; Psik et al., 2014). When children in foster homes are categorized as having “serious emotional disturbances,” they may face barriers to finding permanency in the form of an adoptive family, who may not feel well equipped to deal with these behaviours and expressions of emotion (Akin, Bryson, McDonald & Walker, 2012, p. 79).

Despite available research on the challenges of supporting a child with behavioural or emotional challenges, other research makes note of the need to move away from a presentation of the specific behavioural or emotional symptoms of the child and instead to highlight the promotion of positive mental health for the whole family, in an effort to achieve permanency for the child (Akin et al., 2012). This would shift the focus from the seemingly negative behaviours or emotional dysregulation, to a focus on how to work with these behaviours and what changes may be possible with the right conditions of support.

Adoption Disruption

Adoption disruption refers to when an adoption placement breaks down, and the child subsequently returns to foster care (Coakley & Berrick, 2008). It is reported that about 15% of adoption placements end up breaking down (McCreight, n.d.). The label refers to the placement as unsuccessful because permanency for the child was not achieved. Much of the literature regarding adoption disruption makes connections between the lack of preparation of the adoptive family – for example if the placement was rushed and the family was inadequately prepared or if there was inadequate education for the prospective adoptive parents (Coakley & Berrick, 2008). However, it is also noted that the child’s behavioural challenges or medical history may be the reason for the breakdown, where the adoptive parents were either not aware of the existence or were not aware of the severity of the behaviours or medical concerns (McCreight, n.d.). For

instance, in one study, child sexual abuse that occurred prior to the child being adopted, was said to increase the chances of adoption disruption (Nalavany, Ryan, Smith, & Livingston, 2008). According to Milbrand (n.d.), an adoptive parent, while it may seem that disruptions are occurring because the child's behaviours are seen as too difficult to manage, what is more likely to be occurring is that the parents are either not able to understand the child's behaviours or do not know how to best support the child to heal. Other times, the parents' abilities to manage and respond to behaviours may be limited and as mentioned, they may not have known about some of the behaviours prior to adoption (Milbrand, n.d.).

Attachment

Attachment, also described as strong connection to the primary caregiver(s) in a child's life, is seen as an essential developmental step for the child to have healthy emotional regulation (Cooke, Stuart-Parrigon, Movahed-Abtahi, Koehn & Kerns, 2016). In the literature on adoption, the topic of attachment is specifically explored in relation to how adoption disrupts existing attachments and how attachment difficulties may arise as a result of the experiences of adoption (Golding, 2007). It is often noted that a child with a history of disrupted attachments, will present with behavioural challenges after the adoption and may have difficulty with forming attachments to the new adoptive family (Golding, 2007; Carnes-Holt & Bratton, 2014; Subhani, Osman, Abrar, & Hasan, 2014). At times, it is noted that the more breaks in attachment a child has or the more disruptive their attachment experiences were, the more likely they are to have serious or longer term behavioural challenges and other mental health issues (Hughes, 2006; Perry & Szalavitz, 2006; Purvis, Cross & Sunshine, 2007).

While attachment challenges are often noted to ensure adoptive parents are aware that bonding may not be an easy process, other times more serious attachment concerns are noted,

such as Reactive Attachment Disorder (O'Connor, Bredenkamp, & Rutter, 1999; Howe, 2010; Doom, Georgieff, & Gunnar, 2015), along with discussions about the challenges this presents for the adoptive parents (Gau & Chang, 2013; Theule, Wiener, Tannock, & Jenkins, 2013; Hutchison, Feder, Abar, & Winsler, 2016). Reactive Attachment Disorder is a “consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers” and requires the child to have experienced inadequate caregiving during their younger years in order to receive this diagnosis (APA, 2013, p. 265).

While attachment concerns can lead to a diagnosis, as seen in the diagnosis of Reactive Attachment Disorder as outlined in the DSM-5, there are people who question whether an attachment disorder diagnosis is actually beneficial to explain the presence of attachment challenges (O'Connor et al., 1999). As disordered attachment behaviours are often described in terms of who the child turns to for support and whether they have trouble turning to anyone to be consoled or will turn to anyone, a disordered perspective will demonstrate that these symptoms are based on problems with attachment. However, it may also be seen that the child has challenges with appropriate social responses, instead of attachment (O'Connor et al., 1999). Labelling the child with an attachment disorder may be useful to group together the symptoms that are seen along with the requirement that the child have experienced neglect in their upbringing, however, the social responses or other developmental issues may be ignored through such a diagnosis.

Trauma and Adoption

It is relevant for this research to understand what is defined as trauma. Trauma is often referenced as the basis for challenging behaviours seen with adopted children and potential long-term impacts. The focus of this study is on the pathologizing impacts of trauma, with labels

given as explanations for how children are responding to trauma. There are various definitions of trauma, but they include some kind of a threat to the safety of the person, such as through abuse, accident, neglect, death of a parent and other possibilities that can cause this safety threat or violation (Wamser-Nanney & Vandenberg, 2013). Experiencing a trauma does not mean that a person is damaged, but this may become the focus if a person is spoken of as being “traumatized.” Instead, a person who has experienced a traumatic event may be understood through looking at the behaviours that may reflect that experience and may be present as a protection against experiencing the traumatic event again. The effects of psychological trauma can be difficult to detect as they may present in various forms, some of which are not outwardly apparent, but they all lead to the person feeling unsafe and/or vulnerable (Herman, 1997).

The trauma focused on in the literature in connection to the behavioural challenges seen in adopted children is both from incidences that would be considered traumatic (ie. directly witnessing or experiencing a violent event), being a victim of abuse, being separated from ones birth family or moving multiple times into new environments (Gray, 2012; Perry & Szalavitz, 2006). Trauma that occurs in the lives of young children may teach them that the world is not safe, which affects how their personality develops, how they decide whether to trust another person or not and how they respond to future situations (Gray, 2012).

Different types of trauma can lead to different responses, just as each person will respond to trauma in their own unique way (Wamser-Nanney & Vandenberg, 2013). Due to this, responses to trauma are neither predictable nor do the responses have an expected time frame. Trauma in early childhood has been found to have more long term and serious symptom developments than trauma that occurs in later life (Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2003). While some responses to trauma may be short term or not life-altering in a

significant way, other times responses to trauma lead to long term implications or to a diagnosis related to the trauma response, such as with the diagnosis of Post-Traumatic Stress Disorder.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is another commonly diagnosed condition amongst adopted children due to both possible exposure to a traumatic event, as well as the lived trauma of experiences such as separation from family and previous caregivers (Hoksbergen, ter Laak, van Dijkum, Rijk, Rijk, & Stoutjesdijk, 2003). A PTSD diagnosis in a child waiting to be adopted or an already adopted child, may leave adoptive parents with some fears around the serious and potentially long term implications of such a diagnosis. Exposure to a traumatic event that leads to symptoms as described by the DSM description of PTSD may lead to changes in mood, self-perception and increased negative thoughts (Scales & Scales, 2016). Children who experience trauma, particularly those who experience it before they are able to communicate verbally, are often not able to process what happened to them with the trauma, and instead live with anxiety that may be difficult to identify (Greenwald as cited in Scales & Scales, 2016). PTSD may be diagnosed based on the symptoms shown following exposure to a traumatic event. However, the absence of a PTSD diagnosis does not mean the absence of experience with a traumatic event, nor does a PTSD diagnosis indicate the level of traumatic experience or the intensity of symptoms experienced (Wamser-Nanney & Vandenberg, 2013). This is important for prospective adoptive parents to understand as a child without this diagnosis may still be responding to a serious traumatic event. There is also some question as to whether symptoms displayed in response to a trauma (such as those categorized in the definition of PTSD) are culturally based and not necessarily relevant to the experiences and responses to trauma in other cultures (Hinton & Good, 2015). As the PTSD symptoms listed in the DSM-5 are based on

symptoms shown in adults, there is also some concern that a PTSD diagnosis in children does not fully capture the range of the effects of the trauma on the child (Schmid, Petermann & Fegert, 2013).

Effects of Trauma

It seems that most researchers are in agreement that adoption involves some sort of trauma, and while the impacts of this are both varied and individual, it is generally understood that trauma impacts the child. Within the varied definitions of trauma, the actual need for adoption itself can be seen as traumatic including the separation of the child from their biological family and the break in attachment that follows.

Every adopted child has experienced the trauma of being separated from his or her blood kin under some kind of legal arrangement. Social workers feel it is politically correct to say that the birth mother has made an “adoption plan.” Birth mothers call it “surrendering” the child. Nancy Verrier (1993), an adoptive mother, calls it the “primal wound.” Whatever language one uses, adoptees feel the trauma of the mother's disappearance as an abandonment (Javier, Baden, Biafora, & Camacho-Gingerich, 2007, p. 418).

Javier et al. (2007) speaks to the “cumulative adoption trauma” that children experience through the years and must learn to process and live with as an adult; from the separation from their birth family, to the experience in foster care, to the realization that new attachments must be formed (p. 420).

There are a variety of possible responses to a traumatic event or multiple traumatic experiences that may include changes to a person's ability to attach, demonstrate behavioural and emotional control and regulation, their motor and sensory development as well as potential

impacts to cognitive factors (Gray, 2012; Cook et al., as cited in Hudspeth, 2015). When children grow up in a so-called healthy environment, they have responses to stress modelled by adults around them. However, if a traumatic event occurs or if the caregivers of the child are not able to regulate their own stress, the child learns unhealthy ways to respond and their emotional or behavioural responses may become dysregulated (Gray, 2012).

Trauma is linked with stress (Desborough, 2000; Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson, & van der Kolk, 2005; Matheson, Jorden & Anisman, 2008). For example, prenatal stress, is often considered impactful for a child who was in utero. Many adopted children are born to young mothers who receive minimal prenatal care, which can be stressful for the mother, and is linked to emotional or behavioural difficulties with the child. Stress is also linked to low birth weight, which is known to cause potential risks to physical and mental development of the child (Ingersoll as cited in Javier et al., 2007). Maternal stress is common, as factors such as poor nutrition, physical or emotional stress or anything that increases the cortisol levels of the pregnant mother, may impact the baby's own response to stress (DiPietro, 2004; Javier et al., 2007; Rice et al., 2007; Lazinski, Shea, & Steiner, 2008).

Diagnosis in Adoption

There are a number of diagnoses from the DSM-5 that are commonly seen in adopted children. In one study, adopted children were found to have approximately double the chances of receiving a diagnosis for a behavioural disorder (Keyes, Sharma, Elkins, Iacono, McGue, 2008). While there are many, out of the almost three hundred diagnoses that could be mentioned, for the purpose of this research the focus will be on Attention Deficit Hyperactivity

Disorder (ADHD), Post-Traumatic Stress Disorder (PTSD) and attachment disorders as they are the most common ones that adopted children receive.

ADHD was an addition to the DSM-4 in the 1990's, which does not mean the symptoms were not present prior to that, but instead that they were not categorized under the ADHD label (Watters, 2013). The prevalence of ADHD symptoms has been shown to be higher in adopted children than their non-adopted peers (Doom et al., 2015; Billadeau, 2014). Children who are adopted when they are older are often thought to be at higher risk of developing ADHD, although the research around this is not always clear (Crea, Chan, & Barth, 2013). The overall prevalence of ADHD in all children is approximately 5.29% (Polanczyk et al., 2007, p. 942), while the prevalence of ADHD in adopted children is estimated to be around 22% (Simmel et al., 2001). In adults, ADHD in the general population is around 3.5% (APA, 2013). While the symptoms of ADHD may be linked to a dysfunctional family environment, it is not clear whether this is a cause or consequence of this type of an environment (Howe, 2010).

Disorders such as Reactive Attachment Disorder (RAD) and Post Traumatic Stress Disorder (PTSD) are classified in the DSM-5 under 'Trauma and Stressor-Related Disorders', which requires that a person have experienced a traumatic event to receive a diagnosis under this category (APA, 2013). This requirement makes it a convenient diagnosis for children who have been adopted. For RAD, the criteria includes that the child has experienced neglect or a change in caregivers, both situations that are commonly found in adoption (APA, 2013). Early childhood abuse and neglect is commonly seen as linked to the diagnosis of RAD (Hall & Geher, 2003; Wimmer, Vonk, & Bordnick, 2009). The separation experienced through a child's need for an adoptive home, as well as common experiences of abuse and neglect prior to the adoption

can lead to increased risk for a PTSD diagnosis for both the child and the mother who is no longer parenting the child (Riben, 2016).

Resiliency versus Resistance

There seems to be little research available that speaks in terms of the “acts of resistance” shown by adopted children, both during their early childhood years, experiences of possible traumatic events, the experience of the adoption itself and in the post-adoption period.

