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SOCIAL/EMOTIONAL ISSUES

Tutorial: Sense of Self/Personal Identity

WHAT IS SENSE OF SELF?

Everybody has a sense of self or sense of personal identity. In fact most people have a number of important ways of thinking about themselves that are significant enough to be considered multiple senses of self. Our sense of self includes those roles, attributes, behaviors, and associations that we consider most important about ourselves. These sense-of-self associations can be based on any combination of the following

1. Occupations (e.g., teacher, physician, plumber)
2. Social relationships (e.g., husband/wife, friend, colleague)
3. Familial relationships (e.g., brother/sister; son/daughter; mother/father)
4. Quasi-occupations (e.g., helper, volunteer)
5. Avocations (e.g., athlete, musician, artist, collector, helper, volunteer)
6. Affiliations (e.g., Shriner, Yankee fan)
7. Abilities/disabilities (e.g., smart person, funny person, shy person with a disability, “patient”)
8. Salient attributes (e.g., reliable, hard working, good looking, lazy, dishonest)
9. Spirituality (e.g., child of God, Catholic, Buddhist)

Self-identities, especially those of young people, are dynamic or in flux. Children as young as four years old have a sense of self that is based on some salient attributes that the child considers important and is maintained over time, for example, “I am the strongest or fastest boy in my class” or “I am smart; I figure things out easily” or “I am good at helping people.”. Identities are often imposed or at least encouraged by environmental or cultural forces. For example, if a child is routinely told, “You are really smart” the likelihood is increased that intelligence will figure prominently in the child’s sense of identity. In contrast, when a child routinely hears, “You can’t do anything right”, then incompetence is likely to be central to his sense of self.

Children acquire their sense of self and self-esteem slowly as they mature into adolescents. Furthermore, children do not always feel good about themselves or their behaviors in every situation. Identities are developed over time and may change from time to time and place to place. For example, a child may feel self-confident and accepted at home but not around the neighborhood or in a preschool class. Furthermore, as children interact with their peers or learn to function in school or some other place, they may feel accepted and liked one moment and alienated the next. Emotional stability and acceptance at home and among school staff are important during these times.

Identities are generally “housed” as metaphoric, gut-level meanings rather than literal meanings. For example, an adolescent might think of himself metaphorically as a “Michael Jordan kind of guy” who works hard and achieves at high levels. Alternatively the student might think of himself as a tough guy, a “Take-no-prisoners Hulk Hogan kind of guy”. Furthermore, our sense of self is not judged to be true or false, but rather comfortable or uncomfortable, inspiring or uninspiring, admirable or not admirable. Identities that are culturally valued – associated with competence, status, success, talent, interest, and the like – are more likely to be sustained and nurtured as self-defining identities as children mature into adulthood.

Identities contribute to intrinsic motivation. For example, an adolescent who considers herself a good athlete – a “Mia Hamm kind of person” – will not need artificial motivators to exercise intensely and practice her sport several hours per week. Effort and practice go with being a Mia Hamm kind of person. Similarly, individuals who tie their identity to religious beliefs and religious role models will not need

extrinsic motivation to extend themselves by helping others. Helping others simply goes with being the kind of person they take themselves to be. Students whose identity includes intelligence and academic success will not need a promise of rewards, like money, in order to study hard; rather, they study just because “that’s the kind of person I am; that’s me; I’m a conscientious student – and I know I need to study to do well!” Even hard work can be easy and satisfying if it flows from a person’s sense of “who I am.”

“Construction of identity” is rarely a deliberate, self-conscious process. Students do not set about to create a sense of self as a good student or good athlete or good friend. Rather they simply find themselves over time thinking and feeling about themselves in certain ways. Early in life, sense of self is associated with the security, protection, and acceptance that infants, toddlers, and preschoolers feel when effectively cared for by adults to whom they feel an attachment. By the late preschool years and early school years, sense of self comes to be additionally associated – positively or negatively – with attributes that parents value and model for their children in the way they live their lives. Over the school years, peer values and peer pressure come to play an increasingly influential role in how older children and young adolescents think about themselves. “Cliques” – the “in crowd” versus the “out crowd” – become important components of identity. Identities that have been strongly developed prior to these years often protect against the developmental difficulties associated with these years.

Sense-of-self identification is often associated with physical attributes (e.g., physical attractiveness), physical prowess (e.g., athletic accomplishments), or physical possessions during the elementary and middle school years. By late adolescence, mature students are moving beyond peer pressure, group norms, and predominately physical associations, and come to think about the sort of person they want to be, based on their most deeply held values. With this may come an increasing comfort in being “different” from peers and possibly an increasing need to take risks.

