TREATMENT

Neuro-biological disorders cover a wide spectrum. While many are diagnosed, mis-diagnosis often occurs as mental health practitioners may be unaware of the full range of these disorders and their inter-relatedness. Traditional intervention and treatment tends to focus on physical/behavioral manifestations (e.g. inattentiveness in AD/HD or impulsive actions). A strict behavioral approach to treatment is often assumed or even demanded by managed care personnel as they seek to implement “evidence based practices” that can produce “measurable outcomes.” Stopping an objectionable behavior is considered a success. If I could teach you to fly you would surely think it miraculous because it is not within the physical ability of humans to fly. No modality of treatment can succeed in giving anyone voluntary control over involuntary behaviors. These people’s brains are in charge and no amount of will. power can overcome that control center. It's the natural biological order of things. Birds fly, Touretters tic.

The goals of treatment vary greatly depending on the person’s presenting symptoms and/or diagnosis. Psychotherapeutic treatment, traditionally, is “talk therapy” that takes place in an office, usually for a “50 Minute Hour.” Many individuals, couples and families avail themselves of this form of treatment with or without accompanying medical intervention in the form of psychotropic medication. Such classical therapy relies on clients developing a trusting, meaningful relationship with the therapist. It is through the therapeutic relationship that insight into particular difficulties occurs which then, hopefully, lead to an avenue(s) for change. How long the therapy goes on is really an open-ended question. A mentor/therapist once said to me that it usually continues until the client realizes that they have better things to be doing! In my experience the therapeutic relationship takes on a completely different (nee non-traditional) flavor when working with children and adolescents struggling with neuro-biological disorders. It becomes quite multi-faceted. This section discusses the BTC treatment approach to working with this particular population.

I’ve never met a kid with a neuro-bio disorder that didn’t know, at some level, and whether or not they could express it in adult language, that they were “different.” Kids see that they have a different cadence than their peers and playmates. They see that they have emotional responses out of proportion to events. They see kids that can handle stress better and ones that don’t take everything so personally. They also see kids that are engaged and enjoying their life experiences whether at school, during recess, on walks or bus rides home and during after school playtime. They often wonder, albeit silently, why they can’t get along, why they argue, why they can’t listen or behave or why they feel the way they do which is, oftentimes, out of synch. They just know an awful lot about what’s going on without being able to conceptualize it, let alone verbalize it.

I’ve met countless mental health professionals, teachers and parents who persist in trying to make these types of kids behave, implying that it is only the behavior that is out of kilter. They often believe the behaviors are willful and insist that the kid override biological manifestations (e.g. hyperactivity, defiance, temper tantrums), assuming they even acknowledge that it IS the biology. They are willing to do this at all costs (or, with managed health care, with as little cost as possible). Despite repeated indications and the resultant failures with behavioral approaches (time outs that are countless and endless, a never ending supply of adhesive tape residue on the refrigerator from sticker charts that were stuck up,

tried, torn down and replaced again, or from frustration at an inability to get Magic 1-2-3 to work its magic), there is an insistence to continue to “do it” the same old way, when it’s so obvious to everyone that those ways (insistence on solely behavioral changes) just aren’t working.

I’m reminded of my work with OCD kids and how “stuck” they get, how they freeze and have no ability to get out of their tightly shut box and how therapists are constantly trying to change their behaviors through all sorts of behavioral techniques that have little if any long-lasting effects. It seems to me such therapists can’t get through to these kids because they, themselves, are stuck. Isn’t it time we changed our thinking or at least develop the ability to ask this basic question: “If behavior modification techniques aren’t working with these kids, then why do we keep insisting on implementing them?” I think that hasn’t happened because therapists can’t ask that question. They can’t and don’t ask it because they are stuck. They need to let go of their notions of “I’ll try it again because maybe this time the outcome will be different.” Perhaps though, they just don’t have a clue about how to do it differently; they have no options. In the meantime these kids and their parents have gone through numerous behavioral treatment plans, arguments about following or not following the treatment directives and utter frustration (and at times, despair) that the whole kit-n-kaboodle is a bust. BTC offers an alternative to this never-ending cycle of ineffective treatment.

The BTC approach demands that the therapist not only work with the client, but also with the parents, teachers, treating physician or psychiatrist and various others associated with the case as a team coordinator. While possibly idealistic and not always feasible due to cost concerns or practical due to geographic or time constraints, the approach here outlined is, nonetheless, what is necessary to have the best chance of being successful. In dealing with the client and others associated with the case, the role of the therapist is actually that of a therapeutic manager and coach. It is the therapist who coordinates and directs interventions with the conscious intent of helping the client achieve stability and consistency with regard to their “condition,” hallmarks of mental health treatment.

