

Case History of a Brain-Injured Child

(taken from notes on a Demonstration given at the Vacation Course on "Therapies in Cerebral Palsy" in Johannesburg, October, 1957. Reprinted with the permission of the National Council for the Care of Cripples in South Africa.)

by

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M. is a child who is not motor handicapped but who may be diagnosed as "brain-injured" on the basis of his history and symptoms. His behaviour may also be described as "autistic" (1) (2).

He is now four years eight months of age.

HISTORY: His mother is R.H. negative. She had a "blackout" during pregnancy and whooping cough in the ninth month. M. was a full term baby and weighed 6 lb. 11 oz. He held up his head at three months and sat up at seven months.

At this stage he began to make queer movements of his arms and trunk, and these were diagnosed as "fits." Initially, they occurred after mealtimes, but gradually their frequency increased. Vomiting started at about the same time, and he began losing weight.

At approximately twelve months he was hospitalised for two weeks. His condition continued to deteriorate. An E.E.G. taken at this time showed an abnormal record. An air-study "seemed to indicate slight atrophy of the frontal part of the brain." (verbal report). He was described as hyperkinetic and overactive, and frequent head-dropping was noted.

Fits and vomiting continued until he was 16 months of age. His general condition then improved and he attempted to stand.

At 20 months, the E.E.G. was repeated and again an abnormal record was found "but with considerable improvement." At this stage he was walking. He did not develop speech, took no notice of people, and was unmanageable. A third E.E.G. taken 17 months later showed "a normal record of Cortical activity for his age."

He was admitted to a School for Cerebral Palsied Children in May, 1955, at the age of two years five months.

OBSERVATIONS

BEHAVIOUR. He stood with his legs apart rocking from side to side and humming. He was extremely disorganised. He did not use objects correctly. He would for example, upset his milk and then rub it in his hair. He was hyperactive

in a purposeless destructive way. Unless all cupboard doors were locked, he would inevitably fling the contents in all directions. He stamped on toys and pushed chairs over. He appeared to be unable to control this behaviour. When his activities were limited, he became very distressed. He beat his head, threw himself on the floor and uttered short cries.

In the Nursery School he had to be watched continually and a special nanny came to school with him every day.

SOCIAL RESPONSE. He took very little notice of people and his facial expression seldom changed. He smiled only when he was pleasing himself or when he was being tickled. He never looked directly at anyone. When his attention was arrested, he stood looking with his eyes down, and his head to the side.

SPEECH. He was usually silent, but babbled a little while throwing toys. Again, he seemed to babble for his own satisfaction rather than for communication.

THE AIMS OF THERAPY, were therefore:—

- 1) To establish a relationship with him.
- 2) To decrease his disorganised activity and make him less disturbed.
- 3) To stimulate his speech production and provide him with an atmosphere in which he would want to communicate.

I shall discuss these three aspects of therapy separately, although I believe they are closely related.

TREATMENT

1) **ESTABLISHING A RELATIONSHIP WITH HIM.** The therapist tried to make him feel that somebody was warm and affectionate towards him. He was cuddled most of the time, and spoken to in a calm, reassuring voice. In a concrete way a co-operative relationship was built up by rolling a ball to him and gently making him roll it back. Similarly, the therapist would do a jigsaw puzzle and expect or aid him to pass her the pieces. He was encouraged to respond to relevant speech such as "Give it to me", "Pick it up" and "Do you want a sweet?"

2. DECREASING HIS DISORGANISED ACTIVITY AND MAKING HIM LESS DISTURBED. Limits were set regarding destruction and times for therapy. These were applied unemotionally and it was made clear that he would be punished for destructive behaviour, but that the therapist still approved of him and loved him. He learnt that one behaved differently with different materials and that whereas he could not tear books, he could scribble on paper and knock down blocks.

At first each session followed a pattern. M. knew that as soon as he came into the room he would have to sit down and perform an organised activity. After that he was allowed to play as he liked, until the therapist looked at her watch and said: "Time to go now." Using the watch may have acted as an objective factor of organised behaviour.

M. knew that he could rely on the therapist not to interfere with his play as long as he was not destructive. This trust became mutual as he gained control. He was no longer watched so carefully and the therapist showed that she *expected* certain responses. This approach was carried over to the nursery school where his teacher expected him to take his turn serving milk to the other children.

The Occupational Therapist helped him to play constructively by providing him with material which required purposeful activity, and which incidentally taught matching and discrimination of forms, sizes and colours.

3) STIMULATING SPEECH. The therapist spoke to him at every opportunity without demanding, but expecting, speech from him. All his large movements and vocalisations were imitated, so that he would begin to imitate other people. He heard words such as "open" "close" "pull" "push" "up" "down" in their relevant contexts, and he began to repeat them. The therapist vocalised rhythmically as she drew regular patterns, and again M. imitated. His mother was given an outline of therapy and was asked to continue these activities at home.

RESULTS

M. has progressed well in every way.

He now responds to people, communicates by smiling and speech, and reacts to instructions.

Socially he is becoming a real member of the nursery school group, and is beginning to take part in ring activities. He is fortunate in having understanding and well-trained nursery school teachers who are able to assess his readiness for new responsibilities. If he is occasionally destructive it is usually because he is angry, and he is able to control this reaction.

His play is organised and he concentrates for longer periods. He uses toys and different materials meaningfully. He is sufficiently organised, e.g. to turn the tap on, fill the basin with water, turn the tap off, select the relevant toys (boats, duck and fish) and sail them.

At first he tended to repeat the same activity over and over again. As he progressed he not only chose different play materials, but used the same materials in different ways.

On the emotional side, his facial expression now reflects joy, anger, recognition, mischief and so on.

He uses speech to express his needs and to communicate. He shows interest in naming objects and his vocabulary is growing. He is beginning to look through picture books. He says three word sentences like "look a pic" (Look at the picture) and "I wa a tic" (I want a stick). He enjoys meaningful sounds and repeats immediately that the car says "r-r-r" and the scissors "cut".

As far as psychological assessment is concerned, this has always been difficult because of his behaviour disorder. The psychologist's report on a test given four months ago, was as follows: "M. has improved but it is still not possible to make an accurate assessment of his mental ability as he is too distractible and only able to concentrate for ten minutes at a time." He did, however, pass the Sequin Formboard and the Wallin Peg-board tests at the 36-41 months level, and he was able to correct his errors.

SUMMARY

In summary, I have described a child with history of probable brain damage. He had symptoms of disorganisation, temper tantrums, disturbance in social contact, destructibility, hyperactivity, lack of concentration and possible perseveration. Some of these symptoms may be associated with a diagnosis of autism.

He is at a combined school and treatment centre and is making excellent progress. It will be some time before he is ready for formal school work, and it remains to be seen whether he will have special learning difficulties.

REFERENCES:

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- (2) Kanner, Lee: "The Conception of Wholes and Parts in Early Infantile Autism." *Am. J. Journal of Psychiatry*, July 1951. Vol. 108.