WHY IS SENSE OF SELF IMPORTANT FOR MANY STUDENTS AFTER TBI?

One of the most devastating consequences of acquired brain injury is the challenge it poses to the student’s sense of personal identity. Students who previously staked their sense of self on academic success, athletic abilities, helpfulness, popularity, or physical ability and attractiveness may find the basis for their sense of self to be gone. Academic pursuits may be difficult; sports may be ruled out by physical disability; the student who was a helper may now only be a helpee; friends may depart; and physical attractiveness may be affected by scars or other consequences of the injury.

Changes to sense-of-self as a consequence of the brain injury typically take several different forms and may evolve during the early months and years post injury. The duration of time a student struggles with altered sense of identity will depend on the severity of the injury, the age of the student at the time of injury, and the structured support available from family and teachers to help the student adjust to realistic changes in their functioning. Changes in self-identify are more pronounced in those children injured during middle to late adolescence when they have already acquired a preliminary sense of self. Children injured early in life often do not present the same challenges to self-identity since they were too young at the time of initial injury to have developed a settled sense of self.

Types of altered self-awareness after TBI and possible stages of adjustment are summarized below:

Unawareness: Unawareness of disability is often a direct consequence of the injury. It is a neurologic condition associated with either bilateral frontal lobe injury or deep right hemisphere injury. This unawareness is not a psychological denial (i.e., a condition in which the student resists coming to grips with the consequences of the injury) but rather a genuine inability to grasp the consequences of the brain injury itself, because the part of the brain that enables us to perceive our strengths and weaknesses is damaged. Neurologically-based unawareness (sometimes referred to as “anosagnosia”) is seen on a continuum in students with severe injuries (i.e, comes in degrees), like all neurological conditions. In extreme cases, the student may initially believe that he has no disability – even in the presence of profound physical, sensory, and cognitive limitations. In such cases, no amount of talking about disability or demonstrating real

limitations will convince the student that he is disabled. As time post injury continues and feedback about real changes is provided, students gradually become aware of select limitations (e.g., physical limitations), with awareness of cognitive and behavioral/emotional limitations typically emerging later in the course of recovery. In less extreme cases, counseling and other awareness interventions may be options [See Tutorial on Self-Awareness]

Denial: Denial of disability is frequently observed, with the student actively resisting acceptance of the reality of persisting disability and all of its consequences. Some degree of denial or reduced awareness is healthy initially after the injury, because it serves to maintain hope and prevent the student from falling into a deep depression. Some degree of low awareness or denial may be an essential correlate of hope, which is necessary for maximizing functioning after a brain injury. Denial can be combined with unawareness; often organically-based unawareness gradually gives way to denial and then to a growing acceptance of real disabilities and the need for compensatory interventions. This evolution may require several months or even years after the injury.

Perplexity: Perplexity is a state of confusion that many students experience about their actual versus assumed abilities and disabilities after TBI, and their implications for everyday functioning. Students who are confused or perplexed are not actively denying their disability, but may alternate between a more optimistic and a more pessimistic view of their long-term abilities and their future.

Depression and Learned Helplessness: Depression is an understandable and common consequence of acquired brain injury in both children and adults. Depression is associated with feelings of sadness, hopelessness, worthlessness, and despair; possible loss of interest and motivation, leading to social withdrawal; fatigue and loss of energy; and possible changes in eating and sleeping patterns. Younger children may reveal their depression as excessive irritability, agitation, and aggressiveness. Depression is importantly connected with sense of self because depressed people typically feel out of control, unable to positively influence important outcomes in their life. Depression may be associated with a “sick role” – that is, “I am a patient, I cannot help myself, I am in the care of others and have no control over my destiny”. [See Tutorial on Depression]

Defiance: As awareness of real disabilities begins to emerge, some students with brain injury react angrily and defiantly to the changes in their lives. They may refuse to accept restrictions on their activities and react angrily to any person who attempts to impose restrictions. It is at this point that supportive counseling may be most effective in helping the student move from anger to gradual acceptances of changes in functioning.