Resistance, as described through Response-Based Practice, is the idea that people always work to stop or minimize threats to their safety, regardless of how others view what took place (Coates & Wade, 2007). Language is connected to the way in which we understand violence, oppression, responsibility and actions taken. Response-Based Practice looks at how language can be used to minimize or hide the ways in which people resist mistreatment (Coates & Wade, 2007). For example, a person that is being attacked may fight back or may stay still while the violence is occurring. Both would be considered an act of resistance as there were reasons for why the person responded in the way that they did, and both can be seen as a form of protection. With the person that stayed still and did not fight back, language can be used to minimize the choices made in the moment by saying that the person “did nothing.” By highlighting the act of resistance instead, the reasons for the action can be explored and through that, it might become clear that the person stood still because they knew that meant the attack would be over sooner or that if they ran away someone else may receive the attack, or any number of other possible reasons.

In adoption, acts of resistance are seen over and over in the ways that children protect themselves from getting hurt again or from experiencing another loss. This is done in unique ways. However, resistance is not often described in the adoption literature and instead the

behaviour is more likely to be explained through the child's defiance or by a diagnosis that sees the behaviour as symptoms. For example, if a child does not attach to their next foster parent, this may be explained by an attachment disorder, instead of by an act of resistance that shows the child's understanding of the hurt that can come from getting attached to someone who may not be in their life permanently. While resistance is not often mentioned within the adoption literature, resilience is a common term used in child welfare publications, a term focused on the strength of children to overcome the challenges they have faced (Ager, 2013; Barcons, Abrines, Brun, Sartini, Fumado, & Marre, 2014; Crea et al., 2010).

While many researchers speak of the importance of building resilience in children and provide information around techniques that work to increase this in children, a definition of resiliency is not always provided (Semple, Lee, Rosa, & Miller, 2009; Noether, Brown, Finkelstein, Russell, VanDerMark, Morris, & Graeber, 2007) and instead remains quite broad, with disagreements about whether resilience is based on internal or external factors (McCleary & Figley, 2017). Some believe that resilience is based on internal factors in that some children are more likely to demonstrate resiliency, while others see the existence of resiliency as chance, through a combination of events in the child's life coming together to increase the opportunities for resilience to develop (Masten & Reed, as cited in Brodzinsky & Palacios, 2005). While the understanding of resistance as stated in the literature may lead to an understanding in the general public or with those who work with children that resiliency is important--and it seems to be socially accepted that children must possess this quality to succeed--there is very little specific information about what this means. Ideas for encouraging or increasing resiliency in children include the use of mindfulness based techniques (Semple et al., 2009), incorporating interventions that build strength (Noether et al., 2007), focusing on building supportive

relationships (Kersey & Robertson Malley, 2005) and incorporating spiritual practices into the child's life (Dillen, 2012).

Other researchers define resiliency as a protective strength that works to minimize the impact of risk factors that a child may have or as a healthy self-esteem and confidence to get through tough times (Kersey & Robertson Malley, 2005; Dillen, 2012). From these definitions, it could be inferred that a child who is not deemed resilient will be more likely to be impacted by the risk factors that are present from their life experiences. With this definition, children who are resilient are doing well *despite* what they have been through, while children who are not resilient are not doing well *because* of what they have been through. This not only puts a lot of pressure on children, but fails to highlight the many strengths that children have as individual beings. This belief does not allow much room for it to be acceptable for a child to not be doing well in the face of trauma and does not recognize the strength that has already been shown simply in survival, or in not outwardly demonstrating resilience.

The ideas and strategies for building resiliency in children are often defined in a way that demonstrate the need for them to be conducted within a supportive environment, such as with an adoptive family (Kersey & Robertson Malley, 2005). However, the difficulty with this with children that are available for adoption, is that prospective adoptive parents may already expect the child to demonstrate signs of resiliency to show that they will not be overly or permanently impacted by the potentially traumatic life experiences or adversity that they have faced. This leaves the child to develop resiliency on their own, which goes against what much of the advice states is needed to develop resiliency within ideal conditions and a supportive environment. Without resiliency present, prospective adoptive families may look at the child as "damaged" or unable to overcome what they have been through and develop in an age appropriate manner.

Resiliency is often seen as necessary for the child to do well and reach their expected level of development:

The frequency with which post-institutionalized children show good developmental outcomes despite a myriad of early adverse experiences challenges us to understand the resilience of the human brain and the factors in the postadoption experience that help children reorganize compromised neural systems to support healthy adaptation and more optimal development (Brodzinsky & Palacios, 2005, p. 58).

The concept of resiliency within children has been used to explain why some children who have been adopted do well and others do not, despite having similar experiences of trauma or behavioural expressions. Known as the “resiliency paradigm,” this has also been used to explain the varied research results on the success of adopted children (Brodzinsky & Palacios, 2005, p. 21).

Literature Review Discussion

There is significant research demonstrating that adopted children have specific needs, many of which present as non-compliance, defiance or other behaviours that may be seen as abnormal when compared to other children that fit a diagnosis within the DSM. It is also noted that these symptoms and disorders seem to present at higher rates with adopted children, than with their non-adopted peers.

Resiliency is a word that appears often with an intent to show that with resilience, an adopted child’s challenges can be managed. However, the information on how to build resiliency with children may leave those that do not show resiliency traits behind. Instead, looking at the resistance shown and that the child continues to show, helps to provide a more

fulsome understanding of the child's experiences and how they may present in their emotions and behaviours, outside of diagnoses and pathologized language. In other words, it seems important to highlight that the child has shown tremendous strength and wisdom as well as resiliency by resisting further pain and suffering.

The information found through the Literature Review will be explored in more detail in the following sections of this paper, in combination with what was found through the results of the Discourse Analysis. In the next section I describe and explain the reasons why Discourse Analysis was chosen as a research method. This is followed by a discussion on how changes in understanding and meaning making of the experiences of children that have been adopted may differ from current understanding and may lead to different responses from those responsible for children who have been adopted.

METHODOLOGY

Introduction

Given that qualitative research seeks to explore and describe the meaning and understanding of problems in society (Creswell, 2014), I have chosen to use qualitative research to explore how language used in the context of diagnosis with adopted children creates possible meaning around their experiences of trauma. This study looks at the language applied to children who have been adopted through a Discourse Analysis, which involves a detailed look at the language being used and the possibilities for the creation of meaning within those language choices.

Discourse Analysis provides various means of analyzing language in a way that fits with the context and culture in which it is embedded and with what is being studied (Shaw & Bailey, 2009). From a perspective that aims to look at how meaning is created for the experiences of an adopted child, with the breakdown of language choice and analysis of possible assumptions within that word choice, I have also included discussion around how meaning may shape the adopted child's experience or how others may view the experience, based on the language being used.

In this paper, Discourse Analysis is used as a research method to analyze three pieces of text. The first two are sections from the DSM-5, where the description of symptoms have been classified into disorders which can then be used to diagnose adopted children. Along with this analysis of common diagnoses for adopted children within the DSM-5, a Discourse Analysis of a description of the impact of trauma experienced by adopted children is included in an attempt to provide a wider range of information about an adopted child's experiences of trauma.

While Discourse Analysis provides a variety of options for the actual breakdown and analysis of language, I have chosen some specific techniques to use in order to maintain focus and organization of the Discourse Analysis process. A description of these Discourse Analysis techniques is included below. As the voices of the adopted children are not included in the Discourse Analysis, in this Methodology section, I have included a discussion about understanding how meaning prescribed through language use is important for all involved in the adoption community, in order to provide some space where those voices can enter.

As this research is being conducted with a response-based lens, it is also important to understand Response Based Practice in the context in which it has been used to conduct the Critical Discourse Analysis. A section on Discourse Analysis through the lens of Response-Based Practice is included in the Methodology section as well as recommendations for further research.

Discourse Analysis

Discourse Analysis is a theory as well as a research method (Phillips, 2014). As language is not and cannot be neutral, Discourse Analysis looks at not only language use, but the ways in which meaning is made from the language used, as well as how the audience may receive the information and potentially be influenced (Evans, 2013; Phillips, 2014). Through analysing language patterns, word choice and context, the social world is not only reflected, but also constructed, with Discourse Analysis providing a method to examine the how and why of the creation of meaning (Albers, McMunn Dooley, Seely Flint, Holbrook, & May, 2013; Evans, 2013; Phillips, 2014).

The analysis of language from a certain written work, can provide a snapshot of life during the time that the writing took place, as well as provide insight into the possible context of

what was taking place at that time or what changes were beginning to occur. Discourse Analysis does not just look at language through the written word, but language use in all its forms including the spoken word and how meaning is applied and made through those language choices (Albers et al., 2013). This is difficult to do without having context outside of the discourse being studied. Language in all its forms has the opportunity to present ideological significance, regardless of whether this is in line with the intent of the writer or speaker (Evans, 2013).

Discourse Analysis takes a social constructionist approach to research, through looking at the co-construction of meaning. How this social constructionist approach is held provides some understanding for how the meaning that is ascribed is constantly changing and shaped by the culture in which the analysis takes place (Gehart, 2014; Jakubowska-Branicka, 2014).

When analyzing discourse, it is important to remain constantly aware of the time period historically in which the text was created, as this will help to create a picture of the culture at that time, as well as how the text may have contributed to changes that were already occurring (Fairclough, 1995). As well as examining the historical context, it is important to focus on the potential sociocultural implications found in a discourse, and to consider the explicit messages, but even more salient to examine what is being said implicitly, as that will influence how the explicit text is being understood as well (Fairclough, 1995). Through a careful analysis of the implicit messaging within a text, one can look at what messages are being shared, what assumptions are being made about what is already known by the reader and how this may be contributing to the culture within which the text is being read (Fairclough, 1995).

Critical Discourse Analysis

Critical Discourse Analysis was first introduced by Norman Fairclough (1989). It was presented with three stages: “*description of text, interpretation of the relationship between text and interaction, and explanation of the relationship between interaction and social context*” (Fairclough, 1989, p. 109, emphasis in original). While not a distinct or separate method of Discourse Analysis, Critical Discourse Analysis is just one way of analyzing language in the context of power relations (Fairclough, 1995). Critical Discourse Analysis does not use a specific process to look at the analysis of language, and instead a variety of different techniques are available to use as a way to explore the possibilities of how meaning is created through the discourse (Evans, 2013). Critical Discourse Analysis explores the relationship between discourse and our understanding of the social world (Jørgensen & Phillips, 2002).

Regardless of what techniques or tools are used to analyze discourse, language analysis is not a definitive process, and instead is subjective based on the perspective of the person conducting the analysis. It is not, therefore, possible to have conclusive results, but instead, possibilities and suggestions are presented for others to consider. Through this, there is the opportunity for the generation of new ideas.

Critical Discourse Analysis looks at the construction of discourse and how social identities are developed from those discourses. Within this, the dichotomies of oppression and justice are explored to analyze the ways in which discourse construction contributes to their development (Phillips, 2014). Critical Discourse Analysis explores power inequities along with social hierarchies and the consequences of these inequalities and hierarchies (Ainsworth, 2013). Through analyzing the language used, as well as the inequalities that exist, Critical Discourse

Analysis can create awareness of how language can contribute to the presence of these social inequalities.

Response-Based Practice

Response-Based Practice is based on the idea that resistance is always present when people face oppression, trauma or violence, regardless of what form that resistance takes (Wade, 1997). Within Response-Based Practice, the use of language is of particular importance as certain language choices can hide resistance or shift blame and responsibility for the actions of others (Wade, 2002). As a response-based approach is the lens and perspective by which this research is being conducted, it is important to understand the context as it relates to the Discourse Analysis being conducted.

Through the use of a response-based lens, the Discourse Analysis will look at the ways in which children's resistance to experiences of trauma is referred to through the use of language. The goal is to demonstrate that the language used, diagnoses given and labels provided can and do create meaning for the experiences of the adopted child. The understanding of meaning may change the way that professionals, parents and others respond to the adopted child. Having an understanding of the way this is occurring, can create room for hope, where shifts can begin to occur in adults responses to how adopted children express themselves in relation to the trauma that they experience. These subtle but important shifts can demonstrate the significance of language choice in text and the understanding of symptoms in looking at diagnosis. Moving from looking at symptomology to framing these as responses is an important step in changing the way language is used.

The theory of Response-Based Practice includes analysis of language through looking at the discursive operations that interact to change the way that responsibility is perceived in terms

of victim and perpetrator (Todd & Wade, 2004; Coates & Wade, 2007). As this research is not looking specifically at language in terms of the dynamics of perpetrator and victim, the four discursive operations process as described through Response-Based Practice will not be used, but instead a Critical Discourse Analysis will be conducted to look at where responsibility and understanding about the child's experiences of trauma have been placed. Despite this, what is important to consider is that both Response-Based Practice and Discourse Analysis offer understanding and appreciation for the significance of language, the interpretation of the world and how language has the ability to reframe what has occurred. Response-Based Practice highlights the need to analyze this in terms of the potential impact on those who are facing oppression. In terms of this research, children are the ones who potentially have the most to lose with how meaning is made, understood and responded to in terms of their life experiences prior to, during and after adoption.

