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THE "BRAIN INJURED" ADOLESCENT.

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WRITTEN FOR PARENTS, THIS BOOKLET DESCRIBES THE BRAIN INJURED ADOLESCENT AND THE PROBLEMS AND EXPERIENCES FACED BY THE ADOLESCENT AND HIS PARENTS. EIGHTEEN QUESTIONS ASKED BY PARENTS OF THESE CHILDREN ARE DISCUSSED. THE AREAS COVERED ARE-- (1) SOCIAL EXPERIENCES, (2) GUIDED INDEPENDENCE, (3) SOCIAL SKILLS, (4) SUCCESS EXPERIENCES, (5) LEISURE TIME ACTIVITIES, (6) FRIENDS, (7) TELEVISION, (8) DRIVING A CAR, (9) PSYCHOTHERAPY, (10) SEX PROBLEMS, (11) FANTASIES, (12) SKILL DEVELOPMENT, (13) SPEECH REPETITIONS, (14) SIBLING PROBLEMS, (15) SCHOOL SUCCESS, (16) REVERSE PSYCHOLOGY, (17) FUTURE CONSIDERATIONS, AND (18) REVEALING THE CONDITION TO THE CHILD. THIS DOCUMENT WAS PUBLISHED BY THE NEW JERSEY ASSOCIATION FOR BRAIN INJURED CHILDREN, 61 LINCOLN ST., EAST ORANGE, N.J. 07017. (RS)

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the "Brain Injured" Adolescent

Sol Gordon, Ph.D.

THE
"BRAIN INJURED" ADOLESCENT

Dedicated to the many parents of brain injured children I have known over the years who have taught me virtually all I know about brain injured children.

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For the average child, adolescence is a rehearsal for adulthood. It is a time for striving and seeking...a time for testing the accumulated experiences of the formative years. Physical changes are accompanied by new and often disturbing inner promptings. The phantasy life is enriched by new perceptions. It is not easy, this business of growing-up, especially when the needs of the adolescent conflict with established social patterns. During this period of growing pains and flux, the familiar roles of child and parent require re-evaluation.

For the brain injured child, the ordinary problems of growing-up are multiplied. Because of his situation he often lacks the most basic social skills necessary to survival in a modern teen-age culture. His difficulties are reinforced by his own inferiority feelings and by the anxiety and guilt feelings of his parents..feelings that are sometimes overtly manifested on the one hand by over-indulgence or on the other hand by unrealistic demands.

Until recently, the problems faced by youngsters growing-up with brain injuries have been given little attention by professional practitioners, probably because the nature of the handicap is so varied and pervasive that it becomes almost impossible to generalize. My own experience both in a clinical and private practice has led me to believe that parents are capable of providing the brain injured adolescent with a meaningful "rehearsal for adulthood" when they are properly informed and provided with direction and guidance.

When we consider the concept of "brain injury" we usually think of cerebral palsy, mental retardation, epilepsy, and finally a category of behavior characterized by errors in perception, errors in judgment and learning problems. It is this latter group.. ..often given several different "labels"...minimal cerebral dys - function, neurologically impaired, children with learning disabilities...which is the area of our immediate concern. The label that we shall use in this article is "brain injury" although few are satisfied with this term. Perhaps a better way to describe or diagnose children would be in terms of learning disabilities; but how shall we diagnose those brain injured children who do not have learning problems? Often a school board regulation or a state law forces us to use a "label" in order to secure the special help that is needed. At best the problems of diagnosis is not simple. Some children exhibit all the behavioral characteristics of the "typical" brain injured child but reveal no apparent neurological "signs". Some children with clear, observable and even massive brain damage function without intellectual deficits. In any case a team approach to diagnosis is essential. A neurological evaluation alone is rarely sufficient. But in spite of the difficulty in establishing a diagnosis and until such time as educators, legislators, physicians, psychologists, optometrists and the like agree to a term, parents must find immediate solutions to the problems of educating their children.

The growth and development of adolescents has been of particular concern during the last several decades. In order that we may better understand the problem of the brain injured adolescent, we need to briefly discuss the sequential development of his handicap. We have learned that within certain age limits, children will walk, talk, perform certain motor tasks, and develop the skills to think critically and abstractly. The brain injured child deviates from this established pattern. Because of his handicap, his original potential may be altered. Although he grows physically like other children, and his emotional needs are the same, he has difficulty in relating to his environment. His attempts to cope with his inadequacy often are seen by others as maladaptive behavior or mental retardation. The brain injured child tends to have a stormy school career. He tends to be hyperactive, has trouble keeping his mind on his work, has difficulty in making friends, and often cannot "learn". For him, childhood is at best a prolonged and frustrating experience.

