



# A Family For Every Child

## Matching Assistance Program

### Detangling Diagnoses for Foster and Adopted Youth

From Spring 2009 Adoptalk

By John Sobraske

*John is an adoptee and adoption psychotherapist who lives and practices in New York. The article below is based on the "Diagnostic Conundrums" workshop he presented at NACAC's 2009 conference.*

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The experience of being a foster or adopted youth is both complex and unique. As such, the process of diagnosing mental health concerns can be paradoxical and problem-atic. Unlike other children, these youth have lost their first families. In addition, they may have been exposed to drugs or alcohol, abuse or neglect. They may have endured experiences that taught them to be suspicious of others, including well-meaning adults. Logically, if we are to accurately assess and treat foster and adopted children, we must evaluate them holistically, taking into account a variety of influences.

In my experience, foster and adopted youth may contend with one or more of the following 10 core influences:

- genetics/chemistry (family history/low serotonin depression)
- prenatal exposure/deficiency (cocaine or alcohol exposure in utero)
- postnatal exposure/deficiency (iron deficiency)
- early loss, attachment, grief
- abuse, neglect, trauma
- transitional flux (lived in several foster homes)
- developmental diffusion (some delays and precocity)
- family systems (dynamics in a past or present family)

-larger systems (orphanage, group home)

-societal attitudes (racism, homophobia, foster care stereotypes)

The first two areas would affect a child with genetic depression who was exposed to alcohol in utero. The last area would pertain to a child hassled by peers for being gay and Latino. Any mix of factors can be present. In my practice, early loss and developmental issues are the most common, even for children adopted as infants. For those who spent years in the system and whose parents' rights were terminated, other categories apply. Because each case is unique, clinicians should examine each possible influence.

### **Loss and Attachment Issues**

Children who lose their original family are tremendously impacted. Other losses, such as loss of control and the loss of basic references for self identity, along with one or more placement transitions, compound the effect of the first loss.

Even when feelings regarding early loss, foster care, or adoption are present, however, the child may not be aware of them, particularly if events occurred before the child developed conscious memory. Some say that if incidents cannot be remembered, their effect is minimal, but the opposite is true. The impact is all the more powerful precisely

*because* the child lacks verbal facility, a well-developed sense of self, and the ability to recall memories on command. Feelings go underground where they are difficult to access and can exert a profound influence.

Some youth are dimly or acutely aware of feelings related to early loss and do not want to go there. For others, a defense system automatically shields them from experiencing feelings too directly. These youth unconsciously develop patterns to keep feelings at bay. In both cases, the children may not have any clear sense that they are struggling with adoption issues.

To further complicate things, early loss does not affect every child in the same way. Each child's resilience and perspective is different. For one child, a significant loss may have a moderate impact; for another, the effect may be stronger.

I remember two girls adopted from Russia who struggled with attachment issues. A diagnostician had declared that one had an attachment disorder and the other did not. Their mother acted as though attachment disorder was a fatal disease, and that the child with the disorder was destined for a bad outcome. The other, she expected, would be fine. In truth, both daughters were suffering in similar ways; it was just a matter of degree.

The diagnostic category of reactive attachment disorder (RAD) presents its own conundrums. While attachment problems can in some cases be quite severe and are not to be underestimated, neither should they be over-estimated. Too many therapists predict with conviction a catastrophic future for children so designated: She will never be able to attach to anyone. Such statements irresponsibly scare parents and scar children.

The difficulty is that attachment disorder used to be under-recognized and under-diagnosed. However, once it became fashionable, it tended to be over-recognized and over-diagnosed. Attachment became *the* disorder to reach for when a child's behavioral problems were over the top. While attachment (and perhaps a string of disrupted placements) could be the root cause of these behaviors, many other possibilities exist. In my experience, many children labeled with RAD are misdiagnosed. As often as not, the problem lies elsewhere, or attachment is merely one piece, perhaps not even the biggest piece, of a larger puzzle.

### **Diagnostic Challenges**

It can be tough to decipher which diagnoses apply since many childhood disorders cover similar ground: behavioral problems, poor self-regulation, inability to maintain focus, emotional instability,

aggression, learning problems, defensiveness, opposition, poor peer relationships, low self-esteem. Some disorders also have multiple origins. Depression, for example, can be chemical or situational (brought on by severed attachment, trauma, identity confusion, internalized racism, etc). Focusing problems can involve neurotransmitter dysregulation, hypoglycemia, fetal alcohol or cocaine exposure, anxiety from attachment breaks, etc. The label is not enough; clinicians must discern underlying causes to choose the correct intervention.