While there may be differing definitions for what oppression entails, it can be argued that children in need of adoption fall under this category based on the exposure to abuse or neglect that has led them to enter the child welfare system in the first place (Child, Family and Community Service Act, 1996), as well as through the separation from family. Through a Discourse Analysis, the oppressive experiences of children as described through language choice can be explored. An understanding of the impact and response to this oppression can lead to further understanding of what society's views of adopted children are and in turn, how that may relate to their responses to adopted children.

As each adoption experience is unique, it is not possible for texts, adoption resources or research to accurately reflect the experiences of all adopted children. However, through Discourse Analysis, the potential meaning and interpretation can be explored, and with further

understanding, this can allow adoption professionals and others to gain further insight into what is being reflected and to thereby make more informed decisions.

With the DSM based on symptom classification used to categorize the symptoms displayed by adopted children, an understanding of the language being used to describe those symptoms is essential. The way language is used to describe certain symptoms can be the difference between receiving a specific diagnosis, receiving a different diagnosis or not classifying as a diagnosis at all. For adopted children, this can greatly impact their lives, including whether or not prospective adoptive parents feel qualified to adopt them and meet the potential needs of a particular diagnosis or behavioural symptoms.

While analyzing language is important, what stands out as a priority in this research is to look critically at the potential implications of such language choice. In doing this through a response-based perspective, this allows room for conversations that include discussions around systems of oppression, victimization and the option for new dialogue that may, through a response-based lens change adult's views and responses to a child's expression of or response reaction to trauma.

Understanding Language

Discourse is often thought to involve only the written word, although in the context of Discourse Analysis, it can relate to any form of language or text, including that which is spoken (Fairclough, 1995). In this paper, the Discourse Analysis was applied solely to written text.

Fairclough (1995) emphasizes that analysis of language in any form cannot be done separately from an analysis of the context in which the discourse was created. This includes looking at the culture at the time the text was created, the intended audience, and the potential impact within society. In this paper, the culture of diagnosis, created in part by the DSM, as well

as the culture of adoption are important to understand as a basis for the Discourse Analysis to take place. Discourse Analysis has little meaning on its own without the broader context from which language creates and represents culturally significant meaning (Fairclough, 1995).

As people cannot be neutral in their observations of the world, neither can the language that is used to ascribe meaning to those observations (Jørgensen & Phillips, 2002). However, since people are involved in the creation of meaning, this also means that changes can be created through shifts that occur with observations and interpretations of the world. When looking at this in terms of adopted children, it is important to look critically at the language used in order to advocate for adopted children and ensure that the resources and services are meeting their specific needs. The language used in educational adoption materials is important to consider so that the adults involved in making decisions on behalf of the child can better understand the responsibility involved in these decisions and the needs of the children for whom the decisions are made.

As language is inextricably tied to the construction of social reality and power, language also allows classification and order in society where it can be used to compare and contrast, thus creating space for the creation of a system that falls in or out of that classification (Jakubowska-Branicka, 2014). This is particularly relevant when considering a classification system such as that created by the DSM. An analysis of the language used in the DSM will provide some insight into the nature of how disorders and mental illness are classified and what may fall in or out of those categories as they relate to adopted children. In terms of looking at the experiences of adopted children, an analysis of the DSM can provide an in-depth look at the ways in which responses to trauma are explained through a lens of symptomology and disorders.

Adoption and Discourse

Discourse Analysis also looks at the impact of how power relations play out (Jørgensen & Phillips, 2002). While older children may have some input into their adoption, depending on their age and ability, children have little influence on, and no power over, the final decisions made by child protection authorities or adoption agencies (Adoption Act of BC, 1996; Child, Family and Community Service Act, 1996). The adoption of a child is a decision made by adults, with the best interests of the children in mind, through the development of policies and legislation. A Discourse Analysis must be conducted with these power differentials in mind, while looking at how language choices may contribute to the power dynamic. The idea that language is connected to power has been presented by multiple people throughout history, but for the purposes of this paper, this is based on the idea presented by Foucault that power is everywhere and connected to all forms of communication, including written and spoken word (Foucault, 1978). Based on the idea that language and power are connected, having a more thorough understanding of how language choice plays into the power dynamics present within adoption, may lead to more awareness of ways to minimize that differential where possible.

Analysis of the meaning behind the words used in adoption literature, along with the intentionality behind the language chosen, may highlight how adopted children's experiences are perceived. This perception is important to understand as it can directly influence the adults in positions of power who are responding to and planning for the needs of the children. There are many people involved in the adoption community (professionals, parents, children) and each party will be a part of the meaning that is being made through choice of language and interpretations of language. Perhaps most importantly, is the consideration of how these

interpretations lead to a child's own understanding of their identity, as well as how others choose to respond to them and their experiences, perhaps changing the course of their lives.

Within the adoption community, and throughout the years, adoption language has changed to meet the needs identified by current research and to fit within the current adoption culture. This includes changes from terms such as "real parent" to today's language which uses "biological parent" or "parent" instead. Other language shifts include moving from the phrase "giving a baby up for adoption," to parents "making an adoption plan for a child" (Adoptive Families Association of BC, n.d.). Adoption professionals have recognized the need for such shifts due to the potential harmful implications on the child and others within the adoption community. How the child develops a healthy identity regarding their adoption is influenced by what others say about their adoption, as demonstrated through the language choice that makes sense of the adoption. As a result, positive adoption language is one of the first topics that is covered in Adoption Education Programs throughout British Columbia. However, language choice within adoption terminology is only a start and there is much more work to be done to have a wider range of understanding about the implications of language use in adoption and the related context. This not only relates to language used when speaking directly about an adopted child or the adoption process, but also within the context of other material that speaks more indirectly about their experiences and lives.

Process

For the Discourse Analysis, I will be looking closely at a small selection of material that relates to an adopted child's experience of trauma, either through a description of symptoms that lead to diagnosis within the DSM, or how the DSM and other resources explain a child's response to trauma. The DSM-5 was chosen as a resource to analyze, due to its popularity and

general acceptance as a reliable source of information by those within the mental health community. To maintain a more local focus as well, I have also chosen an article that is recommended through the website of the BC Ministry of Children and Family Development (MCFD) as a resource to provide prospective adoptive parents with more information about trauma as it relates to the children available for adoption within British Columbia. As the DSM-5 is a widely accepted resource, MCFD is also well recognized as a source of information on the adoption process in BC, as well as the needs of the children available for adoption within the BC foster care system.

While there are a number of adoption and trauma-related materials that would be beneficial to provide in a Discourse Analysis, focusing on three selections of text allows for an in-depth analysis to occur. This also allows room to explore the texts from the perspective of the lens chosen and for discussion to take place with the context of this lens in mind. The resources I have chosen to look at involve general diagnosis, as well as more specific information of adopted children's experiences and are both materials that adoptive parents and adoption professionals may recognize and/or use in reference to adopted children.

Through the analysis of these materials, I will look for language that speaks to children's resistance to see if the resistance is highlighted or concealed and if so, to what degree. By understanding how this was done by breaking down the language, the understanding of the power of each word choice can begin to occur in terms of the construction of meaning. With this, the relationship between language choice and resistance is analyzed and discussed further in an attempt to create a realistic picture of the experiences of adopted children and why certain behaviours may or may not be present with the child through an understanding of responses to

trauma. The public resource materials I will be reviewing are available both online and in print form and do not include any private or confidential information.

For the analysis of these materials, I have used the techniques of transitivity, modality and negation within the Critical Discourse Analysis process. First, transitivity will be used to look closely at the language choices being used and from that what intent may be implied. Transitivity looks at the verb, noun and adverb/propositional word choices used in the language and how those choices can potentially change the meaning of the sentence, which may change the ideology created through language (Richardson, 2006; Evans, 2013). This is explored through the analysis of the people spoken about through the language and the children's roles played and their actions taken, as described through verbs and other word choices (Richardson, 2006).

Secondly, the process of modality will be used, in which the language is analyzed for the use of words that allow possible hypothesizing or judgements to occur, which often presents how strongly the writer may feel towards the statement they are making, or the direction in which they are leading the reader (Titscher, Meyer, Wodak, & Vetter, 2003; Richardson, 2006; Evans, 2013). This often relates to the tone used within the sentence, and the level to which authority is conveyed within that tone, or if a level of tentativeness remains present (Miller, 1997). This can be done through a careful analysis of the grammar used within each sentence, as well as how subjectivity of the writer can convey meaning through possible options for interpretation (Fairclough, 2013). Modality and transitivity are related in that they both look closely at intent (Richardson, 2006).

Negation is another technique as used in Critical Discourse Analysis, which looks at how the use of certain words can provide the option for a choice to exist, such as an alternative reality

that exists in opposition to what is being shared through language use (Titscher et al., 2003; Evans, 2013). The use of negative words can convey the meaning that a problem exists, even though the problem itself might not be stated, or that a subject exists, despite not being mentioned (Miller, 1997; Downing, 2000). Negation provides the opportunity for assumptions to be made due to either missing information in the language being used, or a negative context from which gaps are filled in presumptuously. Negation has the potential to influence the reader due to the fact that people are familiar with the existence of the opposite, leading to assumptions when negative terminology is used (Downing, 2000).

Design and Approach

A Critical Discourse Analysis looks at discourse within the cultural significance of the time and for the purposes of this research, I will be looking at text with an understanding of the culture created in part by the DSM. For this research, it is also of significance to look at adoption during the current time period and how adopted children are presented in terms of their behaviour, medical issues and other diagnoses or labels. From these viewpoints that are relevant due to the current sociocultural status, texts within the DSM will be analyzed through a Critical Discourse Analysis, specifically focusing on transitivity, modality and negation, as outlined above.

The sections of the DSM that will be used for the Critical Discourse Analysis were chosen in relation to information discovered through the Literature Review, specifically which DSM diagnoses are common for adopted children. Within this analysis, it is relevant to look at how the DSM diagnoses relate to the adopted child's experiences, and how the words chosen reflect those experiences, or lead to assumptions about their experiences. In order to look critically at this connection to an adopted child's experiences, an understanding of what those

common experiences are is needed. While taking a specific viewpoint is not possible due to the myriad of experiences different children may have, taking a generalized approach to look at trauma, abuse, neglect and other common experiences of children who are in need of adoptive families is a part of understanding the whole picture.

Along with the Critical Discourse Analysis of the DSM, I have included a Critical Discourse Analysis on information about the impact of trauma on children being adopted. This was obtained from an American website, and is relevant due to it being recommended for prospective adoptive parents as educational material in BC. Although there are countless discourses related to adoption, foster care, trauma, diagnosis and many others, these three selections I have chosen provide a snapshot related to the research question and are in line with trying to better understand how society and culture understand and make sense of the experience of adopted children. In understanding the culture in which these discourse selections were created, it was important for me to include the DSM as a representation of what is considered the standard for diagnosing within the mental health community of North America, as well as an article chosen by the BC government, as it is who represents the children in care and works to inform and educate new adoptive parents of these children.

After reviewing the chosen discourse and making notes based on the techniques of transitivity, modality and negation, some common themes were identified throughout the three selections of text. As these themes were noticed throughout the text selections, their importance seemed significant and led to the decision to organize the results based on these themes. Under each theme category, examples are included that look at how the language choices have contributed to the development of those themes.

Future Research

Discourse Analysis is one way of breaking down language and looking at the social construction of the world around us. However, doing so requires a detailed look at language use, which means that only a small snapshot can be done at a time and suggestions will be made towards future research. While this will hopefully start or contribute to a larger conversation, it does not signify the conclusion of this important discussion.

Just as language cannot be neutral, neither can I. This is important to remain aware of throughout my research process and in reading this research paper. While sentence structure and other forms of language compilation can be analyzed, the meaning that is created from that remains hypothetical and subjective. However, this is still an important conversation to have as awareness of language use and meaning may lead to careful consideration of language choice in the future. With complacency in language use, meaning created from those words may begin to shift in a completely different direction. This research relates to my own understanding of meaning in a sociocultural context, with plenty of room for the insertion of new and different interpretations as well. My goal is to be conscious and deliberate in terms of language choice and to inspire others to do the same.

Qualitative research seeks to explore a small piece of the social world, without factual statistics or the ability to replicate any research, as would be done through quantitative research. My focus in looking at discourse within the culture of diagnosis as created through the DSM takes a certain viewpoint, leaving room for further research from this approach, as well as from many different angles. Both the beauty and challenge of analyzing discourse is that it is ongoing, with no completion expected, as new language is continually created and shifts within the dynamics of an ever-changing culture. There are numerous adoption literature works that could

be analyzed, as well as many different lenses from which to analyze those works. The possibilities are endless and within the adoption community, it is important to continue to look at how meaning is made through language use to strive towards a profession where the child's best interests are always at the forefront.

