



EDUCATING THE HEAD INJURED CHILD

In the past few years there has been an increase in the number of head injured children and adolescents admitted to the Niagara Peninsula Children's Centre for treatment and education. Although the staff was used to dealing with a population having diverse needs, their experiences with head injured students have reinforced two ideas.

1. Each head injured child is unique in his physical, educational, behavioural, emotional, and social requirements, as well as his rate of recovery. Although there are many similar deficits among the head injured, the approach to recovery must, by the nature of the damage, be treated very individually.
2. The very fact that the head injured child has so many areas where intervention must be given necessitates a coordinated interdisciplinary approach. No single person has the skills to provide all that is required. An integrated program is needed to treat the physical, cognitive and psychosocial fragmentation that results from a severe head injury.

The five hour school day is a busy one with the possible involvement of occupational, physio and speech therapy, social work, augmentative communication, and recreation, as well as education. On a less frequent basis the student may be seen by psychology, seating or orthotic clinics.

THE WHOLE CHILD APPROACH

The coordinated, interdisciplinary approach is of value to the child, the family and the team itself. The child is treated as a whole with all members of the team realizing the importance of all the contributions of each discipline to the total development of the child.

TEAM SUPPORT

At times there may be difficult situations in which other members of the team can be called on for suggestions. This support helps the team members feel they are not working in isolation.

TEAM GOAL SETTING

Each member becomes aware of the goals of the other members. Parents are encouraged to follow through on those that are appropriate for home. They may also request the team to work on some aspect of social behaviour that is a concern to the family.

CONSISTENCY

The child is dealt with consistently and becomes more aware of what is expected, and secure because all those dealing with him meet situations in a similar manner.

SYNERGISM

Not only are the team members aware of each other's goals, but when appropriate within the various settings, they can work on each other's goals as well as their own, i.e. The teacher is aware of goals for gait training. She can reinforce these when the student is moving in the classroom.

In a well operating interdisciplinary team we see the concept of "synergism" operating, where in fact, the whole is greater than the sum of its parts. Each member takes on some of the skills of all of the other team members. Although as educators we look mainly at the educational aspects of head injury, we feel that it is our responsibility to gain a working knowledge of the other disciplines in order that we can support their goals, as they do ours.

In the development of objectives it has been found useful to keep in mind the age and level of development of the child at the time of the injury as this can act as a rough guide for retraining.

It is also important when working with children to keep in mind that they are integral members of a family. Parents, siblings and grandparents share a profound investment in the child's treatment program. The family members are making tremendous adjustments as a result of this tragedy. It is important to keep them in close contact with the centre so they are familiar and comfortable with the setting and become well acquainted with the team dealing with the child.

In the text, "Head Injury Rehabilitation - Children and Adolescents", Anna Chorazy states the following; as general objectives for head injured:

- The reduction of discernable impairments.
- The development of potential abilities
- The fostering of adaptive compensation for lost or impaired function.
- The development of psychosocial adjustment in a climate that presents the child with acceptance, challenge, and encouragement toward independence.
- Follow-up with the development of support within the child's own family and community.

Along with the above long range objectives, there are some considerations that are made on a daily basis for the management of the child.

SAFETY

Safety is a basic consideration for those students who are confused or have a reduced ability to see hazards. In a building with electric doors consideration has to be made for the child with impaired judgment who could wander away.

MEDICATION

Many head injured children are on some type of medication. Monitoring the effect of medication is important as to how it may affect activity level or behaviour over an extended period of time.

BEHAVIOUR

Positive behaviour change does not just happen. It has to be planned. If you don't have a program for behaviour changes then you don't know what is going to happen. The following techniques work well in combination with each other

- Behaviour modification which focuses on changing behaviour through the manipulation of consequences.
- Manipulation of antecedent conditions which are the events that elicit behaviour.
- Advanced organizers which prepares the individual by verbally going through the steps that he is going to experience with appropriate behaviour discussed.

COMMUNICATION

The solution to more effective communication may be the reduction of the amount that is expected to be processed by the child. The rate of presentation may also have to be altered. In some cases the use of an augmentative system such as signs, symbols or synthetic speech may be required.

SELF-ESTEEM

One of the major goals of the team is to develop self-esteem—to help the child to like the new person that he has become. Providing the child with the opportunity to be successful along with sincere praise are powerful means of developing a positive self-image. In class, success is carefully planned for. When working with a child he should leave the session to go on to the next activity with a feeling of success. Care must be taken to give praise for appropriate effort. If the child feels that it is not deserved he will become confused and the person giving the praise will lose trust and value to him.