Youth in care and those who were adopted from care may not be able to identify what lies behind their behaviors. Commonly, children simply do not make the connection between their behavior and adoption issues.

They may resist the idea of having adoption issues because they are striving to be normal and this label suggests (to them) that they are somehow not. It is like being punished twice by the loss of family: first by the loss itself, and second by the label.. Adding diagnoses does not help since these all end in disorder. A term which again underlines the idea of not normal.

In reality, of course, children may be displaying very well-ordered responses to a disordering situation. That which is normal for adoption only becomes abnormal when placed within the bell curve of the population at large.

Not receiving a label when one is needed, however, can create other difficulties. If a concern needs to be addressed but remains unidentified, the child may not get proper treatment.

Unfortunately, the diagnostic system is fairly brittle and follows the medical model in which you either have the bug or you don't. Practitioners get a little wiggle room by using diagnoses that end with, not otherwise specified. For example, depression not otherwise specified means the person does not meet the criteria for typical depression, but has depression-like symptoms. It can also mean that we need extra time to diagnose the condition more specifically.

We must remember when applying psychological diagnoses that these disorders are not as concrete and definable as medical illnesses. Whether one has tuberculosis is much more definitive than whether one has a histrionic personality disorder. Psychological categories are by comparison a bit arbitrary or constructed.

The recent trend to group a few diagnostic categories as a spectrum of disorders represents a move away from one box toward several that express a range of symptomology. Thus, instead of, you have it or you don't, we are saying, you have some version of this disorder along a continuum of degree. We have spectrum disorders for fetal alcohol and autism. I hope we can find more range for other disorders, like attachment, as well.

Another diagnostic conundrum occurs when clinicians view a child from within their own specialty. An attachment specialist may see attachment, while a sensory integration specialist finds SI and a psychiatrist recognizes bipolar. It is like the six blind men who went to see an elephant. Stationed at different parts of the animal, the men in turn declared that the animal was like a tree trunk, spear, fan, rope, snake, and wall. They were all correct, but none could move past his own limited perspective to put the whole detailed picture together.

One must walk with eyes open all around the elephant to see how the pieces fit together. Otherwise, assessments become a collage of seemingly unrelated fragments. When professionals cannot provide a comprehensive picture, it falls to the parents to do so. In the course of visiting with practitioners and other similarly situated parents (who can be great resources), parents may themselves become experts and advocates. In turn, they can guide other struggling parents.

### **The Holistic Model**

Child psychiatry is still a young science, feeling its way. Neither it nor the medications it relies on are at the level yet of incontrovertible science. That is still years away. Even as it evolves, child psychiatry must struggle with the fact that children, especially those in foster care or adoptive

homes, may display a highly complex composite of symptoms that are not amenable to classification within rigid, brittle, black and white boxes.

A holistic model allows us to think outside the box, and mix and match and blend two-thirds of this disorder with 50 percent of that, and a few traits of that other thing thrown on top. It sounds messy and at first glance a bit haphazard, but if done well, the approach is actually quite artful, informative, and accurate. Three core questions tend to come up in diagnosis: 1. Are there adoption (loss) issues? 2. Is it a developmental issue? 3. Is it nature or nurture? A sensitive assessment can answer the first two questions, but to accurately address the third, clinicians need good information about the birth family's mental health history, the child's pre- and post-natal exposures or deficiencies, and early neglect, abuse, and trauma. These details too often can be exceedingly hard to access. Fortunately, the skilled clinician can still detect subtleties and construct a reasonable picture even without much background history.

The advantage of the holistic approach is that clinicians can more closely approximate the child's true personality structure, condition, and situation. They can also explore interaction patterns between varied components of a child's personality. Often, additional components do not just add a neat layer distinct from other issues. Certain elements interact quite dynamically. Trauma, for instance, can reduce a child's ability to attach, which can in turn keep him from being able to process trauma with help from others. One element, if similar to another, may be harder to detect, and occasionally two elements complement one another.

When clinicians study the whole child, what finally emerges is a complicated weaving together of the 10 potential strands I mentioned at the outset. In each case, usually a few of these influences stand out. Then we must detect the complex dance of their interaction. By ruling influences in and out, and noting how they interact, we can begin to penetrate the fog and articulate the real underlying concerns. And when that happens, the way is clear to more effectively treat children in or adopted from foster care and to help them to heal.

**Jennifer Hancock**

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541-343-2856