RESULTS

Process

Three pieces of text were analyzed using a response-based lens in order to understand how the experiences of adopted children come to have meaning. The first piece of text is the section from the DSM-5 (2013) that defines Attention-Deficit/Hyperactivity Disorder (ADHD) (see Appendix A). The DSM-5 is used by mental health professionals for the purpose of diagnosis. A child receiving an ADHD diagnosis must fit within the categories as described within the DSM. This text selection will be referred to as Text A.

The second piece of text is the section of the DSM-5 (2013) that introduces trauma and stress-related disorders (see Appendix B). This section was chosen as this is the category in which attachment disorders fall -- as noted above, a common diagnosis for children that have been adopted. As the DSM-5 mostly looks at symptoms based on behaviours and mental processing, this section was also included due to its reference to the impacts of trauma, relevant to the experiences of adopted children and may include information that describes children's responses and acts of resistance related to trauma. This text selection will be referred to as Text B.

Thirdly, I have included a text on trauma, from an American agency well known for its work on trauma, that explains the effects of trauma to new foster and adoptive parents (see Appendix C). This was included as it focuses on what to expect when placed with a child who has experienced trauma. My motivation for using this piece is to analyze how the trauma experiences of children are presented and whether the notion of resistance is evident in the language being used. The document is referenced on the BC Ministry of Children and Family Development's website and presented as useful information for prospective adoptive parents

who want to learn more about the children available for adoption in British Columbia (MCFD, n.d.). This text selection will be referred to as Text C.

Analysis

I read through each document multiple times, using a highlighter and pen to make notes and highlight themes. While reading, I attended to the implicit feeling and tone evoked by the words. The messages I was receiving were tied to my subjective experiences and biases, which helped me to explore how meaning is made through the interaction of my own life experiences with the text leading to my own interpretation and exploration of meaning. I was also focused on exploring these documents and searching for themes of resistance, responses and responsibility from the lens of Response-Based Practice. In looking for themes and intention within the discourse, the degree to which children's resistance is highlighted, mentioned, ignored or disappeared was at the forefront of my mind.

Once initial notes were made and themes noticed, I moved on to a more thorough analysis of the text through the use of transitivity, modality and negation as the techniques chosen to support the identification of patterns, themes and intention. Results from this process can be found in the Findings section below, divided by the noticeable themes, patterns and tone within the three text selections.

Context

All three of the documents being used in this Discourse Analysis were developed within the last 10 years, Text A and B from the DSM-5 in 2013 and the material on trauma from Text C in 2008. While the DSM-5 was not developed specifically for use with adopted children, in North America it is the resource used to diagnose mental disorders and therefore is used to assess

children presenting with mental health symptoms. The information on trauma is directed towards adoptive and foster parents. As noted in the Literature Review above, experiences of trauma and a resulting mental health diagnosis are common for children who have been adopted or who are in the foster care system. The purpose of analyzing these materials is to highlight the explicit and implicit messages about children who have been adopted that is being conveyed as this message has the power to shape attitudes and behaviours of adopting families and mental health professionals that will support or interfere with the adopted child's health, growth and identity development.

Findings

Throughout the three selections of text, some general themes and similarities of language use were identified. Within those common themes that were present throughout the three documents, there were also other important factors that were noticed that were not present in all three documents, yet still deemed relevant to mention. Significance was not placed on how often a theme appeared or whether it was present in all three texts, but instead on its relevance to the topic being discussed. The themes are listed and addressed below, with examples of how the language use contributes to these patterns.

Pathologizing and disordered language. In all three texts, the information was presented with language that was pathologizing and disordered. This means that the information was shared with an already existing assumption that something was wrong with the child – that the behaviour or symptoms were not normal and needed to be addressed. This is a large assumption to start from and as it becomes clear that this is in existence when reading the documents, the reader may also begin to believe that assumption, as it is present throughout the

text. This pathologized language led to descriptions of symptoms, long term impacts from trauma and framing behaviours in the context of a disorder.

Text A includes a list of symptoms that have been classified as falling into the category of an ADHD diagnosis, as well as some additional information on this particular disorder. Due to this being a medically-based diagnostic tool, little is left up to interpretation in terms of identifying symptoms and the text includes information about how long the symptoms should have been present to receive this diagnosis as well as how many symptoms the client needs to be currently experiencing:

- A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):
 - 1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities. (APA, 2013, p. 59).

Words such as “persistent” or a descriptor of “six (or more)” draw attention to the seriousness of what is being said with an emphasis on the symptomology and language that speaks to a disorder. When speaking in terms of symptoms, as opposed to responses, the text moves away from speaking of the resistance shown from an adopted child. It would likely be challenging to speak from both a place of resistance and a place of disordered language when listing symptoms in this format that looks to categorize, rather than explain the cause. With a lens of resistance, the word “interferes” could be replaced by an explanation of how these symptoms may be present given current life circumstances. The symptoms would be explained

as a response to a situation or event that may make concentrating difficult and may be resistance to feeling powerless.

It is stated that symptoms must be present for at least six months (APA, 2013), while for an adopted child recently placed in a home, six months may not be long enough for the child to adjust so that it might be unclear how the child's behaviour will actually present in the long term. While the period of adjustment varies in length depending on the child (Kittlitz, 2010), there is no mention of the need to be aware of this in Text A.

The text also speaks of the developmental level of the child: "six (or more) of the following symptoms have persisted for at least 6 months, to a degree that is inconsistent with developmental level" (APA, 2013, p. 59). Developmental level may also be difficult to determine and assess with an adopted child as they may be developmentally delayed due to many different life experiences (Leve, Harold, Chamberlain, Landsverk, Fisher, & Vostanis, 2012). Should the parent or mental health professional not be aware of this phenomenon, the child could be diagnosed as per the conditions laid out in the DSM-5 where children who have not been traumatized are considered normal and children who have been traumatized are delayed. This could be seen as pathologizing the adjustment period needed for a child who has experienced trauma to transition to a new home, as well as pathologizing the normal developmental delays which are in response to poor treatment or conditions in early childhood.

Text B was chosen as a text for analysis because it describes the way in which traumatic events in someone's life may impact a possible mental health disorder diagnosis. Text B looks at trauma in terms of symptomology that may be displayed. For example, one section reads, "in some cases, symptoms can be well understood within an anxiety – or fear-based context" (APA, 2013, p. 265). This statement could be seen as the beginning of a response-based context.

However, the conversation quickly turns into the language of disorders, not allowing much room for understanding the way someone may be responding to a life experience:

It is clear, however, that many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety- or fear-based symptoms, the most prominent clinical characteristics are anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms.

Because of these variable expressions of clinical distress following exposure to catastrophic or aversive events, the aforementioned disorders have been grouped under a separate category: *trauma- and stressor-related disorders* (APA, 2013, p. 265, emphasis in original).

By speaking of “clinical characteristics” this moves the context into medical model based language and away from a response-based view. In a response-based context, this section may speak to displays of anxiety and fear as justifiable in terms of responses to an event or series of events that has heightened a person’s awareness of danger. By using the term “response” instead of “symptom,” a move away from thinking in terms of disorders can begin.

There are few adverbs in the section of text on trauma and stressor-related disorders, with those included being, “stressful,” “prominent,” and “adequate.” These descriptors range from mid-level (adequate) to higher level of intensity (prominent and stressful). These add emphasis to Text B, which speaks to the intensity of what is being discussed, as well as through the use of negatively biased language. The very nature of the DSM can lead to the belief that the symptoms must be serious if a diagnosis of a disorder is being considered. After all, if symptoms were considered mild, the DSM may not be used as a resource.

As this section of the DSM-5 is about disorders that include the experience of a traumatic event as part of the diagnostic criteria, there is some room for assumptions about the symptoms that occur in relation to those diagnoses. For example, should a person experience the symptoms without having been exposed to a traumatic event, their experience may be seen as diminished because of this, or not justified in obtaining a diagnosis. This leaves little room for those that have had difficult beginnings in life, but experiences that may not be classified as traumatic. This also turns the traumatic event into a diagnosable condition that may lead to other assumptions about how people respond to trauma in their lives.

Continuing with Text B, the use of the term, “fear-based” is used to describe symptoms in response to a trauma. However, the use of the word fear can lead the reader to believe that their response is unjustified as they are responding out of fear (worry that something might happen) as opposed to reality or something which has already occurred. This adds judgement where there does not necessarily need to be any. As this section also speaks to the symptoms that exist with exposure to a traumatic event, despite the disclaimer that symptoms may vary, this leads to a possible assumption that symptoms must exist after a traumatic experience. Again, this leads to disordered thinking in the context of response to a traumatic event.

The verb choices used in Text C relate to the behaviours that the child may present, such as how they are sleeping, concentrating, behaving or acting. The intensity of some of these behaviours is highlighted by verbs such as “permeate,” giving the impression of the symptom taking over the child’s life: “The negative beliefs and expectations that fill the invisible suitcase permeate every aspect of a child’s life” (NCTSN, 2008, p.1). The adverbs place qualifiers on the verb choices and relate to the level in which the child may be showing certain behaviours or the level to which the parents must take action. The language used in this document allows room for

hypothesizing and assumptions to be made. While it is clear that the purpose of the text is to prepare parents, it may leave prospective adoptive or foster parents assuming the worst about the behaviours that they will see in their children, along with their ability to manage these behaviours.

The language used in this document (Text C) also assumes that there is a need to “fix” the behaviours that a child may be displaying. “When the contents of the invisible suitcase have been unpacked and examined, re-enactments and negative cycles are less likely to occur” (NCTSN, 2008, p. 3). Should this have been framed within the context of a response, the advice may not have been to change the response, but instead to learn more about it in order to understand the child. A response-based approach may explain how unpacking the suitcase can lead to further understanding about why the child may be responding in such a way, instead of looking solely at the behaviours and looking to treat or change those. For example, the statement may be changed to this: ‘When the contents of the invisible suitcase have been unpacked and explored, you may begin to understand the adaptive nature of the responses your child is displaying and how to support them with the experiences they have faced in their life.’

The child’s resistance as demonstrated by their adaptive behaviours is mentioned briefly in the statement, “The strategies that maltreated children develop to get their needs met may be brilliant and creative” (NCTSN, 2008, p. 3). However, this is then negated by the remainder of the sentence in which the preposition “but” is used to diminish this statement and offer an alternative that the children would be better off if they did not use this behaviour, despite the brilliance and creativity of how they are behaving. The full statement is, “The strategies that maltreated children develop to get their needs met may be brilliant and creative but too often are personally costly. They need to learn that there is a better way” (NCTSN, 2008, p. 3). The

children's behaviour is adaptive and based on a strength, *but* is also too disruptive and needs to be changed. This pathologizing descriptor is similar to how symptoms are worded in the DSM, with an understanding that trauma may lead to certain behavioural symptoms, but they need to be fixed through the diagnosis and treatment of a mental health disorder.

Negative tone. All three texts examined had an overall negative tone. This led to a perception of the disparity between what is "normal" and what is "abnormal" with the disordered language framing a negative or "abnormal" stance. Text A is written from an authoritative point of view and the grammar within the sentences speak to that authority:

The essential feature of attention-deficit/hyperactivity disorder (ADHD) is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. *Inattention* manifests behaviorally in ADHD as wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension (APA, 2013, p. 61).

Authority is portrayed in the language used, and the negative tone, but also in the lack of words that might soften the material being presented. For example, saying "sometimes interferes" or "is not likely due to defiance," would soften the authoritative tone being used and allow more room for possible alternative explanations or statements to occur. From a response-based perspective, this section may be reframed to state: The essential features of responses to trauma include behaviours that may appear to be interfering with expected development. Such behaviours and displays of emotion are creative responses to protect a person from experiencing similar feelings of threats to safety as occurred with a previous experience of trauma. Creative responses to someone who is responding to trauma are needed to meet the unique needs of the

individual and find out more about how the responses to these experiences are showing up in their lives.

The overall tone of Text A is negative and focused on the use of language that speaks in terms of disorders or abnormal symptoms, as per the context of the purpose for the DSM. Through this use of language, it may become clear that the verb choices and negative descriptors through adverb use, can create an alternative option based on the disorder being described. For example, as the symptoms are described in terms of how they create deficits in a person's life, this creates an idea of what "normal" or non-disordered may look like. If the symptoms of behaviour being described are representative of a disorder, then the absence of those symptoms means a person fits into what would be classified as normal.

The verbs in the ADHD section of the DSM-5, focus on the way that a person experiences potential symptoms and not only are these presented from a disordered or pathologized lens, but the words themselves could be seen as negative. This is demonstrated through the use as words such as "overlooks," "misses," "avoids," "loses," and "distracted."

The adverbs used in the ADHD description from the DSM-5 look at the level of which the symptom (explored through the verb) is being experienced. In looking at the use of adverbs throughout this text, there becomes a noticeable pattern of word choices that highlight the negative impact of the symptoms. For example, the adverbs that are repeated often are words such as, "negatively," "often," and "easily:" "Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading)" (APA, 2013, p. 59). In this statement, the word "often" stands out, not only as it is at the beginning of the sentence, but also as it emphasizes how much the symptom occurs. This also does not take into account other possible reasons for a child's inability to sustain focus, such

as the child's attention being distracted by thoughts of a traumatic experience, a recent loss, challenges with understanding language, a child's resistance with being told what to do, physical reasons such as hunger, or a medical concern that is distracting.

