Success with High Risk Children: The Neuropsychiatry Approach

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Neuropsychiatry Approach

- SEEING DIFFERENT PATIENTS?
  - High-Risk due to early brain complications
    - Not head injury rehabilitation kids
    - Not aggressive delinquent kids
    - Not just severe psychiatric kids
  - Psychiatric kids with early, mild, brain disorders
    - More impulsive, irritable, explosive, moody
    - Early brain problem makes psychiatric issue worse
- USING DIFFERENT THERAPEUTIC MILIEU
    - Same as used for brain injury programs
    - Low stimulation, no confrontation, positive discipline, less insight oriented therapy, more behavioral therapy

For Neuropsychiatric Kid

USE DIFFERENT ASSESSMENTS

- QEEG with ERP, Neuropsychology Testing

- USE DIFFERENT MEDICATIONS
  - Target medication to brain problems, not diagnosis
  - Medication use more like Neurology than Psychiatry
- USE DIFFERENT THERAPIES
  - More behavioral, less verbal, more action -based
- USE DIFFERENT THERAPEUTIC MILIEU
  - Less stimulation, slower pace, no confrontation
- USE DIFFERENT DISCIPLINE (No Boot Camp)
  - Positive discipline mostly; avoid punitive approach

Case #1: Age 6

- Born 2 weeks premature, complicated birth
- Age 4, diagnosed with ADHD, started Ritalin
- Age 10, depressed, multiple medications, suicidal,
- SYMPTOMS of "Neuropsychiatric Kid":
  - Impulsive, irritable, moody, suicidal, aggressive
- Admit Meridell: Neuropsychology: visual learner, shows poor attention. ERP abnormal in temporal
- Plan: Inattentive - use "action" play therapy
  - QEEG suggests target meds to temporal lobe
  - Use '"Neuro" milieu (less stimulation, positive discipline, avoid confrontations, slower pace, shorter sessions)

Recommendations-Case #1

- Neurocognitive status:
  - Poor attention/memory; Suggest repetition, use of diary
  - ADHD interventions: Suggest classroom modifications
- Psychotherapy: Individual/Family/GroupTherapy
  - Poor candidate for verbal therapies; consider non-verbal play therapies, small group, short duration
- Education: Strong use of visual aids
  - Is largely a visual learner (Special Education)
- Discipline: Use “Positive Discipline” only
  - Avoid punitive discipline, no confrontations, don’t yell

Case #2: Age 15

- Neonatal seizures; language delay
- Second grade, daily tantrums in school
- Explosive temper, oppositional, hyperactive, suicidal, aggressive, poor school grades
- Age 15, irritable, aggressive, mood swings
- Prior diagnoses: ADHD, Anxiety Disorder, Bipolar Disorder, mild brain disorder
- Admit: abnormal ERP in frontal lobe; Neuropsychology shows poor language skill
- Plan: “Neuro” milieu & Cog/Beh Therapy
  - ERP suggests medication directed to frontal lobe

Recommendations- Case#2

- Neurocognitive status:
  - Very impulsive; Use ‘neuro’ milieu, positive discipline
  - Poor language skill: Brief, simplified verbal therapies
  - ADHD interventions: Suggest classroom modifications
- Psychotherapy: Individual/Family/Group Therapy
  - Poor candidate for insight therapies; consider Cognitive Behavioral Therapy; Stay in the “here and now”
- Education: Use Collaborative Problem Solving
  - Misbehavior due to skill deficit s; impulsive/language
- Discipline: Use “Positive Discipline”
  - Avoid punitive discipline, no confrontations, don’t yell

“NEURO” APPROACH

- Not suited to delinquent, conduct disorder
  - Designed for impulsive, irritable, moody
- Not suited for psychosocial issues
  - Designed for brain disorder plus psychiatric
- Not suited for ‘Traditional Psychiatric”
  - Neurocognitive skill deficits make them different
- Not suited for normal discipline
  - Short tempered, impulsive, need positive discipline
- Not suited for normal milieu
  - Need quiet , softer milieu similar to neurology units