We know it is difficult to express the despair often suffered by the parents of the brain injured child. Initially, they face the frustration of trying to arrive at an explanation for their child's behavior. I need not detail the self-searching, and feelings of guilt experienced by parents when their children appear, often inexplicable, other than normal. It is particularly confusing to parents that professional workers are often unable to agree on a diagnosis, let alone a course of treatment. Articles appear calling attention to the "myth" of brain injury. Often, parents of brain injured children find themselves in the ludicrous position of having to explain the idea of "brain injury" to physicians, psychologists and teachers. Even when the child is fully diagnosed, the course of treatment is rarely defined, nor are treatment centers available. It is only recently that schools have established special classes* for brain injured children at the elementary levels. Parents of adolescents have had to "go it alone". But the picture is not entirely bleak. Some professionals have taken an active interest in this field and have begun to develop a wide range of research and training programs. I have been particularly impressed with the work done by some optometrists exploring the relationship of perception to learning problems.

By the time the brain injured child reaches adolescence, his early maladaptive behavior has been modified. For the most part, the child appears less aggressive, less restless, less given to mood shifts. He appears more easily managed. If he attends a public school, the demands for blanket conformity have softened with his advance through the grades. The child is still demanding, still unaware of his impact upon others, still unable to exercise the social judgment that would cushion his collisions with other children. A few are doing well in school but most are experiencing serious learning problems. He may have friends or he may be an "isolate". He probably still is a source of irritation to his brothers and sisters...and to his parents.

Physically, he is probably poorly coordinated although a few may be pretty good at sports. He probably has good command of gross muscle movements but poor command of fine muscle movements. In many ways he has learned to "compensate" for his handicap. His defenses have colored his personality. It is impossible to create a classic case since each child differs in the extent and nature of specific symptoms.

But it is not really necessary to create a "classic case" in order to understand the dilemma of brain injury. As Lewis, et al, have

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* Parents have encountered increasing opposition to special classes from educators who have not understood the problems of the brain-injured. Parents must make it absolutely clear that their demands for special classes are educationally sound. Many brain-injured children do not learn or function satisfactorily in regular classes but do learn in special classes. Of course, any handicapped child...brain injured or otherwise...who can learn and profit from a regular class should remain there. Indeed, special classes should be developed in order to prepare most of their children to return to regular classes. While it is educationally unsound, even directly harmful to group mentally retarded children with the "brain injured", some educators (and I among them) believe that educative procedures used with brain injured children appear to offer equal advantage to hyperactive, emotionally disturbed children.

stated in THE OTHER CHILD, this youngster is a "normal child who has acquired a handicap which has caused him to develop and respond to the environment in other than normal way". Typically, the brain injured child and adolescent exhibit areas of intellectual competence or adequacy coexisting with areas of incompetence or retardation. This is in sharp contrast to the mentally retarded child who is not "adequate" or "average" in any area of intellectual functioning.

What are the "other than normal" responses of the brain injured adolescent? What areas of incompetence distinguish him from his peers? To what extent are we able to effect remedial measures? It is important to emphasize that because of a limited ability to generalize, the brain injured adolescent has difficulty in coping with new experiences. He perceives things differently than other children, and is easily panicked into paralysis by threats from an environment which he does not understand. His lack of success in the past has created for him additional emotional problems. It cannot be taken for granted that the brain-injured adolescent will understand and follow ordinary directions. Each task the adolescent is asked to perform must be broken into component parts. Each step must be learned in detail and practiced until the many parts fall into place. In general, the "watch me do it" approach is ineffective. Learning by experiencing, guiding, directing, touching gives better results. Our work with the brain-injured adolescent is again complicated by his difficulty in drawing upon past experiences. Because of that, he often appears stupid or inadequate. Many brain injured children are found in classes with mentally retarded. Some are inappropriately classified as mentally ill.

A handicap of the nature I have described can be devastating for the adolescent. He tends to be shunned by other children who are at a stage where they are quite concerned about having the "right" friends. He is unable to fathom accurately the nature of his difficulty, nor is he able to formulate alternate patterns of behavior. By the time he reaches junior high school, he appears withdrawn, hyper-sensitive, shallow and "odd". He has little capacity to apply himself over long periods of time. He seldom has been accepted as a member of the class "in" group. It is quite likely that he just gives up trying. A few are so frustrated that they "act out" through impulsive, irrational behavior.