The emphasis within Text A as shown through language choice is through a deficit approach in which the focus is on what the person is unable to do, instead of what they can do. This leads to an assumption that the opposite must be the goal – that if a child is unable to focus in school, that focusing in school is what is considered normal and expected. This leaves much room for interpretation, such as potential reasons of why the child is distracted in school or what might be missing in this context, such as the child's interest in the social aspect of school which may be distracting them from sitting still and concentrating. The verbs presented are neither negative nor positive language on their own, while the adverb adds the context to the verb. For example, with the verb “loses,” the context could be that someone “rarely loses focus” or “never loses anything,” but instead, the adverb “often” changes the context to a more negative one, such as in the sentence: “Often loses things necessary for tasks and activities” (APA, 2013, p. 59). In this case, the adverb has added qualifying context that appears to be focused on the deficit instead of a positive qualifier. Again, this may be linked to the purpose and context of the DSM-5 which is based on a classification of symptoms in terms of how they relate to disorders and the disordered approach involves looking at the context of how the symptoms impact the person's life in terms of what is deemed normal or abnormal.

Modality refers to the tone of the text. It highlights assumptions or bias that leads to predetermined conclusions. The tone of the DSM-5 is that of a professional text and does not seem to be designed for the lay person or those outside of the mental health professional community. As mentioned above, there is also a tone that seems to be deficit based, as per the

purpose of the text to be used as a diagnostic tool. The assumptions made are that someone experiencing the symptoms of ADHD will be experiencing them this way, but also that this particular combination of symptoms is indicative of a disorder. The assumption made is that someone is experiencing these symptoms because of a disorder, not because of any other combination of life events or circumstances that may lead to the same symptoms. While this interpretation itself is neither positive nor negative, it is important to recognize that it is an assumption that contributes to the premise from which this book was written.

Text B creates the option for an alternative way of understanding to exist through the way the language is presented. The experience of the symptoms presented are “disordered” through the use of pathologized language, while the alternative is what is considered “normal.” However, from the way language is used in this section, it appears that all who are exposed to a traumatic event will experience similar symptomology. This has the potential to lead those who have experienced a traumatic event and/or who are experiencing symptoms as laid out in the DSM-5 to feel that they are not where they are supposed to be in terms of their response to their life experiences. The comparison ends up being between those who have and who have not been traumatized. When compared to people who have not experienced trauma, people may be seen as having abnormal behaviour without consideration of the context.

Along the same lines as the first two text selections, the overall tone of Text C also has a negative or deficit based tone. This text was written as a guide for foster/adoptive parents with the goal of explaining the unique challenges of parenting a child who has experienced trauma and is demonstrating behavioural responses to those experiences. While trying to present practical caretaking information to potential parents, the sense of hope for the lives of these

children can get lost in the words that speak to the challenges and long term impacts of a child's behavioural issues and the diligence that the parents must attend to these challenges.

Permanency. All three documents contain a felt sense of hopelessness, indicating the lifelong impacts of responses to trauma and difficulty in adjusting to or changing behaviours that are present with children. From this, there is often an inference that the impact was permanent, leading to little room for hope of treatment or recovery that would allow the child to live a “normal” life. This inference also means that treatment or recovery are the only possible options, instead of learning to adapt to the behaviours and respond in a different way that does not see them solely as symptoms of a disorder.

In looking at the way in which these three documents are presented, it became clear that the audience to which the text was written was an important piece in analyzing the language used and the message intended. The DSM-5 is designed for use by mental health professionals and was specifically developed for the classification of mental disorders. Therefore, the list of symptoms presented under the ADHD description (Text A) are listed in a way that speaks to the professional who may be reading the document. As such, there are many missing nouns that speak to a person as the subject of each sentence. Instead, the subject of each sentence becomes the symptom listed. For example, “Often has difficulty sustaining attention in tasks or play activities” (APA, 2013, p. 59), does not address to whom this is referred. This leaves space for the professional to fill in the gap and address the symptom listings in the context of their client or patient. Instead, the nouns used in this selection of text speak to what the person (child, adolescent or adult) may be having trouble with, which in this example is the tasks or play activities or behaviour that they are unable to control. For example, “Often unable to play or

engage in leisure activities quietly” (APA, 2013, p. 60). The noun listed is not a person, but instead is “leisure activities,” which becomes the subject of the sentence.

The lack of nouns and words that speak directly to the person the text is about, may imply that this text was written with the idea that the subject/person it was referring to would not be reading it and interpreting the symptoms themselves, but someone else would be looking at the symptoms in reference to that person. However, should the person who it is referencing be reading this document (the child, adolescent or adult), it does not read in a way that is personalized or sensitive to filter what is being said about that person. This overall tone leaves the text more generalizable, with space to fill in the missing information.

Similarly to the section of the DSM-5 on ADHD, Text B is written to a generalized audience, without reference to a specific person or audience to whom the text is addressed. This is noticeable through the lack of nouns that reference a person. The idea of this text is that it addresses the mental health professional using this reference book, but this context is not addressed specifically within the text. Again, it is likely written with the idea that the people it is about (the person being diagnosed) will not be reading it, but instead someone else (a medical professional) will be using it to reference the person who may be diagnosed. Were it written to speak to the people experiencing the symptoms, I would imagine a softer and more supportive approach that showed understanding for what the person has been through, what they are experiencing and the challenges they may be facing as a result.

The audience for the third piece of text on trauma (Text C) is the parents, not the child and not professionals working with the child. In looking at the nouns used, this becomes clear in the way the children are described, such as saying “traumatized children” (NCTSN, 2008, p. 1), instead of “children who experienced a traumatic event” or “children who are responding to a

traumatic event.” Were the text written to the child as the audience, it is likely that the language would have been softened a bit by using wording that has the possibility of other ways of describing the child than solely through their experience. The descriptor of “traumatized” implies that is what the child is, instead of the many other characteristics that could be used as descriptors. In looking at the description of the people discussed in the text through the noun choices made, assumptions can be made about how the children are viewed and what message the text is trying to get across to the audience. In this case, some of the messaging is that the children will have behavioural issues and will behave in a way that may be both challenging and frustrating, but the message to parents is that they can learn how to manage these behaviours as well as take care of themselves. With the child absent from the intended audience, the message is not intended to tell the children anything about themselves or their experience, instead it is being relayed to someone else.

Reaction versus response. The term “reaction” was used most often to describe the symptoms/behaviours that the child was displaying. In reading this, the use of reaction stands out to me due to the implication that one does not have control over a reaction and tends to do so without much forethought. In contrast, a response implies a sense of being and in my view, lends itself to more options than a reaction allows. The following is an example from Text C:

As a result, children who have experienced trauma often exhibit extremely challenging behaviors and reactions that can be overwhelming for resource parents. These problems may include aggression, outbursts of anger, trouble sleeping, and difficulty concentrating. (NCTSN, 2008, p. 1).

In this section, behaviours and reactions have been placed together in the same category, inferring that the child has little control over these actions. The reactions/behaviours are also

further described through a description that includes “outbursts of anger,” again implying that the child has no control. While the child may not have full or conscious control over their behaviours or actions, I believe they have agency in making decisions that lead to increased safety or unconscious responses that fit the circumstances. The article goes on to explain the concept of “re-enactment”:

Re-enactment is the habit of recreating old relationships with new people. Re-enactments are behaviors that evoke in caregivers some of the same reactions that traumatized children experienced with other adults, and so lead to familiar – albeit negative – interactions. Just as traumatized children’s sense of themselves and others is often negative and hopeless, their re-enactment behaviors can cause the new adults in their lives to feel negative and hopeless about the child (NCTSN, 2008, p. 1).

The use of the word “habit” again implies that the child is reacting without conscious thought or without reason. Response-based language would demonstrate more of the intent behind the anger and show how it is actually adaptive to their situation (whether conscious or unconscious). One such example is the idea of “inducement” in adoption, where the child’s behaviours are seen as intentional in a way that allows their parents to feel some of the pain they are experiencing (Blechner, n.d.). When the child is placed in their new adoptive home, behaviour challenges will usually emerge shortly after and this can either be seen as the child “acting out” with little reason as to why, or instead can be reframed as inducement behaviour. With the lens of inducement, the child is behaving in a certain way because they have experienced the pain of loss before and at some unconscious level know that “acting out” may cause that loss again. However, as protection, the sooner this happens, the sooner the pain will be gone (Blechner, n.d.). This view could help to shift the response of adults to adopted

children's behavior, moving from a perception that children need help in building resilience, to a perception that children can be supported in building on the resistance they have already shown. The difference being that where children have been assisted in building resilience despite what the child has been through, they could instead be helped to focus on resilience because of what the child has been through. By shifting the focus, behaviours and challenges can be viewed through a lens of empowerment instead of as a deficit.

Placement of responsibility. Lastly, the theme of placement of responsibility. In this theme, blame seems to be placed on the child or even on the abuse that occurred, without reference to the people that conducted the abuse. The placement of blame might lead to beliefs about the child having choice in their behaviours that are used as a form of protection, as opposed to choice in response to mistreatment and traumatic experiences. This also takes blame away from people that were acting intentionally abusive and places some of that blame on the victim. With a response-based lens, it is important for the language to demonstrate the responsibility of what has occurred for the child, such as placing blame on the perpetrators of abuse or on the situations that led to experiences of trauma. Within this, language can also be used to present the child as a victim who is responding to their circumstances, not a child who is choosing to act in a way that is inconvenient for parents or professionals.

In analyzing the word choice and sentence structure in Text A, I noticed that words such as "inhibition," "control" and "constraint" may take away agency from the person experiencing these symptoms. "ADHD is associated with reduced behavioral inhibition, effortful control, or constraint; negative emotionality; and/or elevated novelty seeking" (APA, 2013, p. 62). This leads to a possible impression that a person has no control over their actions or behaviours and from that, potentially no control over the ability to make change. This is the opposite of what a

response-based approach is as the focus is on explanation of the person's actions and seeks to make sense of the behaviour based on a response to life experiences of that individual. From a response-based approach, this statement may change to express that the behaviours or emotional regulation seen with the person are significant when compared to themselves, not to the standards of what is considered normal and that these changes in behaviour may be significant due to the impact they are having on the individual's life, not on what others deem to need changing.

The judgements that come from the tone in which the DSM-5 was written, and in particular Text A, is that something is wrong with the person experiencing these categories of symptoms classified as ADHD. This creates the divide of what is normal and what is not. Even if the person does not fit the full description of this disorder, it still seems as though any experience of these symptoms is outside of the range of normal.

In addition to language that pathologizes children's behaviour, the DSM itself might provide hypothesizing, in that when a mental health professional picks up this book and goes through the list of symptoms, for example in the ADHD section, they likely have a hypothesis that their client will fit this description. While hypothesizing in this manner is a part of the process of diagnosing disorders, it can also lead to assumptions where the professional may look for symptoms to fit their existing hypothesis. In that regard, they may read the ADHD description in a way that allows the disorder to fit the client who is in front of them, to confirm their hypothesis was accurate.

From a response-based perspective, the language used also works to hide the responsibility for what happened to the children in terms of any abuse, neglect or traumatic experiences that occurred. For example, "For children who have experienced trauma –

particularly the abuse and neglect that leads to foster care...” (NCTSN, 2008, p. 1). This statement speaks of the abuse and neglect that leads to the need for foster care, not the people who are responsible for the abuse and neglect that the child experiences. While this may have been done in an attempt to avoid placing blame without the full context of what occurred with the abuse, leaving out the placement of responsibility has the potential to be harmful. When responsibility is not placed, this can lead to assumptions being made about who or what is responsible and leaves the child in a vulnerable place where the responsibility for what occurred could be located with them or with an outside factor that the child may feel was in their control. Placing the responsibility where it belongs takes away the possibility for this to occur, leading to a focus on what matters through the purpose of the article, which is supporting the children through the abuse and/or neglect of which they are a victim.

Along this same line, is looking at how the child’s responsibility in their actions is understood. This seems to be explained not only through what happened to the child, but also in the choices that the child makes after experiencing trauma: “Re-enactment is the habit of recreating old relationships with new people” (NCTSN, 2008, p. 1). The use of the word ‘habit’ implies that the child has a choice in their behaviour, and that they may get something out of it, such as someone who is in the habit of smoking because they enjoy it. This takes away agency for the child, as well as an understanding of the abuse that took place at the hands of another person. By defining the behaviour as a habit, the reason for the behaviour is not explained. Through a response-based perspective, re-enactment could be reframed as a response and the statement may be: A child learns how to respond to people throughout their childhood. If a child was taught or modelled unhealthy relationships or experienced a traumatic event that led to a disruption in their development, the child may begin to respond to people in ways that protect

their safety and work to prevent themselves from getting hurt again. Should this occur, the child may continue to respond to people in this same way, despite the threat of recurrence of the traumatic event not being present.