The key coaching word is discipline. All of us institute some form of discipline in our lives to give it structure, purpose and meaning. It is the basis of our daily routines. For Moms, raising kids is their discipline for many years, often today not at the exclusion of their other numerous endeavors such as career or advocating strenuously for services for their kids. Dads, when the primary breadwinner, effect their disciplined routines by going to work and developing a career path. Kids go to school, college students go to class, some people pursue martial arts, some yoga, some work out at the Y, some read daily, etc. All of these routine activities afford the person doing them, discipline. Such discipline is crucial to those with neurological disorders. It is through a disciplined approach to dealing with their disorder(s) that they can effect stability and consistency in their lives. The BTC approach is the medium or tool that affords one the opportunity to generate appropriate and meaningful discipline, one that is specifically established and instituted to attend to neuro-biological disorders.

We all have work to do on ourselves in order to improve, to advance, to lead a more enjoyable and fruitful life. Someone with diabetes needs to pay attention to that condition as it has clear health implications and risks if they do not. For instance, blood sugar levels need to be taken on a regular basis and diet and weight need to be regulated, activities that require

discipline. In other words, consistent attention and appropriate action is necessary. The same concepts are true for those with mental disorders.
Going to therapy itself, let's say once a week in an office or out-patient clinic setting, can be helpful. When working with children and adolescents with neuro-biological disorders, though, more is required. In my work, I spend at least a couple hours with someone. We go to McDonald's, pizza places (and other food joints), the mall and parks or play video games. We take walks, go bowling, miniature golfing and many other activities that allow for a more casual therapeutic environment. These outings or endeavors, and this is crucial, present the client with actual, real-life situations with which to interact. If, for example, one wants to help a kid with OCD, one needs to see how that kid experiences OCD in their life. "In vivo" situations allow the therapeutic coach to not only "see" what really happens, more importantly, it provides an opportunity for an actual, real-time intervention to occur.

In working with a teenage girl diagnosed with TS, OCD, ADHD and gosh knows what else, we usually ventured out into public. This young lady was so "on top of things" that even during neighborhood walks she would warn me about uneven pavements, as if I'd never seen a sidewalk, let alone had ever walked on one. During regular "talk therapy time," we discussed this "attitude" of her's. As a result of these chats, she said, "I'm too bossy," a wonderful insight that clearly indicated a need for some work. Doing it with me, though, was one thing. Seeing how it might manifest in public was another.

On one of our sojourns we went to play miniature golf. It was an outing that had been planned (another whole series of interventions) and we waited for a nice day. Such activities afforded her the opportunity to be playful and more light-hearted, a distinct contrast to her usual worrisome, irritated demeanor. While enjoying the nice day and the activity, it didn't take long for her "bossiness" to rear its head. Long about the fifth hole, amidst having a rather delightful time, she began interacting with others in the vicinity. As I'm quite personable, I knew she was modeling me here as she had done on other occasions. Rather than merely make idle friendly chatter, however, she began telling them how to play the game, how the hole was laid out (we were ahead of them) and how best to hit the ball. It was obvious to me that the others were annoyed by this intrusion. As I endeavor not to embarrass anyone, I needed to wait for an appropriate opportunity to discuss this with her.

I pointed out to her that she had plenty to do to play her own game which was a lead-in to bringing her attention to her interactions with the other players on the course. Over the next ensuing holes we continued to discuss her desire to talk and to be friendly with people vis a vis her urge to be bossy. The intent was to help her become aware, through a real-life interaction, that what she needed to do for herself and what she imagined others needing from her, were not the same. In miniature golf, being more concerned about how someone else is playing and being more focused on correcting their play will definitely decrease one's enjoyment in playing their own game with their own companions. With her, these situations occurred regularly and afforded numerous intervention opportunities, all geared toward helping her confront her OCD and to find ways to lessen its impact on her life. I refer to these situations as practice times. Direct intervention during the actual episode carried a lot more weight than having an office discussion about it, if in fact it would have even come up

As should be obvious, I'm an active participant in the process. I believe strongly that such an approach is required to treat this population with these disorders. I work to get them in shape (trainer) by demanding that they practice more and try harder. I urge and encourage them

(cheerleader) to improve and applaud them when they do (and yes, lots of pats on the back and hugs too). I go to bat (advocate) for them with others such as parents and teachers. I listen to their life story (therapist), help them feel better (healer) about themselves and I correct them (disciplinarian) in an appropriate, non-embarrassing fashion. I do this by developing a real, trusting relationship with them, by believing they want to get better, by hanging out with them when many others won't and by showing them (role-model) that their life can not only be different, it can be better. This is done in real-time with real-life situations, not in an artificial, sterile setting.

