Pre-School Language Education for the Brain-Damaged Child

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It is essential that the speaker restrict his discussion in certain ways. In the first place, he does not have practical training nor experience in the academic education of the brain-damaged child and any comments made concerning this discipline would be based upon purely theoretical considerations. As a matter of fact the title of this paper should be "The Language Development of the Preschool Brain-Damaged Child," but in view of the over-all panel topic, the word "education" as inserted makes my presence more acceptable.

There are so many facets to the generic term *brain-damaged* that we sometimes spend many professional years in happy argument with colleagues (who are obviously in error in their thinking) before we realize that we are not talking about the same child, the same age level, the same damage or even the same educational levels or processes. In view of this, I would like to define the various terms I shall be using.

The children I am discussing are of preschool age and have central involvements which do not result in primary symptoms of athetosis, spasticity, ataxia or flaccidity. In other words, they are not cerebral palsied in the usual connotation of this term. It is, of course, true that these physically handicapped children may have some of the language problems with which I am concerned.

It is possible that we do not all use the term *language* with the same concepts in mind. In this paper, language will refer to all of the symbolic processes which enter into human communication; it includes facial expression, emotional outcries, gestures and words whether they are perceived or used by the children under discussion. The term *speech*, on the other hand, refers to the process of articulating words and though I am certain that speech problems of central etiology are commonly seen, I am not concerned with them in this paper.

Finally, the preschool children I wish to discuss are intellectually normal or dull normal, do not have significant sensory involvements of audition, and have given medical and/or psychometric evidence of brain-damage. Though defective audition may play a considerable role among some of of these children, I am eliminating from discussion those with losses between 500 and 2000 cps in excess of 25 db. as well as those with precipitate losses above 1000 cps. It is not apparent that we are interested in, and working with, a rather homogenous group of children and I am sure that most of you have anticipated one of the most difficult problems confronting us; the procedures needed to identify these children adequately.

Proper evaluation is, in my estimation, the first step in the training process and, in many ways, one of the most difficult. Inasmuch as we are interested in the brain-damaged, language-retarded child, the evaluative process usually starts in the home. Parents become alarmed when their children fail to use words at appropriate age levels. Their first stop is the pediatrician who then utilizes the services of the neurologist who in turn refers to the psychologist, audiologist and speech pathologist. This team provides the therapist with a delineation of the child's assets and liabilities, if the various members have done their work properly and, of course, providing each was able to conduct an examination. In addition, each member of the team conducts his habilitative-treatment function, though in many instances relying on the reports of other members when determining what to do.

LANGUAGE EDUCATION

I am concerned with the language-education process, so will devote a little time to a view of the team information as seen through the eyes of the teacher-therapist. From the medic, she wants to know the following:

1. Does the neurological report show evidence of brain damage?
2. If drug-therapy is in progress, what is the contemplated effect on the child's behaviour, i.e. should it slow him down or speed him up?
3. Are seizures to be expected or are they under drug control?
4. If EEG results are positive are they focal or general and what interpretation does the psychologist make of the pattern?
5. If there is no apparent neurological evidence of brain damage, should the teacher observe the child for a period of time and report her observations before subsequent examinations are made?

From the psychologist, the teacher-therapist wants to know:

1. The child's intellectual level.
2. His perceptual capacities — visual, auditory, tactual.
3. His social development levels,
4. If possible, some information regarding the parent-child relationships.

The audiometric results should ultimately confirm the presence of hearing within normal limits and information from the speech pathologist should report the child's language level though in many instances the language evaluation is made after observation over a period of time by the therapist. After considering all of the information given her, the teacher is ready to begin language training and though training is a group process, each child's capacities are considered and each gets some individual work as he progresses.

Socialization is the first step in therapy. By socialization I do not mean just a reduction in the behavioral problems of the brain-damaged child. On the contrary, there are many specific processes to be altered and social behaviour changes accordingly. Socialization in the sense I am using it involves alterations in the child's self-concept, development of parallel play, then cooperative play and establishment of identification with parents, teachers and other children. These changes are brought about by parent counselling, structured free play activities in which limits are gradually set up, and by providing each child with responsibilities commensurate with his age level. More specifically, these changes are effected by providing a therapy environment which minimizes previous frustrations such as a lack of oral communication, but provides recognition and builds up a sense of self-worthiness.