There are many techniques that will help develop skills with the head injured. For any of them to work as well as they might it is important that the interpersonal relationship be strong.

Some years ago I heard a saying that I think applies to the head injured, their problems, and how we deal with them. "We can't change the wind but we can trim the sails". There are abilities that the head injured have lost along with skills that are no longer there. This does not mean that we can't get to some of these objectives it just means that "We have to trim the sails" and take another approach to give them some of the techniques they need to get around the problem.

Marion Ballinger, a teacher at the centre sees this as her job and will now tell you how she “trims the sails” to give her students success.

As a teacher at a special centre I have encountered many head injured students in the past twelve years. Today I would like to share with you some of the methods I have used with some success. I am fortunate in that I have a small class, a full time teaching assistant and several volunteers who have been with me for many years. One of my volunteers is a man who is himself head injured and unable to hold a paying position. By watching him and observing his problems I have gained an insight into the problems of the children.

Before a new student comes into my class I find out as much as I can about him—age, academic and cognitive strengths and weaknesses before the accident, learning style, personal interests and hobbies, and how the accident happened. By knowing the pre-traumatic behaviours and learning styles I can determine those that have been acquired as a result of the injury and program accordingly. Problems such as lack of motivation, poor concentration or rebellion may have been there before the accident and if so they will be much worse after it.

It is also important to prepare the other students in the class, other staff members and other children in the school. They must understand that the new student may have physical, learning and social problems as a result of the accident.

Each head injured child is unique. The amount of time unconscious, time in hospital, type of child before the accident will each have an effect upon the recovery rate. If the physical recovery is good, parents expect the child to quickly return to pre-injury level. However, after the accident all of the treatment has been physical and so there is a great deal of academic ‘catching up’ to be done. I have found that the child is most comfortable when placed with children at the same academic level, even if the children are much younger. There is not the high frustration found when placed in the same age group especially when the child is aware of the fact that he could once work at the same level as those of the same age but are now unable to do so.

When a child is placed in my class, I discuss his problems with him. At first he may not accept his injuries and may not understand that he can no longer do the things he once could. HE MUST ACCEPT HIMSELF AS HE IS NOW BEFORE NEW LEARNING CAN TAKE PLACE. He must understand that pre-injury strategies may no longer be effective and that automatic behaviour responses may have changed and need to be adjusted. It is important that he must know that if he does not understand what is expected of him he may ask for help without fear of ridicule or punishment. Within a year of returning to an academic program many children recover most of the skills which had become automatic before the accident. However, recall of learned material may be ragged and variable and while single word recognition and decoding skills may be good, comprehension skills are usually far below the pre-injury level.

When a child first returns to an academic program he may have inappropriate group and social behaviour. He has been the centre of attention in the family and hospital setting and has had little opportunity for ordinary interaction with peers and adults. His behaviour may be very demanding and controlling. He must relearn how to interact appropriately with others. He may ask embarrassing questions, make personal remarks, undress in public and be easily led by other students into inappropriate behaviour.

I have found that in these instances it is best to place the student in a very small group and discuss the rules of behaviour at the beginning of each group session. I encourage the child to observe and follow the behaviour of others in the group by sitting him by me so that I can touch him as a reminder to behave and praise all progress however small. The child must be given extra time to answer questions in group discussion. The accident may have

slowed processing and speech and the child may be suffering from lack of confidence. Impulsive answers are not accepted.

The child is encouraged to take thinking time before answering a question. If the student's behaviour is disruptive of the group he is removed—not as a punishment but for a short rest and then he returns to the group and is included in all group planning sessions—parties, shopping trips, etc.

Not knowing expected behaviour, the head injured student may be unable to cope with unstructured “free time”, such as recess and lunch hour breaks. He may be verbally or physically abusive, disruptive and attempt to control play situations. It is important that his “free time” should be monitored by an adult or responsible student. I have found that a “buddy” system often works. I provide structured activities such as board games and provide guidance and suggest appropriate behaviours until the student is able to cope for himself.