The stated purpose of Text C is to educate perspective adoptive or foster parents and to provide some practical advice through the explanation of what a child may be experiencing. As such, the audience that it is addressing is that of the prospective parent who may be seeking to better understand the experiences of the child that will be coming into their home.

Another theme within Text C, was that of holding children accountable for their behaviours, instead of working to understand what the child is going through. This is described in the following segment of text:

This does not mean giving children a free pass on their negative behaviours. As a parent, you must still hold children accountable, give consequences, and set expectations. But with the invisible suitcase in mind, you balance correction with praise, and deliver consequences without the negative emotions that may be triggered by the child's re-enactments (NCTSN, 2008, p. 3).

While other areas of the text look at how the trauma experienced by the child explains their trauma, this section of text begins to negate that, by saying that the child must be corrected, thereby assuming that the behaviour is in part correctable and not solely related to a trauma, but instead a behaviour that the child is able to stop if the correct consequences are given. If a parent were to observe a behaviour that they are curious about and try to interpret it instead of reacting, they may be able to figure out more about what is going on for the child and respond in a way that meets the specific needs of the child. This is not about balancing consequences and praise, but instead about seeking to understand the behaviours and respond with empathy and support.

Providing consequences to a child in an attempt to “correct” a behaviour shows a lack of desire to understand and make sense of the behaviour and instead shows the belief that a child can just stop responding a certain way with the right guidance. Looking at what is underlying a behaviour is essential in providing support that fits that particular child’s response. “Correction” is needed in terms of demonstrating, modelling and supporting the child to feel loved and know that they are safe, which may in turn begin to change the way they respond. Correction for the behaviours/responses will not make long-term change, but instead may instill fear in the child and teach them that the way they behave or respond is wrong or abnormal.

The statement that children “...need to learn that there is a better way” (NCTSN, 2008, p. 3), demonstrates the belief that the child’s behaviours are not normal and behaving in this way would qualify as unacceptable behaviour. This creates the construct of acceptable and not acceptable, normal and disordered, and behaviours that are okay versus those that need correcting. From a strengths-based approach, the focus is instead on the need for children to build upon all of the wonderful things that they have going for them, including their ability to respond in a way that is adaptive to their situation. This may be the strength a child demonstrates in responding in a way that is protective and works to keep them safe. Instead of learning a better way, this could be rephrased to say: Children need demonstration that they are safe. Their current behaviours indicate that they may not yet feel safe and secure. This takes time, love, trust and unconditional support, but with these things in place, children may begin to feel that safety, and respond accordingly.

Discrepancies

Although some of the negative themes present in all three documents were mentioned, there are also some positive and potentially useful points made in each. These include

understanding of the child's experiences of trauma, recognition of the connection between trauma experiences and symptomology or behaviours present, as well as some hope for the future in terms of supporting the child through the more difficult times and finding some strategies that work to support them with the tough times. Text A demonstrates that some of the behaviours present with a person experiencing similar symptoms may be disruptive to their ability to focus at school or work and that strategies may need to be developed to support a person through these challenges (APA, 2013, p. 59). Text B acknowledges that experiences of trauma can lead to changes in the behaviour and emotional responses of people and that it is important to not separate the presence of these behaviours from a traumatic experience (APA, 2013, p. 265). Text C also acknowledges that trauma can lead to difficult experiences for children and that these responses to trauma do not end after the traumatic event has ended. This text also shows the importance of supporting the child, and also the caregivers that may need support to be strong in their ability to be there for the child, during the difficult times.

I was surprised to find some language that was representative of a response-base perspective, such as the recognition of the child's ability to develop protective factors as a response to trauma that they have experienced. Although these statements were not delved into further, it was encouraging to see a basis for understanding how experiences of trauma impact the way that children respond. This was particularly noticeable in Text B and Text C showing an awareness of the connection between trauma and a child's behaviours. While these were not framed as responses and instead as behaviours or symptoms, this connection is an important step in understanding how and why children respond in various ways and implies ways for caregivers and professionals to support children. Without seeing a reason for the behaviours and creating this separation from the trauma, it would be more difficult to begin to understand how to best

support children. Reading about this trauma and behaviour connection that has already been made is indicative of the changing nature of text, and society, and points to further research and information that could or might be provided.

Summary of Results

The three text samples were selected as a representation of what is available to mental health professionals, adoptive/foster parents and the general public in terms of understanding the trauma a child has experienced and the potential behaviours that may be related in some capacity to these challenging early life experiences. These discourse selections are only a small representation of the material available on this topic. They have been analyzed for the choice of language used, choices that reflect and represent the experiences of adopted children and other children who have experienced trauma in their lives. It is important to critically reflect upon this representation in order to understand the way that these word choices are creating the culture in which understanding is present, creating a cycle that has the potential to help or harm children living with these experiences.

Through this analysis it is apparent how qualifying words such as adverbs and prepositions can highlight or diminish what is being said and add meaning to the strength of the statements being made. I also recognize that along with others, my own understanding and interpretation of these texts is based firmly in the culture in which I am a part of and the text and cultural context cannot be separated in order to conduct an analysis. Without the cultural context, the words and statements have little meaning, so the connection is both relevant and essential.

The texts themselves do not speak for the experiences of children who have lived through traumatic events, as only the children themselves give voice to their experience. However, as

children do not always get this opportunity, adults learn from professionals, usually in the form of written material that is made available to those working with or caring for adopted children. As such, these documents are important to have, but equally important that they accurately represent children who have been adopted. It is not the job of a child that has been adopted to educate the community on what their experiences have been like, or how their responses to their experiences are being displayed. It is the job of those working in the mental health or adoption field to be aware of the impact of their words and the potential that these words have to create meaning for others.

DISCUSSION

Overview

The goal of this study was to shine light on the ways in which language can be used to make meaning of the experiences of adopted children, through the many different discourse materials that relate to children's experiences of trauma. Through a Discourse Analysis, different lenses and perspectives can be used to highlight what is being said or the way in which word choice allows for certain factors to be diminished. In this paper, the lens from which the analysis took place was that of Response-Based Practice. This was chosen as a lens because it recognizes that children's resistance is always present and seeks to bring that resistance forward in a way that highlights that children are never passive in their responses. This perspective is important because it is an attempt to understand the perspective of the child who has had the experience of being adopted, rather than to focus solely on the difficulties that children's responses create for adults. My goal is to bring attention to the experiences of adopted children - their feelings and the possible reasons behind their actions or responses. Although the results of this Discourse Analysis may not be generalizable or create far-reaching change in itself, each time the words and language of various texts are questioned or analyzed, the more conscious thought is involved in how to represent the experiences of others; in this case of adopted children. While the subjective nature of this research project is important to recognize, the very nature of questioning through analysis of possible meaning can provide the impetus to continue this questioning and become more aware of the potential meanings interpreted through language use. Language is not and cannot be neutral due to the social location of the people making the language choices (Tremain, 2005). As this is realized, the more thought may be put into the way language is used, particularly in relation to putting meaning to the experiences of others.

Just as meaning is made in the context of language choice within the selections of text highlighted in this research project, meaning is made from the language choice within this paper. This is both the meaning that was intended through its writing, as well as the meaning as interpreted through the experiences and perspective of the reader, the culture in which the text was created and the many options for alternative possibilities that exist within the context of the paper (Phillips, 2014).

Interpretations

Children in need of adoption have usually experienced some kind of traumatic event, whether that be abuse, neglect, abandonment, death of a parent or many other possible scenarios (MCFD, n.d.; Perry & Szalavitz, 2006; Gray, 2012; Post, 2013). While each situation experienced by a child is unique, there are some common themes that are observed and noted through the many research studies available on the topic of adoption. This includes the statistic that adopted children are up to 15 times as likely to receive an ADHD diagnosis than their non-adopted peers (Simmel et al., 2001), or that the experience of a traumatic event, through neglect, trauma or abuse is a requirement for a child to receive a diagnosis of Reactive Attachment Disorder (APA, 2013, p. 265) or Post-Traumatic Stress Disorder (APA, 2013, p. 271), as indicated in the DSM-5. In learning about these statistics as they relate to adopted children, I wanted to learn more and explore these diagnoses and descriptions of trauma to see how the connection to a child's experience of trauma is made, understood and explained.

While the research began with looking at the labels given to adopted children and how their resistance and responses to trauma were highlighted or disappeared, a deeper context began to emerge and it became clear that there are a myriad of factors to consider in looking at the experiences of adopted children as they relate to explanations of trauma. Research is not

conducted in isolation and as such, a part of the culture and time period in which the research was conducted is relevant in studying and analyzing discourse and interpretations of meaning. In looking at the research on adoption, it became clear to me that there was an emphasis on diagnosis – providing labels to address categories of symptoms displayed by children in response to behaviours that are thought to be connected to experiences of trauma.

Through further exploration, I realized that this is occurring in a culture of diagnosis, one in which symptoms are medicalized, classified and provided labels to explain their existence. From a Response-Based Practice perspective, symptoms are explained in terms of appropriate responses and labels are not needed to classify or understand how someone is responding in their own unique way. Instead, the culture of diagnosis seems to rely on pathologizing to explain why a person responded in an expected or unexpected way. It suggests there is a right way and a wrong way of being in the world, creating a line between what is normal and what falls outside expected and accepted responses. From this, I was able to see that language plays a large role in the way that this medicalization of responses takes place and the way in which responses are shifted to symptoms and classified into disorders. I began to understand that the use of words such as “disorders” can begin to shift how the culture views people’s experiences and responses. Through this, I wondered if there was a way to combine the medical/psychological understanding of responses to trauma with a compassionate approach that recognizes the unique ways that resistance is shown.

In looking further into the medicalization of mental health, it is apparent that the development and evolution of the DSM was one of the contributing factors of this shift. As such, it was important for me to look at the DSM in relation to adoption and how words were used to provide symptomology for the experiences of trauma. It would be easy to separate the

material that speaks of trauma from those who have experienced the trauma, particularly, such as in the case of the material chosen for this research, when the material is addressed to professionals and parents. However, it is the information provided in that material that is directly relevant to the adopted child – with the DSM informing mental health and medical professionals about how to respond when presented with certain behaviours and with the information on the experiences of trauma provided to adoptive or foster parents as a training guide of how to respond to the behaviour they may see from the children who have joined their family.

It is clear through the analysis of the chosen texts that resistance of children is not a viewpoint from which the adoption literature tends to focus. While children's resistance was not mentioned in a direct way, I would also argue that it was not mentioned indirectly either, with any evidence of resistance hidden and silenced by overtones of symptomology and categorization. With the focus so strongly on symptom description and diagnosis, there seemed to be little room left for the child's responses to be normalized or validated. With the pathologizing of the child's response to trauma, the focus becomes on the fixing of the behaviour and on the implications of the potential long term impacts of such responses. The medicalization of trauma has shifted the focus to diagnosis and cure, instead of highlighting that the child's changes in behaviour in response to a traumatic experience may be justified in terms of protecting themselves and working to keep danger from occurring again in the future. This view leads to helping children to recognize that they are in a new situation, where there is the opportunity to have new responses.

It is apparent now, that a simple change in word choice or sentence structure can change the entire meaning of the text and therefore the implications for meaning derived from this text.

While noun and verb choices can change the context of the sentence, adverbs and propositions can shift meaning or add emphasis to the strength or weakness of a statement, thus changing the implications or meaning. In the context of looking at how children respond to trauma and the description through a symptom-based lens, this can be the difference between justifying a child's response and blaming them or pathologizing their response. It can also provide hope through the normalization and validation of what the child is experiencing and how they act, or diminish hope through an emphasis on the severity or long term nature of what is occurring.

In conducting this Discourse Analysis, the importance of understanding context in reading a selection of text is evident. In doing so, one has more insight into what assumptions might be present, who the intended audience may be and the ways in which word choice may be connected to the intent of the document.

It is clear that the resistance through responses of children who have experienced trauma were minimized or hidden in the discourse included in this study. Instead of identifying responses, behaviour was presented as a disorder that needed to be treated. It is not clear whether or not the traumatic experiences of these children were treated solely on symptomology and ideas based on disorders. I would be curious to explore this through the analysis of additional texts.

Implications

In looking at the ways that language choice either works to show the strengths of resistance or diminishes the autonomy of such responses, there are many possible implications for the child's life. This includes the expectations of professionals and parents, the impacts to the development of self-image, labels that may follow them for life and impacts based on the fears of the prospective adoptive parents. These potential impacts are varied and unique, based

on the individual experiences of the child, but may include risks of adoption disruption, parental stress, longer wait times for children to find adoptive homes, increased moves for children within the foster care system, and the potential that a child may not find an adoptive home at all, leading to a lack of support and permanency.