Awareness Combined with Resolve/Determination: The ideal long-term goal is to have students with brain injury increase their understanding of and adjustment to the disability, combined with an optimistic determination to be as successful as possible with the abilities that remain after the injury. Even in mature adolescents, it is likely that this state of adjustment and resolve can be achieved only after at least a year or two of emotional struggles. [See Tutorial on Self-Awareness]

WHAT ARE THE MAIN THEMES IN INTERVENTION AND SUPPORT FOR STUDENTS WITH ALTERED OR PROBLEMATIC SENSE OF SELF AFTER TBI?

Altered sense of self is viewed as a typical process in adjustment to brain injury, rather than a psychiatric problem or maladjustment. At times, disorders associated with an altered sense of self can result in the student becoming significantly depressed or anxious. In these situations, (e.g., depression, anxiety disorder), a consultation with an appropriately trained and credentialed professional is indicated.

An important theme in sense-of-self intervention is that it is impossible to avoid contributing to the student’s evolving sense of self. Whether educators are critical of the student, appropriately respectful and reinforcing, overly reinforcing, neutral, supportive, or unsupportive, they have an impact on how that

student comes to formulate a new self-image. Every interaction with students with a disability – successful or unsuccessful, positive or negative – contributes in one way or another to that student’s sense of self. With this as background, it is logical that staff and family should combine forces to organize their approach to the student’s evolving sense of self. The following concepts and procedures are germane to helping a student develop a “new” and positive sense of self. The list can be used as a checklist to ensure that staff and family are doing what they can and should do to help the student with brain injury.

Procedures for Contributing to the Construction of a Positive and Productive Sense of Self:

1. Acceptance and Respect: For very young children, acceptance, emotional attachment, and ongoing nurturing are the primary basis for a positive sense of self. However, acceptance and respect from relevant adults remain strong contributors to a student’s sense of personal identity at all ages. Acceptance and respect are equally important from family, school staff, and peers.

Respect is communicated, among other ways, by expressing genuine interest in the thoughts, interests, and activities of the student and by holding her to reasonably high standards of behavior and academic performance (with sufficient support available to meet those standards). The key point is not to simply react to the student’s performance (e.g., with grades), but rather to communicate to the student that she is capable of reasonably high quality work – and then to provide the supports needed to enable performance at that level.

2. Success With Meaningful Tasks: For school-age children and adults, a positive sense of self and self-esteem are derived ultimately from meaningful achievements. It is sometimes said that self-esteem is a product of motivational talk or other forms of self-talk therapy, which then results in higher levels of achievement. However, most research suggests that the causal relationship goes in the opposite direction – engagement in meaningful activities and some type of meaningful achievement are the basis for building a positive self-concept and self-esteem, rather than simply relying on self-talk approaches.

This poses a dilemma for many students with brain injury who evaluate their accomplishments based on pre-injury criteria, rather than current abilities – and therefore routinely find themselves falling short, based on those criteria. Parents and educators must therefore be creative in identifying activities and tasks in which the student can experience meaningful success and ideally a sense of contribution. With some students with more severe injuries, it is possible to capitalize on their disability and injury history in achieving this goal. That is, the student can build a sense of self by helping others understand TBI, by providing information based on their experience, or participating in school projects for which their injury history gives them unique knowledge and insight. In other situations, collaborative supported engagement in meaningful project-oriented work at school or at home can create a basis for a sense of accomplishment and associated elevation of sense of self.

3. Association of Positive Role Models and Sense-of-Self Metaphors With Successful Task Completion: Many studies have shown that when people are reminded of some strongly valued or heroic persons prior to beginning a difficult task, they throw more effort into the task and achieve at higher levels than if they had not had the positive association before beginning the task. The heroic identification provides inspiration, motivation, and energy. This is the psychological reality underlying the common practice of wearing a bracelet inscribed with an inspirational religious slogan or reminder of a religious leader. The underlying idea is that the person wants to be like a religious leader, a hero, or perhaps a parent; therefore, when the person has that positive role model or image in mind, she will try harder and succeed at a higher level. That is, “I can be a _____ kind of guy or girl”, where the blank is filled in with some personally meaningful and positive hero or other metaphor.

These ideas form the basis for an important way to help students who are confused, disorganized, or otherwise uncertain about their altered sense of self. Somebody who knows the student well can, collaboratively with the student, identify a heroic person or other inspirational image (e.g., a powerful animal identification) that then can be systematically associated with hard work and successful performance. For example, a student with anger control problems who admires Clint Eastwood can be

reminded, “When you’re being a Clint Eastwood kind of guy, you don’t lose control, but rather react in a calm and composed way.” When this association becomes strong, the student will associate power – and an attractive sense of self – with reserved, thoughtful responses rather than out-of-control angry responses.