PARENT COUNSELING

Parent counselling is of paramount importance at this time. Because of the child's language deviation, he is often overprotected and has usually been sheltered from his peers. He has seldom had the opportunity to play with a variety of children of his own age. The result is a dependent child whose parents are still undressing him, bathing him carrying him and catering to his every need, often even at the age of five years. Paradoxically for the parents, they are usually confronted with a hyperactive, uninhibited and destructive child whose behaviour is so varied and unreasonable that it defies their understanding. Parents are faced with a situation involving on the one hand their desire to overprotect, and on the other hand a rejection of their overtures by their offspring. The result is usually emotional confusion and ambivalence which is conveyed to the child.

The teacher must also be able to accept the activities of her charges and not allow anger, frustration or impatience to appear. She must recognize that the same organic limitations which have caused the delay in language development may be responsible to some extent for the typical behaviour and inability to relate to others. By building a play environment in which the children feel accepted yet within which they are, to some extent, restricted according to the limitations set up by the therapist,

the latter has actually provided her pupils with security. They then begin to identify themselves with the teacher, parents and peers. One of the important language by-products often seen in this period of training is the ability to express emotions appropriately. Many of these children do not smile, laugh, cry or appear sad when confronted with situations appropriate to the expression of the emotion. Part of the therapy programme, then, should be devoted to the development of situations which are funny or surprising to the group, with the therapist setting the example by an appropriate response.

LANGUAGE STIMULATION

The second step in training involves language stimulation. The children are given more play situations structured by the therapist in such a manner that communication among the children becomes increasingly important. The teacher, however, must guard against formal speech training during this phase. Parents, siblings and relatives have constantly pressured these children to "say something," with a resulting frustration and finally rejection of speech by the child. De-emphasis on the act of speaking, accompanied by play situations normally requiring spontaneous communication, is imperative. At the same time the therapist must use simple language in abundance as she participates in the activities or develops the teaching situations. Tape recording a complete therapy session and then listening to it will be helpful to teachers in this part of a training programme. It is quite difficult to confine your oral activity to stimulation and example and not to try to force a speech response from a pupil. Listening to their part of the play session will reveal to teachers many of their errors.

The language stimulation aspect of training, through properly directed co-operative and competitive play, will gradually bring about the child's awareness of a need for communication. At this point gestures and pulling may turn into jargon. An occasional word used by the therapist, or one of the children in the group, will be repeated, possibly out of context with the actual play situation. Again, no attempt is made to force a repetition or to emphasize speech per se. Parent conferences on an individual and group basis should include discussions of the reasons for eliminating speech pressure, the development of a home stimulation programme that involves looking at and talking about familiar objects in the home or in suitable picture books, and considerable repetitive language during meals and other home group activities. The practice of showing off the child's new word to friends and relatives must be avoided.

The next progression in therapy is concerned with the elaboration of vocabulary and useful speech. At this time field trips to zoos, farms, and other stimulating areas should be planned. The play activity within the classroom situation should be widely varied to provide for greater language example and stimulation. During this period useful words appear and become integrated into two word sentences. For the children language becomes a means of asserting themselves. The words which appear will be misarticulated more often than not, but no correction should be made.

It is sometimes difficult at this time to keep from initiating speech therapy for articulation errors; however, the teacher will resist if she remembers that chronologically her charges may be four or five years of age, but so far as language development is concerned they now range between 16 and 20 months. From here on vocabulary development is accompanied by a school readiness programme. We frequently utilize the services of a good nursery school or kindergarten at this time by placing some of our children among normal speaking children for short periods of time each day. Finally, they are left in the new school environment, but with a speech therapist observing and conferring with the new teacher when it seems essential. Attention to articulation may accompany this phase of the programme.

The programme I have outlined functions on several premises: 1—that these children by age four are in a language readiness state; 2—that language pressures and frustrations have added a strong psychological overlay to what was basically an organic problem; 3—that direct speech therapy or training will tend to further inhibit speech and language as well as to increase emotional problems; and 4—that the emergence of language follows socialization and development of a need for communication.

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