Parents are in the best position to help brain injured children. In the past they have been most effective in stimulating support for special classes and programs*. While Associations for Brain Injured Children have accomplished much in the way of educating parents and calling public attention to the problem, much is yet to be accomplished. There is a pressing need for specialized diagnostic and rehabilitation centers, for residential schools, and recreation programs. Resources that are now available have been doing a fairly adequate job but frequently lack the full complement of facilities that are specifically designed for the brain injured child. Even some of our finest medical and mental health centers have failed to prove helpful to parents of brain injured children.

But the real challenges are created as parents attempt the daily task of helping the brain injured adolescent achieve a meaningful existence. Such challenges are best met by persons who are able to develop strategies and techniques that help the brain injured child advance through adolescence. To that end, I have drawn upon the questions asked me by mothers and fathers of brain injured children, and I have put together a list of practical suggestions. At best, such an approach is fragmentary, but hopefully, it is a beginning toward basic understandings.

1 SOCIAL EXPERIENCES ARE IMPORTANT. Parents should strive to organize social experiences for their children. Many of these children have trouble making and keeping friends. Parents should seek to "team" their children with other brain injured adolescents. It would be worthwhile to explore the possibility of a summer camp, clubs, or play groups. Such experiences are non-threatening, and for many children they provide the only relief from isolation. Even the first "date" can be arranged.

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* See "Helping the Brain Injured Child" by Ernest Siegel, published by the New York Association for Brain Injured Children. Recently, too, a model recreation program for brain injured children, staffed by volunteers, was initiated by the Central New Jersey Section of the N.J. Association for Brain Injured Children (co-sponsored by the Jewish Community Center of Highland Park and the Middlesex County Mental Health Clinic). Serving 40 children, the program also included group guidance sessions for parents.

2 GUIDED INDEPENDENCE IS THE KEY TO MANAGEMENT. Don't be afraid to structure the world of the brain injured adolescent. Many parents fear that they will over-protect the handicapped child. The adolescent needs "guided independence". He is often incapable of making difficult decisions without help.

3 TEACH SOCIAL SKILLS. Work at teaching brain injured adolescents "social skills". Many adolescents become isolates because they cannot cope with the simplest of social situations. They don't know how to dance. They don't know how to order from a menu. They don't know how to pay the bill or leave a tip. Parents should never take for granted that their children will learn social graces in normal interaction with friends. In my experience, I have discovered that many brain injured adolescents could neither shop in a department store nor help themselves at a self-service counter at the local grocery store. These are the skills that are taken as a matter of course for the average adolescent, but must be taught one at a time to the brain injured. If, however, a parent is in a fairly constant "struggle" with his adolescent, it is better to leave teaching "social skills" to recreational and guidance groups organized for this purpose. Even within the framework of a "group", many children will require individual instruction. Such skills as bowling and swimming should be taught in virtually "empty" alleys and pools .....shopping when the stores are not crowded, etc.

4 PROVIDE THE ADOLESCENT WITH SUCCESS. As brain-injured adolescents become more confident, they will assume more responsibility for their affairs. The adolescent may find initial satisfaction in picking out his own clothes or in shopping for small items. Parents should remember, however, that these adolescents have trouble making good decisions. They may make mistakes, or they may choose patterns of action beyond their scope. The brain injured adolescent achieves a major success when he is able to find his way around town. For some children this "skill" is a result of months of planning and guidance by the parents.

5 **LEISURE TIME ACTIVITIES.** It is important that parents of brain-injured children provide opportunities for various body-building and isometric exercises, for sports that are non-competitive, and for games and hobbies geared to the intellectual capacity of the individual. Sports such as swimming, hiking, ping pong, bowling, billiards, and bike-riding; hobbies such as collecting stamps, rocks, coins; games such as checkers, cards, even chess, are all excellent. Spectator sports are, of course, worthwhile. Encourage special interests such as: theatre, ballet, concerts, foreign films, and museums. Suggest that they read the "amusement" section of the local paper. Knitting and cooking skills are very important for girls. Boys should be taught the rudiments of preparing simple meals.

6 **CHOICE OF FRIENDS.** Are we not harming our child if he socializes only with other handicapped children? Naturally, it is better if he can make friends with "normal" children. However, social experiences with brain injured children can be a rehearsal for other relationships. Having already acquired a minimum of social skills with his own peers, the child can be more easily encouraged to enter the more competitive society of other non-brain injured children.