Children as young as toddlers can benefit from such heroic associations. For example, young boys being potty trained often find inspiration when told, “You can be just like daddy; you can go in the potty chair; you’re such a big boy.” Thus there are few cognitive building blocks for generating improved sense of self and elevated performance by creating positive associations of this sort.

4. Honest Feedback Associated with Sense of Self: Most students are able to distinguish between empty praise, on the one hand, and genuinely respectful and honest appreciation and feedback on the other. When a child hears, “Great job!” over and over, but knows that the outcomes were not good at all, the likelihood is that the net effect will be opposite from that intended by the praise. At best, the empty flattery is a short term distraction. Worse, the student may think, “That was lousy work I did. If my teacher is telling me that this is great, she must think that I am totally incompetent.”

Rather, teachers and parents should present feedback and praise that are honest and respectful – and therefore more likely to contribute to a positive sense of self. Here is an example: “You really worked hard on this; that’s terrific. I think this part turned out very well because.....; I think you’ll agree that this part needs more work. When you work hard [like your hero], you do fine work.”

5. Feedback Focused on Appreciation, Interest, and Respect, Not Just Praise: Students tend to develop a mature sense of self when adults express genuine interest in the student’s interests and thoughts, and provide honest feedback rather than focusing exclusively on praise. When students know that their interests, thoughts, and behaviors are taken seriously by people they respect, they develop a sense that they are real people, not just students who follow instructions and produce required work.

Parents should look for opportunities to express interest in and work with students on their school projects. Parents can also invite the student to participate with them in their activities and projects. Family discussion times as well as discussion times at school are ideal times for such expressions of appreciation, interest, and respect. At school, students can take their turn as teacher’s helper, group leader, or other contributor role. Even oppositional students tend to feel respected when asked to play a leadership role.

6. Genuinely Challenging and Meaningful Tasks: Many students with significant brain injury return to school at academic levels lower than they held prior to their injury. Or they may return to school at the same grade level but have a modified curriculum. Children injured at an early age may lose academic ground as they age, resulting in a need for additional services and modified curriculum that presents tasks that may appear to the student to be at an immature level. Thus even though a student succeeds with these academic tasks, there may be no inherent sense of satisfaction – no affirmation of self – because the student does not believe that the tasks are at an appropriate level for a person of his age and ability.

Therefore, staff must be creative in presenting work that is appropriate for the student’s current level of ability while also appearing to be relevant to her age and sense of self. At home, the student can be given meaningful responsibilities, like caring for pets, that create a sense of meaningful contribution while also adding organization and responsibilities to the daily routine.

7. Opportunities for Meaningful Peer interaction: Students with disability after brain injury may see friends fall by the wayside because the disability blocks meaningful participation in activities valued by the friends. This common phenomenon contributes to the student’s downward emotional spiral and threatens an already vulnerable sense of self.

At school, staff can try to organize peer support systems, friendship circles, or even school clubs as contexts for ongoing peer social interaction. At home, parents can invite other children to the house, making sure that there are enticing games and activities that are within the ability levels of all of the students, so that time spent with the other students or family members is fun and rewarding.

8. Coping With Defeats: Defeats and associated emotional crises are part of growing up for all children. Defeats are more common for students with disability, particularly if their standards of success and failure are based on their pre-injury accomplishments. Experiences of academic or social failure threaten the child's already weakened sense of self.

Parents can help the student by making clear that their love and support remain unchanged. When the crisis has passed, parents and teachers alike can reflect with the student about what contributed to the problem and how problems of that sort might be avoided in the future. Denying the reality of the child's perceived problems is of no help and is likely to reduce self-confidence rather than bolstering it.

Tutorial: Social Competence

(See also Tutorial on [Friendship and Peer Acceptance](#))

WHAT IS SOCIAL COMPETENCE (SOCIAL SKILLS)?

For students with and without identified disability, the ability to interact successfully with peers and adults may be the most important aspect of development in relation to outcome as an adult. Socially competent individuals generally have the following attributes: (1) They have knowledge of social rules, roles, and routines that apply in social situations that are personally relevant (e.g., school, home, recreational areas, social gatherings). (2) They interpret others' behavior and "read" others' emotional states in a generally accurate manner. (3) They react to others' emotional states and behavior in an emotionally consistent manner (empathy). (4) They want to act (i.e., intentions) and are disposed to act (i.e., habits) in a way that is generally consistent with their knowledge of social rules, roles, and routines, and with their "readings" of others and their needs. (5) They have the confidence needed to interact socially and accept the vulnerability associated with potential rejection. (6) They generally do act in a socially competent manner. The important outcomes of social competence are acceptance within relevant peer groups and friendships.

