SWINGLE CLINIC

# THE BENEFITS OF BRAINWAVE TREATMENT WITH THE ADOPTED CHILD

**Paul G. Swingle, Ph.D., F.C.P.A., R. Psych.**

She came bopping into my office, jumped into the chair behind my desk, and started twirling herself around while watching to see if her mother or I would react. Her mother was about to admonish Susie but saw that I was smiling and extending my hand to her daughter. “Pumpkins sit here,” I said, pointing to some chairs on the other side of my desk. Susie ran to the other chair while giggling, “You’re a cucumber!”

Marnie clung so tightly that her mother had difficulty walking into my office. She was clearly very frightened, climbing into her mother’s lap and burying her head into her mother’s neck. When I addressed her, Marnie’s grip tightened to the point that her mother had to peel her off so she could breathe.

Very different children with different backgrounds? Surprisingly, no! Marnie and Susie were very close in age, racially identical, and adopted at about the same age from very similar circumstances. Why then is one boisterous and pesty, and the second child shy and fearful? The answer to that question lies in the subtle neurological differences between these two children and how the differences alter the impact of very similar circumstances the children have experienced.

All adopted children have attachment and abandonment issues. You can be the greatest parent on the planet but your adopted child is still going to experience abandonment. Abandonment is traumatic but these children often experience additional severe emotional trauma that further impacts their social and emotional development. If they are neurologically at risk because of poor stress tolerance, predisposition to depression and/or anxiety, perseverative thought processes, emotional impulsivity, or social learning deficiencies, then the trauma and abandonment are going to manifest in a manner consistent with the functional patterns of the brain. So the differences between Marnie and Susie lie not so much in their experiences, which were quite similar, but in their brain functioning that altered the significance of that experience for each child. And herein is the great benefit of neurotherapy for helping these children. We find the anomalies in brain functioning, correct or normalize them, and then proceed to the behavioral therapies that can now be effective because the child is no longer “fighting” the neurological predispositions.

What we were taught in medical and graduate school when I was a student is just wrong! In the past decade huge advances have been made in understanding the role of genetic predispositions, behavioral effects on brain functioning and, most importantly, the great plasticity of brain functioning. We knew that the brain had to be plastic for some time but the incorrect notion of the rigidity of brain functioning pervades the health professions, even to this day. A good example of the interaction of genetics and environment is the identical twin studies of mental disorders such as schizophrenia. Some studies report that if one twin has schizophrenia, the probability that the identical twin will have the same condition is about fifty percent. The important statistic in this finding is that fifty percent will not!

So back to Marnie and Susie. Marnie's brainwave assessment revealed that she had marked deficiencies at the back of the brain (poor stress tolerance and anxiety), a marked trauma pattern (poor retention of information and fearful imagery), and a slow frequency disparity in the frontal cortex (emotional volatility). Susie's brainwave assessment, on the other hand, showed elevated alpha in the frontal cortex (poor ability to sustain attention, chatty) and an alpha imbalance (oppositional). The back of Susie's brain was well within normal limits so her stress tolerance was good.

The neurological treatment of these two children was very straightforward. The above conditions were normalized with neurotherapy. There are several general forms of neurotherapeutic treatment. The most important is neurofeedback, or brainwave biofeedback. This treatment involves measuring brain activity and when the brain is functioning more closely to normal, icons move on the computer monitor. In other words, the child plays a video game with her brain! When the brain is doing what we want, bugs move across the screen, Pacman eats up dots or spacecraft fly through intricate mazes.

The neurological portion of the treatment is neither the most difficult nor the most critical. The most vital aspect of the treatment of these children is to modify their core emotional beliefs about themselves. A child who experiences abandonment always develops negative self-regard. The child is faced with a psychological dilemma. Why were they abandoned? If they believe that they were voluntarily given up then a psychologically reasonable conclusion is that they must be deficient, evil, unlovable, ugly, stupid, and/or repulsive. Of course, they do not think in these terms but these are the emotional realities for these children. What if the biological parent was killed? Same problem presents itself to the child. Why did God do this to ME and not someone else? Must be because I am worthless.

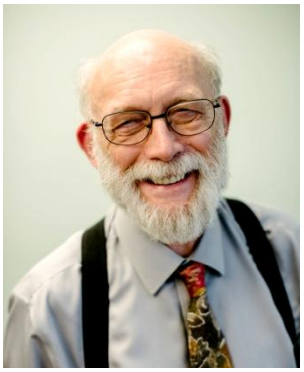
Self-loathing is not too strong a term to capture the emotional pain of these children (and adults), although this pain may be strongly buried and manifest as personality disorders such as narcissism, histrionics, avoidance, or paranoia, or with marked depression and/or anxiety. We have a saying in my clinic: "Change a child's self-esteem and you change everything." Changing self-esteem can be very difficult because the core beliefs are so deeply rooted. However, on occasion we get lucky as in the case of Linda.

Children are always frightened when they are being evaluated, particularly those who have negative core beliefs about themselves. They expect more bad stuff about themselves! During the follow-up after the brain assessment, I always find something positive in the brain map to show to the child. In Linda's case, I made the statement: "Linda, you have the frontal lobes of a rocket scientist." I showed her the numbers and briefly elaborated on what I meant. She seemed pleased. About a week later, I received a call from Linda's mother. She told me that the change in Linda was nothing short of miraculous. She went home after my assessment and announced to her family: "Dr. Swingle said I have the brain of a rocket scientist!" Her attitude to school and homework dramatically changed, so much so that her teacher called her mother to inquire what happened to give rise to such a dramatic change. Her mother also commented that Linda's severe oppositional behavior seemed to have just "evaporated." Of course, we are rarely this fortunate and we need to devote a number of sessions to helping the child modify these crippling negative beliefs. However, because the brain is normalized, this process of changing beliefs moves very efficiently.

We should also keep in mind that the neurological and psychological profiles of the adoptive parents are important. If the parent has a neurological condition similar to Marnie's, then that parent is likely to have problems with the stresses of parenting that in turn will affect the child.

Also of importance are the needs of the adoptive parents. Some parents are themselves very needy and strongly reinforce clingy and dependent behavior of their adopted child. These are issues that are relevant to every family, of course, but with adoption these variables become more critical because of the abandonment/attachment struggles of the child, as discussed above. When treating the adopted child, we encourage the parents to be mindful of their own psychological issues so that they do not unwittingly reinforce maladaptive behavior in their adopted child.

## ABOUT THE AUTHOR



Paul G. Swingle, Ph.D. R.Psych. was Professor of Psychology at the University of Ottawa prior to moving to Vancouver. A Fellow of the Canadian Psychological Association, Dr. Swingle was Lecturer in Psychiatry at Harvard Medical School and during the same time period was Associate Attending Psychologist at McLean Hospital (Boston) where he also was Coordinator of the Clinical Psychophysiology Service. Dr. Swingle was Chairman of the Faculty of Child Psychology at the University of Ottawa from 1972 to 1977 and Clinical Supervisor from 1987 to 1997. He has also taught at McGill University, Dalhousie University and McMaster University. He is a Registered Psychologist in British Columbia and is certified in Biofeedback and Neurotherapy. Since 1997 he has been in private practice in Vancouver, British Columbia. His newest book “Biofeedback for the Brain” was published by Rutgers University Press.