7 **HOW MUCH TELEVISION?** One of the dangers of indiscriminate television watching by the brain injured adolescent is that he tends to "escape". This form of escape tends to isolate him even more from the world. Although some television watching is a good thing, other substitutes should be planned during the day or evening. Reading is often difficult after a heavy day in school, but Classic Comic books and "Mad" type magazines are easy to read and amusing at the same time. Parents make a mistake when they prematurely "push" reading. Needless to say, children who enjoy reading have less problems with leisure time.

8 **ALL HE TALKS ABOUT IS A CAR.** It is a universal dream among adolescents that they own or drive a car. The brain injured ad-

olescent is no exception. If he is able to manage, driving a car is an excellent way to earn membership into the group as well as increase his sense of power and self-esteem. Parents worry, of course. In general those adolescents who are good in sports can successfully learn to drive a car. Parents should not attempt to teach their own children to drive. Let an expert from a driving school help decide whether your child can safely drive a car.

9 IS PSYCHOTHERAPY HELPFUL? In general, traditional forms of psychotherapy which deal with unconscious motivation of behavior are not helpful. Children who have difficulty handling abstract ideas are often confused by the rigors of a therapy session. Brain injured children need guidance and support. I shall never forget the adolescent who, after extensive psychotherapy, confessed, in a first interview with me, that he was ashamed that his mother still helped him with his bath. He didn't need help washing, but was afraid that he'd break the glass shampoo bottle. When I suggested a plastic bottle, his face lit up and he appeared much relieved. The years of "insight" therapy had not helped him in dealing with the everyday problems of life. It is important to note that he could not make the simple transfer from a glass bottle to a plastic bottle by himself. As distinct from insight psychotherapy, group and individual guidance programs are often helpful. Parent guidance groups are particularly helpful if the group focuses on an exchange of ideas on how parents can assist each other in coping with everyday problems in the management of their children.

10 THE QUESTION OF SEX. I have been asked many questions about the brain injured adolescent and sex. It should be remembered that whether a child is handicapped or not, the basic needs are the same for all children. Parents need only be concerned if their children are uninformed. For parents who are uncertain as to when and how to tell their children about sex, I strongly recommend.."What To Tell Your Children About Sex"..a paperback published by the Child Study Association of America. Reading

magazines like Playboy (for boys) and Seventeen (for girls) help the brighter brain injured adolescent appreciate the interests and fads of "normal" adolescents.

11 PHANTASIES ARE NORMAL. With the coming of adolescence, new and often disturbing thoughts enter the mind of the child. It is extremely important to convey to the brain injured adolescent (and indeed all adolescents) that all phantasies, thoughts, and dreams are normal. I refer to the entire range of sexual and aggressive phantasies that tend to haunt the child who is vulnerable in the first place. Parents should try to explain that thoughts and wishes of sex, death, aggressions, and hate are perfectly normal. When an adolescent feels guilty about his phantasies, he tends to become preoccupied with them. Guilt is the "force" which stimulates the repetition of "unacceptable" thoughts. If a child (handicapped or otherwise) knows that all phantasies, ideas, dreams, are normal, he tends not to become obsessively preoccupied with them. Even seriously handicapped children can appreciate the difference between thinking and doing.

12 HOW COME MY 13 YEAR OLD CANNOT TIE HIS SHOE LACES EVEN THOUGH HE CAN DO THINGS CONSIDERABLY MORE COMPLICATED? If you are certain that he has the basic requirements for the skill....then it is likely that the problem is psychological. The chances are that he was asked or forced or begged to try "it" prematurely. At this point it has become an issue (or a struggle of will...your will against his...and his always "wins"). The best approach is not to make any reference to the particular issue for six months. While it is difficult to follow this kind of advice, it is worth trying, even if only to find out why it is difficult for you to let an issue ride.

13 HOW TO COPE WITH REPETITIONS? Nothing is more irritating to parents than to be constantly "pestered" with the same question. The most patient and well-intentioned parents crack under that strain. Yet, there is a way to cope with the problem. I recall a

boy who asked me the time every few minutes. I finally made a deal with him. I promised I'd tell him the time three more times. After that, instead of answering the question, I counted the number of times he asked the same question out loud. After a few repetitions, he became aware of his problem. Patterns of perseveration may often be broken with such techniques. The objective, of course, is to make the child aware of what he is doing. When the mother "counts" instead of "exploding" she is also helping herself.