There's an additional role I play, often with parents and teachers and other support personnel, that of educator. In this role I explain the various disorders, suggest books and articles to read or direct them to additional internet resources. Adequate and appropriate information goes a long way in helping parents and others put the child's situation in perspective and help allay fears and misgivings they may have about these conditions.

The above illustration is but one example of therapeutically coaching someone about improving their own disorder's impact on their life. To me, those with neuro-biological disorders need to be in training. The training requires a lot of time, commitment, and persistence over the long haul. As such, it requires resources in time and money. Some invest in health club memberships, go to the club on a regular basis and reap the benefits of that consistent discipline over time. Some do not. The old adage of you get out of it what you put into it is never so true with regard to physical and mental health.

In my multi-faceted role, I operate as a coach, trainer, cheerleader, role model and disciplinarian. I'm also a strong advocate for necessary and appropriate educational services and often meet with school personnel and attend IEP meetings. I also consult regularly with the treating physician or psychiatrist to keep them informed of the client's progress and to monitor medications. And, I work with parents as well as entire families (which can include siblings, grandparents and family friends) in order to assist them in helping their child or teenager.

Clearly, mental health services are expensive and my approach is, perhaps initially, more expensive than traditional interventions. The usual services such as the 50 minute hour once a week (if you can get that), a 15 minute medication check, crisis hospitalizations (if there is a bed available) which often comes with an oversubscribed medication cocktail (with the intent of behavior stabilization), high rates of therapist turnover and/or endless rounds of advocacy confrontations with service providers and managed health care combined with the confusion and frustration that accompanies the quest for meaningful and adequate services, is a nightmare. Further, inappropriate methods of treatment (an almost complete reliance on behavior modification) instituted by untrained and/or incompetent professionals in a disjointed manner, make for a very unhealthy situation for those needing treatment. The bottom line is that it isn't working.

While the main focus of the BTC approach is not on behavioral changes for the sake of better behavior, it does not turn a blind eye to the behavioral concerns. Trust me, if I had the power to overcome or change or even fix how someone's brain is wired and knowing that in doing so it would result in well-behaved individuals, I'd do it in a heart- beat. Constantly trying to alter established, if not ingrained, behavioral patterns is a prescription for endless confrontations, repeated frustration and continual failure. Hence, it's not really a viable

option. These people are more than their observed behaviors. They are intelligent, they think and they have feelings like everyone else.
Of course behavior is important, especially in this culture where the pressure to conform is enormous. Demanding or coercing someone to change their behavior is, however, a real quagmire when not done within a context of also attending to the person's emotional, psychological and social states. Although I can't possibly guarantee "success," the BTC approach at least affords a better shot at alleviating distress for the child/adolescent, the family and school personnel alike. This approach has succeeded in lessening the frequency and intensity of meltdowns which result in less stress for everyone. It has also seen significant reductions in the use of medication and fewer, if not an absence of, hospitalizations. Ultimately, with a concerted effort over time, the situation has a good chance of improving. The result is more enjoyable relationships at less cost financially and emotionally.

A couple final notes. While intervening, even later in life, is better than not, early intervention is key to long term success. A student with ADD who receives treatment for the first time when in college would, no doubt, have been better served had s/he received services In elementary school. Early identification and intervention afford the best chance for sustainable success.

These disorders tend to be chronic, life-long situations. Nothing we know of today can fix them. Accordingly, long-term intervention and support is beneficial. While the more intense, regular therapy described here will not necessarily be needed over time, having someone to touch base with, having a life-line (I call it a tune-up), can assist immeasurably.

Finally, after all is said and done, those with neuro-biological disorders need to find their place in the universe, a place that allows for their particular nuances and one that utilizes their gifts and strengths appropriately. When you think about it, that is not really any different from what anyone else would like to see happen for themself. We all need to feel accepted for who we are and to feel connected in a meaningful way. For those with these disorders, such goals are especially challenging. Beside the individual work on one's self that is critical to success, a more knowledgeable, understanding and tolerant attitude from those less afflicted would go a long way. We really are all in this together.

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