My hope is that research in this area continues, both in terms of understanding the significance of language use, but also in looking at children's responses to trauma from a response-based perspective. Further understanding and exploration in these areas can only advance the empathy and consciousness of those who make decisions for adopted children; primarily adoption professionals, mental health workers, doctors and parents. The advancement of understanding the implications of language choice may continue to bring consciousness to language choice. In turn, this could lead to the development of appropriate strategies to support children who have been adopted in healing from trauma and in adapting to a new and safe life.

Along with the benefits of understanding the power of language choice from the point of view of the children, it is important to further understand the culture that pathologizes experience and attempts to correct it. While there are areas where the medicalization of symptoms is needed and useful in terms of treatment planning however, it is obvious from the discussion above that all possible implications need to be considered. The issue is not with the medical field or the need to classify symptoms based on the medical system per se, but rather with the language of pathology and the culture of diagnosis which can minimize the resistance shown by people who have gone through trauma. The concern is that the voices of children who have been adopted will be diminished and replaced with the language of disorders which can silence or mask their unique and individual experience, and negatively shape the development of their identity.

Diagnosis itself is not necessarily a negative process, and in fact, many people find it helpful to receive a diagnosis or label that explains their symptoms (Heitler, 2012). However, the impact can be that the person with the diagnosis is then defined solely through people's understanding of what that diagnosis means, or in a way that does not represent them as a whole person beyond the description of the diagnosis (Heitler, 2012). As has been described, the diagnoses provided in the DSM-5 come from a classification system of symptoms. This means that people with the same diagnosis (and therefore similar symptoms) may not have anything in common, but are now grouped together into a similar category, leading to the risk of generalizations being made for treatment plans.

An adopted child who receives an ADHD diagnosis may benefit by having what they need to get support and help in the community, and to begin an adequate treatment plan with their doctor. The problem is not in diagnosis as a stand-alone issue, but rather in using diagnosis as the only method to explain what the child has been through and to understand their responses. With this, the potential now exists for the child to be defined by their symptoms, instead of by the resourcefulness and strength they demonstrated through various examples of resistance they enacted. For example, if an ADHD diagnosis does not only explain behaviours or symptoms, but rather is connected solely to the diagnosis it provides a description of the lifelong impact of ADHD, along with a range of severe and difficult challenges. This quickly moves from providing information that could lead to a positive treatment plan, to a diagnosis that has the potential to define all aspects of a person and place blame on the behaviours/responses of the child, instead of on the people or situations that lead to experiences of trauma and abuse.

It is clear that it is both relevant and essential to provide adopting parents with information on the specific needs of the child so that the parents are best able to meet those needs

and find the resources to support them. When adoptive parents are making a decision about the child they would like to adopt, sometimes the uniqueness and strength of the child can get lost in descriptions of what the child has experienced, the behaviours that are present and the diagnoses that the child may have received. If prospective adoptive parents understand more about the culture of diagnosis, about the difference between resilience and resistance and about the amazing ways in which the child is responding to their life experiences through acts of resistance, they may better be able to meet the specific needs of the child, and see past the list of labels or diagnoses.

Along the same lines, providing a broader perspective for adoption professionals so that they can better understand how culture can shape perspectives, the more successful they may be in supporting adoptive parents in understanding a more complete picture. This perspective could assist in finding permanent homes for children. While increasing understanding may appear to be a simplified concept, the implications of adoptive parents not having the knowledge and understanding of the child's needs can be serious and detrimental to the children. Some of the risks of this range from the child growing up in an unsupportive home, the child struggling to feel like they belong, the child's needs not getting met, to the breakdown of the placement. Along with further contributing to the child's experiences of oppression by not allowing their own voices to be heard, adoptive parents who proceed without understanding the reality of children's needs risk ending up disrupting the adoption, leaving everyone involved with the grief, loss and trauma that comes from this.

My hope is that this type of research is continually conducted and shared with adoption professionals as well as potential adoptive families in an effort to demonstrate the implications of adoption language and the realities of what has occurred in the child's life to lead them to this

point. This might allow for a deeper understanding of why the adopted child may have specific needs and the best way to meet those within the context of what the child's actions and behaviours may be demonstrating. My ultimate goal is for a shift to start to occur in the adoption field so that inaccurate or incomplete labels are no longer used and the right questions are asked so that children can be better assisted in remaining in permanent homes. While this may support adoption professionals in their work with adoptive families and adoptive parents by educating them on the skills needed to parent an adopted child, most importantly this will impact the child by allowing their experiences to be accurately represented and understood, thus not contributing further to the oppression they have experienced.

Understanding more about the responses of children to their experiences is also essential to having more services that meet their specific needs to ensure that the children's best interests are met. The success of adoption placements is complex, and includes the adoptive parents' preparation for the adoption and the quality of their support system (McCreight, n.d.). Along with the stress of bringing a new child into their family, adoptive parents may feel stress regarding the child's behaviours that are connected to past behaviors of trauma (Child Welfare Information Gateway, 2015, p. 8). Additional challenges that adoptive parents may have when entering into the adoption process may include a range of their own experiences, such as infertility, grief and loss, relationship issues, and unresolved childhood trauma. While difficult or unexpected behaviour or the perception that the child is not adjusting quickly enough may be blamed for the breakdown of an adoption, the children cannot solely be held responsible. However, children will be the ones facing the harmful consequences of an adoption breakdown with the potential for lifelong emotional impacts (Macrae, 2004).

As mentioned, adoption disruption is a common topic in the literature with the adoption disruption rate of approximately 15% of adoptions, often linked to the high needs of the child and the inability of the parents to meet those needs (McCreight, n.d.). It is not always clear why a disruption has occurred but it is commonly thought to be either a misunderstanding about the needs of the adopted children or that the adoptive parents have been inadequately prepared to meet the specific needs of the child. More research is needed to explore the idea that children are displaying behavior that is an appropriate and understandable response to their life circumstances rather than disordered behaviour.

Limitations

Limitations in this research exist based on the few short selections of discourse that were analyzed due to the scope of the project. Limitations are also present due to the subjective nature of such research, including my bias in choosing text selections and the lens from which they have been viewed and the process through which they were analyzed (Flick, 2009). However, the research method allows for the reader to interpret the research based on their own experiences, opinions, and responses to the lens of Response-Based Practice that was applied. In the search for meaning through discourse, each person's opinion matters as much as the next. There is no one true and valid answer as to what meaning is presented within discourse, so in that regard each opinion about this subject is relevant and contributes to further understanding the meaning that may be presented and the various ways in which it can be interpreted. Although also connected to supporting theories, Discourse Analysis remains subjective (Breeze, 2011).

Further Research

The research conducted through this study is not over, and is barely scratching the surface of possibilities of exploration that exist within the areas of adoption, Response-Based Practice and Discourse Analysis. This type of research is not finite and can continue for as long as it is still relevant. As culture starts to shift, so does the meaning that we create within the context of culture, thus changing the meaning of discourse, as well as the discourse being created (Albers et al., 2013; Evans, 2013; Phillips, 2014). As well, qualitative research itself is a continual process with new research constantly being contributed to the field, as statistics are analyzed and new information about what is best for the children is presented based on long term studies of people who have been adopted (Flick, 2009).

Personal Experience

Throughout my years of work with adoptive families, I have many images in my mind; of incredible children, of dedicated families and of adoption professionals that go above and beyond to work in an ethical manner. However, it was the faces of the children that were in my mind throughout this process, reminding me that this is important work and can change the shape of their future as they grow and begin to understand their identity. Just as with anyone, part of this identity is based on the experiences in their life that have led them to where they are today. The way they begin to understand and process those experiences is shaped through the culture they are a part of, as we all look to outside sources for a reflection of our own beliefs about ourselves.

In conducting this research and writing this paper, I remained constantly aware of the children I was speaking about. This became particularly relevant in the Discourse Analysis when I was acutely aware of how choices in language can change the meaning and implication of what is being said. This led to my own conscious thought in the word choices used in this paper

and the meaning implied through those choices. As such, the process became personal to me as I did not feel that I was writing it only for professionals, but on behalf of children all over the world who may one day find themselves involved with a mental health professional who works from the lens of the DSM.

Conclusion

This paper approaches the topics of meaning creation through language choice as well as the resistance shown by children who have experienced trauma. Language use is relevant to understand in all areas of qualitative research as language is the lens through which we seek to understand the world (Bryman, 2016). In this case, the resistance shown by adopted children is not often reflected in adoption literature that is used to educate and inform those involved with adoption. The connection between language and acts of resistance in adoption is not only relevant, but crucial to better understand in terms of developing a sense of where western culture is currently at with understanding and responding to children's experiences. In the context of adopted children, this distinction in approaches through language use is important to understand not only in how adopted children's behaviours and potential special needs are presented, but in the context of how prospective adoptive parents and adoption professionals understand the child's unique experiences in a way that allow them to support the child's strengths.

Through an exploration of current literature as it relates to the experiences of adopted children, with a focus on the common behavioural and other concerns often identified, it is apparent where adoption begins to fit into the sociocultural context. From there, the cultural context that exists as a basis for the existence of adoption literature, becomes evident. This Discourse Analysis allows a snapshot of language choices as they relate to the experiences of adopted children to be broken down, providing insight into how meaning is made from the

experiences of trauma and the ways in which the culture of diagnosis contributes to this understanding of the creation of meaning.

This research provides a broader understanding that may create awareness, thus leaving space for new ideas and possibilities to evolve. Through this, my hope is that children's resistance can be highlighted and their voices heard.

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Appendix A

Attention-Deficit/Hyperactivity Disorder

Diagnostic Criteria:

2. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):
 1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least 5 symptoms are required.

 - a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
 - b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
 - c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
 - d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
 - e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
 - f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing form, reviewing lengthy papers).
 - g. Often loses things necessary for tasks and activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
 - h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
 - i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).
 2. **Hyperactivity and impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

- a. Often fidgets with or taps hands or feet or squirms in seat.
 - b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
 - c. Often runs about or climbs in situations where it is inappropriate. (**Note:** In adolescents or adults, may be limited to feeling restless).
 - d. Often unable to play or engage in leisure activities quietly.
 - e. Is often “on the go”, acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
 - f. Often talks excessively.
 - g. Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).
 - h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
 - i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).
3. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
 4. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
 5. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
 6. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Specify whether:

314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months.

Specify if:

In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.

Moderate: Symptoms or functional impairment between “mild” and “severe” are present.

Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

Diagnostic Features

The essential feature of attention-deficit/hyperactivity disorder (ADHD) is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. *Inattention* manifests behaviorally in ADHD as wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension. *Hyperactivity* refers to excessive motor activity (such as a child running about) when it is not appropriate, or excessive fidgeting, tapping, or talkativeness. In adults, hyperactivity may manifest as extreme restlessness or wearing others out with their activity. *Impulsivity* refers to hasty actions that occur in the moment without forethought and that have high potential for harm to the individual (e.g., darting into the street without looking). Impulsivity may reflect a desire for immediate rewards or an inability to delay gratification. Impulsive behaviors may manifest as social intrusiveness (e.g., interrupting others excessively) and/or as making important decisions without consideration of long-term consequences (e.g., taking a job without adequate information).

ADHD begins in childhood. The requirement that several symptoms be present before age 12 years conveys the importance of a substantial clinical presentation during childhood. At the same time, an earlier age at onset is not specified because of difficulties in establishing precise childhood onset retrospectively. Adult recall of childhood symptoms tends to be unreliable, and it is beneficial to obtain ancillary information.

Manifestations of the disorder must be present in more than one setting (e.g., home and school, work). Confirmation of substantial symptoms across settings typically cannot be done accurately without consulting informants who have seen the individual in those settings. Typically, symptoms vary depending on context within a given setting. Signs of the disorder may be minimal or absent when the individual is receiving frequent rewards for appropriate behaviour, is under close supervision, is in a novel setting, is engaged in especially

interesting activities, has consistent external stimulation (e.g., via electronic screens), or is interacting in one-on-one situations (e.g., the clinician's office).

Associated Features Supporting Diagnosis

Mild delays in language, motor, or social development are not specific to ADHD but often co-occur. Associated features may include low frustration tolerance, irritability, or mood lability. Even in the absence of a specific learning disorder, academic or work performance is often impaired. Inattentive behavior is associated with various underlying cognitive processes, and individuals with ADHD may exhibit cognitive problems on tests of attention, executive function, or memory, although these tests are not sufficiently sensitive or specific to serve as diagnostic indices. By early adulthood, ADHD is associated with an increased risk of suicide attempt, primarily when comorbid with mood, conduct, or substance use disorders.

No biological marker is diagnostic for ADHD. As a group, compared with peers, children with ADHD display increased slow wave electroencephalograms, reduced total brain volume on magnetic resonance imaging, and possibly a delay in posterior to anterior cortical maturation, but these findings are not diagnostic. In the uncommon cases where there is a known genetic cause (e.g., Fragile X syndrome, 22q11 deletion syndrome), the ADHD presentation should still be diagnosed.