We use the term "social competence" rather than the more commonly used term "social skills" because the term "skills" often suggests that practice of certain socially positive behaviors is all that a person needs to be socially successful – to be accepted in relevant social groups and to have friends. "Skills" in this sense are certainly NOT all that is required for a person to be socially competent and have friends. For example, a person may possess the skills (behaviors), but not use them or not use them on the right occasions. Alternatively, a person may possess the skills (behaviors), but lack the ability to "read" others, correctly interpret social realities, or react in an emotionally appropriate manner, thus failing to act in a socially successful way. Similarly, a person may possess the skills (behaviors), but lack the confidence needed to enter the social "playing field" and play the social game. Finally, a person may possess the skills (behaviors), but simply not be interested in acceptance by peers or having friends.

In addition, the specific skills or behaviors associated with social competence vary from one social context to another and from one social group to another. For example, the social behaviors observed in the science club at school tend to be quite different from those observed in groups of skate boarders on the street. To be sure, there is a central set of social skills needed to be successful in school (e.g., specific interactive competencies with teachers, specific classroom behaviors, and the like) and these skills may need to be taught. However, success with friends and within peer groups varies with the values and expectations of the relevant individuals.

Social competence includes, but is not restricted to effective social communication. Non-communication components include dressing and hygiene, competence with activities that are popular within relevant social groups (e.g., video games, sports, dancing, and the like), transportation to relevant social gatherings, impulse control, cognitive skills such as effective social problem solving, reading of nonverbal cues, and the like. However, communication skills are critical. For example, the best predictors of social acceptance in the early grades are the ability to (1) enter into (ongoing) interaction (i.e., initiate), (2) maintain social interaction, and (3) resolve conflicts. As a child ages into later childhood and adolescence, other social "plays" become important, including joking, teasing and receiving teasing, complementing and receiving complements, arguing assertively but not aggressively, maintaining conversation about topics popular in relevant social groups, and the like. Although these social challenges are not necessarily negotiated with language, they usually are. Thus language and, more broadly, communication skills are critical to social competence.

WHY IS SOCIAL COMPETENCE IMPORTANT FOR MANY STUDENTS AFTER TBI?

Social competence is important for all students because it strongly influences peer acceptance and friendship, which in turn influence school success and adult outcomes. Students with brain injury often

have newly acquired social re-integration problems. These challenges may result from poor general impulse control associated with damage to the under sides of the frontal lobes of the brain. Impulsive students talk out of turn, say things that may be offensive or embarrassing, make sexually inappropriate comments, and the like. Alternatively, students with brain injury may lack initiation and seem socially unengaged (also a frontal lobe problem) – and therefore be left out by other students. Other students may have difficulty correctly “reading” and interpreting social situations, non-verbal cues, and other behaviors of their communication partners (also related to front parts of the brain), resulting in socially awkward responses.

In each of these cases, friendship and peer acceptance are threatened. Unfortunately it is common for students with acquired brain injury to lose the friends they had before the injury and to have a hard time acquiring new friends. Thus, attention to this important domain is critical to the development of social competence after TBI.

WHAT ARE THE MAIN THEMES IN INSTRUCTION AND SUPPORT FOR STUDENTS WHO HAVE REDUCED SOCIAL COMPETENCE? (See also Tutorial on [Friendship and Peer Acceptance](#))

What NOT To Do: Traditionally, social skills training has included the following components: (1) An existing curriculum is used that targets skill components that may or may not be important for the student in question; (2) Skills are taught in the context of social skills groups and in a training setting, such as a classroom or clinic room; (3) The following procedures are commonly used: scripting, modeling, role playing, prompting, cuing, reinforcing. If the training is successful, the outcome is acquisition of declarative knowledge (“This is what I should do in this situation”) and procedural knowledge (“This is how I do it”) of specific social behaviors or skills. These approaches have a poor track record in the research literature, with most populations of students who have been taught with these approaches gaining little of practical value from this type of training.