Academically the head injured student is unable to concentrate, is easily distracted and is unable to keep on topic. To improve these problems I work alone with the student in a quiet corner of the room and make a small office by using a cardboard polling booth to isolate the student. Tasks are changed frequently, never more than 10 minutes on each task and I give frequent “time outs” when the student is allowed to go outside, look at classroom pets or do some exercises. If the child is physically tired he is allowed to rest for a short period of time. Gradually the time outs and rest periods are reduced; the time spent on tasks is increased and the child's desk is brought closer to the other students in the room. As most head injured students cannot work independently for any length of time responsible volunteers gradually replace me to give academic support for many tasks.

Once the child is brought into the ‘main stream’ of the classroom he often suffers from disorientation or confusion. He cannot find his way around the room, cannot find materials and may not know what is expected of him. I find it important to have a quiet uncluttered environment with a consistent arrangement of materials in the room. I label everything with words or pictures and attach a time table to the child's desk and teach him to use it. I walk through activities with the student e.g. take out math books and put away your reading book. I provide verbal clues such as “in five minutes we will start our spelling time.” I place a clock on the desk and often use a timer for a student unable to keep track of time. I encourage the other students to give help by use of a “buddy system.”

When the child is required to leave the classroom for therapy or other activities I make sure that he knows the way by taking the student myself and point out landmarks. Later another student may take my place. When I feel the child may go alone, I ask him to verbalize the directions and often give clues such as mark one hand with a magic number so that he knows to turn right by following the mark on the right hand. Head injured students are easily distracted so I obtain help from other staff members and I often use a ‘timer’ and when the bell rings the student remembers to go to his proper destination.

After an injury a child may have poor fine motor skills. He may no longer be able to use the dominant hand, formation of letters may be poor and slow. Often pointing, spacing punctuation and use of capital letters may have to be retaught. I find it best to reteach printing and then progress to creative writing skills. If printing is difficult I teach the child to use a typewriter often with a special guard. I have an easy word processor which is used on a computer with a printer. I use adapted work sheets and workbooks in which the answers can be circled or underlined. Math is done on the blackboard in combination with a calculator. Specially adapted scissors are used for cutting activities.

To relearn skills, I take the child back to a level where the child can feel a sense of achievement. I try not to use material that the child has used before. If this is impossible I cover his books with brightly coloured wallpaper. This also helps the child to find his own books. I use ungraded material so that the child cannot see the level at which

he is working simplifying the worksheets and adjusting assignments to the length of the students attention span. I find it important to be sure that the student understands what is required by limiting the amount of information presented at one time and having the student repeat all instructions verbally before beginning each task. Once the child has reached some ability to work independently I set up a verbal signal with him which I use in order to keep him "on track."

Reading comprehension is very difficult for head injured students so I do all reading orally at first and work with the student alone. He reads short passages and then discusses it. He is shown how to look for key words in a paragraph and when the complete story has been read we discuss the whole story for detailed, cause and effect etc. In order to keep his place he may have to use a marker or point with a finger when ready to do so. I place the child with other students in a small group at the same reading level but continue to read orally. When the child is ready to read silently and independently he is started at a much lower level in order to gain a sense of achievement.

Rate learning and math is very difficult for most head injured students. They are unable to use regular math books because there is too much on a page. I have them do work on the blackboard until a skill is mastered (it is easy to rub out) by making my own simplified worksheet and a sample of the skill at the top and the student is taught to use a calculator.

Once the child can work independently he is encouraged to develop strategies to help him with memory—this may be to write down lists for himself or use a small tape recorder to record a list of tasks. I find that if the child is easily discouraged with mood swings and feelings of inadequacy it is important to assure the student that he can do the work and to emphasize the progress he has made by comparing past and present work. As head injured students may work slowly I allow extra time to complete each task and use a timer and give a small reward if he is still working when it rings. I use a pre-arranged signal to keep him on track. Most important I make sure that the student asks for help when he needs it—and help is always given. To build feelings of self-worth and self-esteem, I stress the skills that the student can do well e.g. we have class spelling bees and I have him help the younger children in the class with flash cards and games.

In my class academics are alone in the mornings. In the afternoons we have a program of activities of Daily Living. The children are taught social skills and the way to behave when out in the community. They read and use recipes, shop for supplies, study the ads for bargains, learn good nutrition and the correct use of kitchen equipment. I have a kitchen in my classroom and once a week the children cook nutritious meals often using adapted equipment. Leisure skills are developed. The children have pets in the classroom and look after plants and bulbs. We have an outside garden. They play individual and group card and board games. Every Friday we go bowling at a community bowling centre. In this way the children relate their academic skills to everyday situations.

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