14 MY OTHER CHILDREN RESENT HIM. It is not easy to be the brother or sister of a brain injured adolescent. Mother seems to devote most of her time to him. When she's not with him, she worries about him. Many families suffer from a preoccupation with the handicap of one child. It is important to convey to the siblings that such preoccupation is both intentional and necessary. However, you appreciate the fact that this makes them angry.*

15 WHAT ARE HIS CHANCES OF SUCCESS IN SCHOOL? Some brain injured adolescents function well in a regular school situation. Others must be taught in special classes although some should be in school only part of a day or have specially arranged courses; others need home tutoring; and still others require a residential school. Parents should also be aware that perceptually handicapped children are fatigued easily by long periods of study. It is better for them to study in spurts. Some children work best with the radio on and some require absolute quiet. Parents should be guided by what works best for their child. Gym class or shop may present problems for the adolescent and the teacher should be forewarned. In general, it is better for parents not to help their brain injured child with homework if this is at all a source of irritation. Try to secure the services of an outstanding student in the high school for this purpose. Sometimes the mere presence of a parent in the room where the child is studying is sufficient. Many brain injured adolescents complete high school with a regular diploma. A considerably larger number would "complete" high school if "certificates of completion" instead of diplomas would be issued....as is the practice in some progressive schools.

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* An excellent general guide book for parents who are experiencing difficulty with their "other" children is "Between Parent and Child" by Haim G.Ginott published by the Macmillan Company in 1965. Please remember that this book is for parents who are having difficulties with their "normal" children.

16 THE FINE ART OF REVERSE PSYCHOLOGY. Brain injured adolescents are often faced with problems they are not really equipped to handle. What, for instance, should a handicapped youngster do if a sibling or another adolescent calls him "stupid"? It is important that parents anticipate such situations and plan ahead. From hard experience, I have learned that the best defense for brain injured children is "reverse psychology". To the taunt of "stupid", the brain injured adolescent might well say, "Yes, I know I am". To the taunt of "You are no good in baseball", the appropriate answer might be, "Yes, I know. But I'd like to try to get better at it". It is interesting to note how quickly children stop making offensive remarks when they get this type of response. At the same time the brain injured adolescent feels more secure about knowing how to handle threatening situations. It is clear, however, that some adolescents cannot cope with a problem in this way and they are the ones who suffer the most.

17 WHAT DOES THE FUTURE HOLD? Parents are most concerned that their child be able to secure employment, earn a living, marry and have children. It is important to recognize that a handicap in itself seldom determines whether a person will be able to function adequately. In the same way, a person without a physical handicap is not guaranteed success in life.

My own experience with brain injured adults suggests that there are many jobs where they can achieve success. The main component of success seems less the extent of brain injury and more the self-image of the individual. I know brain injured adults who are practical nurses, traffic managers, file clerks, post office employees, gas station attendents, farmers and semi-skilled factory workers. Indeed, a wide variety of office jobs such as sorting, filing, and collating, as well as service and sales occupations, are suitable. For the small group that cannot fill these occupations sheltered workshops with specialized training are available.

There is no reason why a brain injured adult who is gainfully employed cannot also marry and fulfill his obligations to his family. He or she will probably need no more "help" than is presently offered the average American couple by their "interested" parents.

18 WHAT SHOULD WE TELL OUR CHILD ABOUT HIS CONDITION?

Tell him the truth. Tell him that he is handicapped. Above all, don't tell him that he is normal like everybody else. He won't believe you. Don't praise or encourage too much. If you do, he won't have confidence in your judgment. Above all, don't say to him, "You can do the work if you try". Say to him, "I know it is hard for you to concentrate. I know that it is difficult for you to sit still". Don't give up by sending him out to "make friends" or to "get some fresh air". Don't tell him things such as"if you are nice to other children they will be nice to you". The plain fact is that your child may be "too nice" and other children mock him because of this. As regards his problem of friends, agree that "It is tough when you don't have friends",...and guide him towards achieving his goals. Of course, some children will use being brain injured as a crutch. Don't let it "throw you". To a comment of one adolescent who tried to get out of a chore because...after all he was brain injured....a wise father replied, "Don't push a good thing too far".

Tell your child that there are only two ways of responding to a handicap. One: Spend the rest of his life unhappy and feeling sorry for himself. Two: Learn to make the best of his assets and become as independent and self-sufficient as possible. Cite examples of handicapped persons...blind, palsied. etc., who have gone on to do well in life. Above all, you, his parents, must inspire confidence by your own confidence. Inspire faith by your own faith. The guilt, the despair and the pessimism will feed the child's symptoms. Confidence will promote confidence.

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