The declarative and procedural knowledge trained in traditional social skills groups is often already possessed by students with acquired brain injury. Their problem is actually USING their knowledge when they act – acting on what they know – rather than lack of knowledge. Furthermore, they tend to have difficulty generalizing from the setting in which they acquire a skill to the settings and contexts in which they need to implement the skill. As a result, it is reasonable to conclude that traditional out-of-real-social-context social skills training would be even less effective for students who retain pretraumatically acquired declarative and procedural knowledge of social rules, roles, and routines, but have difficulty applying that knowledge without support in social situations.

What To Do: The following components of intervention and support are particularly important for children and adolescents with social interaction difficulties after brain injury:

1. Competent Social Partners: Critical to social success is having knowledgeable, understanding, and competent communication partners who therefore do not misinterpret and react punitively to neurologically based awkward behaviors that result from impulsiveness, failure to initiate, misreading of social cues, anxiety, and the like. Therefore, education and training for everyday communication partners, including peers, family members, and school staff, may be critical to social success.

2. Selection of Socially Important Skills: It is important for the student to practice and be coached on those specific and personally important skills that make a difference in real social contexts.

3. Scripting: When students have significant problems with social interaction, it may be useful to create specific scripts for specific situations. These scripts should be negotiated so that the student is adequately comfortable with the script. The interactive script can then be videotaped for the student to view repeatedly as part of a process of making the script automatic. For students with an interest in sports, these scripts can be called “plays” and viewing them can be labeled, “watching the game films to learn the plays.”

4. Context-Sensitive Practice: Students may need extensive practice of social behaviors in the specific situations in which they are required, with satisfying natural and logical consequences for successful performance. A natural and logical consequence for effective social behavior is, for example, maintenance of a satisfying social interaction, not a sticker, praise from a teacher, or other consequence not logically related to the social behavior.

5. Situational Coaching: Situational coaching in real social situations includes advance cues (presetting) prior to potentially problematic interactions.

6. Training in Social Perception: Students with brain injury often need focused situational training specifically designed to improve their social perception and the ability to interpret – to “read” – the behavior of others. In cases of extreme social perception impairment, the student may need to be trained to say things like, “Let me be sure I’m understanding you correctly.”

7. Training in Self-Monitoring: Students with brain injury often need situational training focused on improving self-monitoring of stress levels. These students may need to gain confidence and comfort in removing themselves from stressful situations as needed.

8. G-O-P-D-R Orientation: Staff and family should apply the general Goal-Obstacle-Plan-Do-Review format to social interaction so that the students understand that the goal is their social success, not “social appropriateness” understood abstractly as some authority figure’s goal. **[See Tutorial on Self-Regulation Routines]**

9. Counseling: Some students with brain injury may benefit from counseling specifically designed to help them develop a personally compelling sense of self that includes positive social interaction as a component.

To overcome the resistance that many students with TBI experience when faced with this effort, we often frame their relearning process as a “Project” that will result in insights and perhaps in a product that can help other students. Thus, the student with brain injury is engaged as a collaborator in a helping project, while at the same time addressing social issues of personal concern.

Written by Mark Ylvisaker, Ph.D. with the assistance of Mary Hibbard, Ph.D. and Timothy Feeney, Ph.D.

Tutorial: Social Perception

(See also Tutorials on [Social Competence](#); [Friendship and Peer Acceptance](#))

WHAT IS SOCIAL PERCEPTION?

Being competent in social perception includes three domains of competence: (1) knowing that other people have thoughts, beliefs, emotions, intentions, desires, and the like, (2) being able to “read” other people’s inner states based on their words, behavior, facial expression and the like, and (3) adjusting one’s actions based on those “readings”. That is, a socially competent person can make note of other people’s facial expressions, tone of voice, posture, gestures, words, and the like, and on the basis of these clues, make reasonably accurate judgments about that person’s state of mind, emotions, and intentions. Socially competent people then use these inferences about other people’s inner states to make good decisions about how to behave socially.

Social perception is one important component of social competence and social success (including peer acceptance and friendship). In addition to social perception, socially competent people must have knowledge of social rules, roles, routines, and scripts in their social lives. Furthermore, they must make use of this knowledge and of these scripts in their decision making and acting. They also have a concern for other people and make it a habit to adjust their behavior based on the needs of others. Finally, they have the confidence needed to interact socially and accept the vulnerability associated with potential rejection.

WHY IS SOCIAL PERCEPTION IMPORTANT FOR MANY STUDENTS AFTER TBI?