Prevalence

Population surveys suggest that ADHD occurs in most cultures in about 5% of children and about 2.5% of adults.

Development and Course

Many parents first observe excessive motor activity when the child is a toddler, but symptoms are difficult to distinguish from highly variable normative behaviors before age 4 years. ADHD is most often identified during elementary school years, and inattention becomes more prominent and impairing. The disorder is relatively stable through early adolescence, but some individuals have a worsened course with development of antisocial behaviors. In most individuals with ADHD, symptoms of motoric hyperactivity become less obvious in adolescence and adulthood, but difficulties with restlessness, inattention, poor planning, and impulsivity persist. A substantial proportion of children with ADHD remain relatively impaired into adulthood.

In preschool, the main manifestation is hyperactivity. Inattention becomes more prominent during elementary school. During adolescence, signs of hyperactivity (e.g., running and climbing) are less common and may be confined to fidgetiness or an inner feeling of jitteriness, restlessness, or impatience. In adulthood, along with inattention and restlessness, impulsivity may remain problematic even when hyperactivity has diminished.

Risk and Prognostic Factors

Temperamental. ADHD is associated with reduced behavioral inhibition, effortful control, or constraint; negative emotionality; and/or elevated novelty seeking. These traits may predispose some children to ADHD but are not specific to the disorder.

Environmental. Very low birth weight (less than 1,500 grams) conveys a two-to three-fold risk for ADHD, but most children with low birth weight do not develop ADHD. Although ADHD is correlated with smoking during pregnancy, some of this association reflects common genetic risk. A minority of cases may be related to reactions to aspects of diet. There may be a history of child abuse, neglect, multiple foster placements, neurotoxin exposure (e.g., lead), infections (e.g., encephalitis), or alcohol exposure in utero. Exposure to environmental toxicants has been correlated with subsequent ADHD, but it is not known whether these associations are causal.

Genetic and physiological. ADHD is elevated in the first-degree biological relative of individuals with ADHD. The heritability of ADHD is substantial. While specific genes have been correlated with ADHD, they are neither necessary nor sufficient causal factors. Visual and hearing impairments, metabolic abnormalities, sleep disorders, nutritional deficiencies, and epilepsy should be considered as possible influences on ADHD symptoms.

ADHD is not associated with specific physical features, although rates of minor physical anomalies (e.g., hypertelorism, highly arched palate, low-set ears) may be relatively elevated. Subtle motor delays and other neurological soft signs may occur. (Note that marked co-occurring clumsiness and motor delays should be coded separately [e.g., developmental coordination disorder].)

Course modifiers. Family interaction patterns in early childhood are unlikely to cause ADHD but may influence its course or contribute to secondary development of conduct problems.

Culture-Related Diagnostic Issues

Differences in ADHD prevalence rates across regions appear attributable mainly to different diagnostic and methodological practices. However, there also may be cultural variation in attitudes toward or interpretations of children's behaviors. Clinical identification rates in the United States for African American and Latino populations tend to be lower than for Caucasian population. Informant symptom ratings may be influenced by cultural group of the child and the informant, suggesting that culturally appropriate practices are relevant in assessing ADHD.

Gender-Related Diagnostic Issues

ADHD is more frequent in males than in females in the general population, with a ratio of approximately 2:1 in children and 1.6:1 in adults. Females are more likely than males to present primarily with inattentive features.

Functional Consequences of Attention-Deficit/Hyperactivity Disorder

ADHD is associated with reduced school performance and academic attainment, social rejection, and, in adults, poorer occupational performance, attainment, attendance, and higher probability of unemployment as well as elevated interpersonal conflict. Children with ADHD are significantly more likely than their peers without ADHD to develop conduct disorder in adolescence and antisocial personality disorder in adulthood, consequently increasing the likelihood for substance use disorders and incarceration. The risk of subsequent substance use disorders is elevated, especially when conduct disorder or antisocial personality disorder develops. Individuals with ADHD are more likely than peers to be injured. Traffic accidents and violations are more frequent in drivers with ADHD. There may be an elevated likelihood of obesity among individuals with ADHD.

Inadequate or variable self-application to tasks that require sustained effort is often interpreted by others as laziness, irresponsibility, or failure to cooperate. Family relationships may be characterized by discord and negative interactions. Peer relationships are often disrupted by peer rejection, neglect, or teasing of the individual with ADHD. On average, individuals with ADHD obtain less schooling, have poorer vocational achievement, and have reduced intellectual scores than their peers, although there is greater variability. In its severe form, the disorder is markedly impairing, affecting social, familial, and scholastic/occupational adjustment.

Academic deficits, school-related problems, and peer neglect tend to be the most associated with elevated symptoms of inattention, whereas peer rejection and, to a lesser extent, accidental injury are most salient with marked symptoms of hyperactivity or impulsivity.

*Appendix B***Trauma-and Stressor-Related Disorders**

Trauma-and stressor-related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders. Placement of this chapter reflects the close relationship between these diagnoses and disorders in the surrounding chapters on anxiety disorders, obsessive-compulsive and related disorders, and dissociative disorders.

Psychological distress following exposure to a traumatic or stressful event is quite variable. In some cases, symptoms can be well understood within an anxiety- or fear-based context. It is clear, however, that many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety- or fear-based symptoms, the most prominent clinical characteristics are anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms. Because of these variable expressions of clinical distress following exposure to catastrophic or aversive events, the aforementioned disorders have been grouped under a separate category: *trauma- and stressor-related disorders*. Furthermore, it is not uncommon for the clinical picture to include some combination of the above symptoms (with or without anxiety- or fear-based symptoms). Such a heterogeneous picture has long been recognized in adjustment disorders, as well. Social neglect – that is, the absence of adequate caregiving during childhood – is a diagnostic requirement of both reactive attachment disorder and disinhibited social engagement disorder. Although the two disorders share a common etiology, the former is expressed as an internalizing disorder with depressive symptoms and withdrawn behaviour, while the latter is marked by disinhibition and externalizing behaviour.

Appendix C

The Invisible Suitcase: Behavioral Challenges in Traumatized Children

The Invisible Suitcase

Children who enter the foster care system typically arrive with at least a few personal belongings: clothes, toys, pictures, etc. But many also arrive with another piece of baggage, one that they are not even aware they have: an “invisible suitcase” filled with the beliefs they have about themselves, the people who care for them, and the world in general.

For children who have experienced trauma – particularly the abuse and neglect that leads to foster care – **the invisible suitcase is often filled with overwhelming negative beliefs and expectations.** Beliefs not only about themselves...

- I am worthless.
- I am always in danger of being hurt or overwhelmed.
- I am powerless.

But also about you as a caregiver...

- You are unresponsive.
- You are unreliable.
- You are, or will be, threatening, dangerous, rejecting.

You didn't create the invisible suitcase, and the beliefs inside aren't personally about you. But understanding its context is critical to your helping your children overcome the effects of trauma and establish healthy relationships.

The Invisible Suitcase and Behavior

The negative beliefs and expectations that fill the invisible suitcase permeate every aspect of a child's life. Children who have been through trauma take their invisible suitcases with them to school, into the community, everywhere they go. They have learned through painful experiences that it is not safe to trust or believe in others, and that it is best not to give relationships a chance.

As a result, children who have experienced trauma often exhibit extremely challenging behaviors and reactions that can be overwhelming for resource parents. These problems may include aggression, outbursts of anger, trouble sleeping, and difficulty concentrating. Very often, the behavior problems that are the most difficult to handle – those that may even threaten the child's placement in your home – come from the invisible suitcase and

its impact on relationships. One way of understanding why this happens is the concept of reenactment.

Reenactment is the habit of recreating old relationships with new people. Reenactments are behaviors that evoke in caregivers some of the same reactions that traumatized children experienced with other adults, and so lead to familiar – albeit negative – interactions. Just as traumatized children’s sense of themselves and others is often negative and hopeless, their reenactment behaviors can cause the new adults in their lives to feel negative and hopeless about the child.

Why Do Children Reenact?

Children who engage in reenactments are not consciously choosing to repeat painful or negative relationships. The behavior patterns children exhibit during reenactments have become ingrained over time because they:

- Are familiar and helped the child survive in other relationships
- “Prove” the negative beliefs in the invisible suitcase, by provoking the same reactions the child experienced in the past. (**A predictable world, even if negative, may feel safer than an unpredictable one**).
- Help the child vent frustration, anger, and anxiety
- Give the child a sense of mastery over the old traumas

Many of the behaviors that are most challenging for resource parents are strategies that in the past may have helped the child survive in the presence of abusive or neglectful caregivers. Unfortunately, these once-useful strategies can undermine the development of healthy relationships with new people and only reinforce the negative messages contained in the invisible suitcase.

What Resource Parents Can Do

Remember the suitcase

Keep in mind that the children placed in your home are likely to re-use the strategies they learned in situations of abuse and neglect. Because of their negative beliefs, children with an invisible suitcase have learned to elicit adult involvement through acting out and problem behavior. These behaviors may evoke intense emotions in you, and you may feel pushed in ways you never expected. Some common reactions in resource parents include:

- Urges to reject the child
- Abusive impulses towards that child
- Emotional withdrawal and depression
- Feelings of incompetence/helplessness
- Feeling like a bad parent

This can lead to a vicious cycle in which the child requires more and more of your attention and involvement, but the relationship is increasingly strained by the frustration and anger both you and the child now feel. If left unchecked, this cycle can lead to still more negative interactions, damage relationship, and confirmation of all the child's negative beliefs about him-/herself and others. In some cases, placements are ended. And the suitcase just gets heavier.

Provide disconfirming experiences

Preventing the vicious cycle of negative interactions requires patience and self-awareness. Most of all, it requires a concerted effort to respond to the child in ways that challenge the invisible suitcase and provide the child with new, positive messages.

Messages that tell the child:

- You are worthwhile and wanted.
- You are safe.
- You are capable.

And messages that say you, as a caregiver:

- Are available and will not reject him/her.
- Are responsive and will not abuse him/her.
- Will protect him/her from danger.
- Will listen and understand him/her.

This does not mean giving children a free pass on their negative behaviors. As a parent, you must still hold children accountable, give consequences, and set expectations. But with the invisible suitcase in mind, you balance correction with praise, and deliver consequences without the negative emotions that may be triggered by the child's reenactments.

- Praise even the simplest positive or neutral behaviors. Provide at least 6 instances of warm, sincere praise for each instance of correction.
- Stay calm and dispassionate when correcting the child. Use as few words as possible and use a soft, matter-of-fact tone of voice.
- Be aware of your own emotional response to the child's behavior. If you cannot respond in a calm, unemotional fashion, step away until you can.
- Do not be afraid to repeat corrections (and praise) as needed. Learning new strategies and beliefs takes time.

Establish a dialogue

The strategies that maltreated children develop to get their needs met may be brilliant and creative, but too often are personally costly. They need to learn that there is a better way. Children need to learn that they can talk about the underlying feelings and beliefs

contained in their invisible suitcase. They need to understand that you as the caregiver can tolerate these expressions without the common reactions they have come to expect from adults: rejection, abuse, abandonment. Help children learn words to describe their emotions and feelings and encourage them to express those feelings. When the contents of the invisible suitcase have been unpacked and examined, reenactments and negative cycles are less likely to occur.

The Suitcase and You: Tips for Avoiding Compassion Fatigue

Caring for traumatized children and adolescents can take quite a toll on resource parents. Remember that paying attention to your own feelings and needs is just as important as attending to the needs of your child. Without proper self-care, you can become physically, mentally, and emotionally worn out – as if you are carrying the child’s traumas all on your own shoulder. Some people call this “compassion fatigue”. When this happens, you may experience:

- Increased irritability or impatience with the child
- Denial of the impact traumatic events have had on the child
- Feelings of numbness or detachment
- Intense feelings and intrusive thoughts about the child’s past traumas that do not lessen over time
- Dreams about the child’s traumas
- The desire to get away from the child or get the child out of your home

If you experience any of these signs for more than two to three weeks, seek counseling with a professional who is knowledgeable about trauma. To avoid compassion fatigue, take the following preemptive steps.

- Beware of isolation. Successful resource parents know that they cannot go it alone when caring for children with trauma. Work in a team, talk to other foster parents and therapists, and ask for support.
- Accept your reactions. All too often, resource parents judge themselves as weak or incompetent for having strong reactions to a child’s trauma. These feelings are not a sign of weakness or incompetence, rather, they can be the cost of caring.
- Work on understanding and processing your own traumas. Adults with a history of unresolved traumatic experiences are more at risk for compassion fatigue. Seek help to make sure your own traumatic history and reactions to trauma reminders do not get in the way of your being an effective parent.
- Keep your perspective. Remember, you are not just a resource parent. Make time to interact with children and adolescents who have not been maltreated, to socialize with adult friends, and to find joy in every day. Be sure to laugh often.

Adapted from “The Invisible Suitcase” by Jennifer Wilgoeki, MS, LCSW and Jim Van Den Brandt, LCSW, ACSW.

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