The ability to “read” other people’s inner states accurately relies on specific neurological circuits in the frontal lobes and limbic system of the brain. Studies suggest that the right hemisphere frontal lobe is more involved than the left. Thus when one sees in neurological or neuropsychological reports that the frontal lobes – particularly the right frontal lobe – were injured, one should suspect some difficulty with social perception.

Furthermore, social perception may not be specifically impaired, but weak nonetheless because of the many cues that need to be processed in order to “read” social situations accurately. Many people with brain injury have restrictions on how much information they can process at any one time. Thus if they are focusing on the content of the other person’s message, they may not be able to attend to nonverbal cues, like facial expression or tone of voice. They may not be able to integrate other context information. Misinterpretations and “misreadings” may be the consequence.

Another source of “misreadings” is impulsiveness. A student who is generally impulsive may leap to quick conclusions about others’ intentions, emotions, beliefs, and the like, and therefore not take into account all of the relevant evidence. Impulsive judgments about others are likely to be mistaken.

Furthermore, if students with brain injury are depressed or anxious, they may routinely “misread” others’ intentions in specific ways. For example, depressed students may routinely believe that other students are criticizing or ridiculing them, when in fact they are not. Anxious students may routinely believe that others are criticizing them when in fact they are not. Most people have a tendency to explain others’ behavior in terms of their internal intentions, for example, “He said that because he wanted to hurt my feelings.” When a student with brain injury is depressed or anxious, this tendency is exaggerated and may result in seriously mistaken perceptions of others’ internal states.

Mistaken social perceptions may be validated because they become self-fulfilling prophecies. That is, a depressed person may misidentify others’ behavior as negative and critical, and then behave negatively in response. This negative behavior may then result in others becoming critical, thus apparently confirming the original misreading – and setting off a downward spiral.

Impaired social perception can have serious social consequences. For example, an adolescent boy might misread a girl's sympathetic smile as a romantic invitation, and proceed to respond in a sexually offensive manner. Or a child might misread a peer's teasing gesture as a threat and react aggressively. In these cases, the socially unsuccessful responses were not a result of inadequate social skills. Rather, they resulted from social "misreadings", that is, impaired social perception. As these examples suggest, effective social perception contributes in important ways to social success, peer acceptance, and friendship..

WHAT ARE THE MAIN THEMES IN INSTRUCTION AND SUPPORT FOR STUDENTS WHO HAVE DIFFICULTIES WITH SOCIAL PERCEPTION? (See also Tutorials [Social Competence](#); on [Friendship and Peer Acceptance](#))

1. Understanding the Problem: As with all neurologically-based difficulties, the first step in helping is to understand the problem. A combination of observable behavioral evidence combined with the neurology and neuropsychology reports can confirm that the student has neurologically-based problems with social perception. If so, some combination of the following supports and interventions would be relevant.

2. Environmental Supports: Success in social interaction for students with social perception difficulties may require environmental supports.

Competent and Sensitive Social Partners: For students with weak social perception, it is critical to have knowledgeable, understanding, and competent communication partners who therefore do not misinterpret and react punitively to neurologically based awkward behaviors that result from misreading social cues. Therefore education and training for everyday communication partners, including peers, family members, and school staff, may be critical to social success.

Explicit Clues to Partners' Mental States: Interactions with students with social perception impairment may need to include explicit statements about communication partners' mental states. For example, a communication partner may need to say "Let me tell you a joke..." rather than just telling the joke; or the communication partner may routinely add "Just kidding" after a tease rather than leaving it up to the student with social perception impairment to figure out that it is teasing. In these and other ways, communication partners make their mental states known to the student with social perception deficits.

3. Instructional Strategies to Assist Students with Social Perception Problems

Context-Sensitive Social Perception Training Social perception training and coaching can occur as the adult discusses the child's inner life, the adult's own inner life, and the inner lives of others. For example, young children need to be able to perceive whether others are happy, sad, mad, or scared (the four earliest identified emotional states). Adults can identify the state that the child is in and say why they think so (e.g., "You're smiling and jumping around; I think you must be happy"; "You're crying; you must be very sad about something; let me give you a big hug"). The same judgments along with the evidence can be made by the adult about the adult's mental state or about others' mental states. The point is to attach words to mental states, and to associate the mental state words with evidence that the person is in such a state and what to do about it. For older children and adolescents, the inner state words can be progressively more refined and abstract (e.g., jealous, resentful, excited, ambitious, etc).

Sometimes this training is done in therapy sessions, using photos of people to illustrate emotion words. As with all decontextualized training, this is second best to actual situational coaching. However, decontextualized presentation of this sort may be useful at the beginning of the intervention to explain the mental-state language.

Practice During Book Reading and Dinner Time Conversations: With young children, practice of this sort can be ideally implemented during evening book reading time. For older children, dinner time conversations are

an ideal time to talk about daily events and explore the mental lives of people, their beliefs, emotions, desires, motivations, and the like.

Objective Readings of Others: It is important that these conversations about inner states (e.g., emotions, feelings, thoughts, beliefs, desires, etc.) emphasize the ease with which one can misperceive others true feelings, intentions, motivations, and the like.

Requesting Verification: “Am I right?”: When students know that they are routinely mistaken in their readings of others mental states, it may be important for them to get into the habit of requesting validation. For example, the student may be taught to say, “You seem angry about something; am I right about that?”

Written by Mark Ylvisaker, Ph.D. with the assistance of Mary Hibbard, Ph.D. and Timothy Feeney, Ph.D.

Tutorial: Anxiety and Anxiety Management

WHAT IS ANXIETY?

Anxiety is the most common mental health issue for persons of all ages. Although everyone experiences anxiety from time to time, anxiety becomes a problem when these feelings begin to interfere with day-to-day functioning. Anxious feelings include both physical responses, such as increased heart rate and blood pressure, trembling, and sweating, and a variety of emotional responses to either a feared or actual threat. Anxiety disorders can be short term or long lasting. Young children may express symptoms of anxiety indirectly as physical complaints, such as headaches and stomach aches, over-activity, acting out, separation difficulties, or sleep difficulties. Older children and adolescents are better able to describe their anxiety, but more likely than adults to display disruptive behaviors as a part of their anxiety disturbance.

Anxiety manifests itself in many different ways with differing psychiatric labels given to differing cluster of symptoms:

Generalized anxiety disorders (GAD) are the most common anxiety disorders. A person with GAD experiences constant worry and anxiety that is out of proportion to the level of an actual (or perceived) stress or threat. The anxiety occurs most days, lasts for more than six months, and is usually accompanied by complaints of fatigue, difficulty concentrating, irritability, and sleep problems. Persons with GAD often feel unsure of themselves, tend to be overly perfectionist and rule bound, and may experience bouts of depression between episodes of anxiety. (See Tutorial on [Depression](#).)

Obsessive compulsive disorders (OCD) are common and long lasting anxiety disorders. Individuals with OCD experience repeated, persistent thoughts, images, or impulses that are unavoidable and very distressing; often these thoughts or impulses are accompanied by repetitive or ritualistic behaviors, called compulsions, that are performed in an attempt to control the fears. OCD behaviors interfere with daily functioning and consume considerable amounts of time each day. Frequently OCD is not identified since persons are often embarrassed by these symptoms and hide them from others. In children, OCD behaviors can be mistaken for behavior problems, for example, taking too long to do homework because of perfectionism, or refusing to perform a chore because of fear of germs.

Panic disorders (PD) include periods of intense, but short-lived attacks of extreme anxiety accompanied by intense physical discomfort (e.g., rapid heart beating, sweating, shakiness, shortness of breath). These "attacks" may occur spontaneously or only in response to a particular situation. Recalling or re-experiencing even harmless circumstances surrounding an original attack may trigger subsequent panic attacks. Adolescents are at increased risk of developing PD.

Phobias involve overwhelming and irrational fears that cause a person to avoid specific situations whenever possible. In some cases, the anxiety related to the feared object or situation can be incapacitating. Phobias are categorized by the type of situation that causes the problem: for example, a paralyzing terror of being in places or situations from which the person feels there is neither escape nor accessible help is called agoraphobia; a fear of being publicly scrutinized and humiliated is called a social phobia; an irrational fear of a specific object or situation is called a specific phobia.

Post-traumatic stress disorders (PTSD) are chronic anxiety reactions to a violent or traumatic event that is usually outside the "norm" of human experience. Such events can include experiencing or even witnessing sexual assaults, accidents, combat, natural disasters (such as earthquakes), a near death experience, or an unexpected death of a loved one. Symptoms of PTSD can occur months or even years after the traumatic event and can include emotional withdrawal, avoidance of reminders of the trauma that interferes with personal and work activities, feelings of hopelessness, self-destructive behavior, personality changes, mood swings, difficulty with sleep, and guilt over surviving the event. In children, engaging in play in which traumatic events are repetitively enacted is common.

Separation anxiety disorders are the most common anxiety disorders in young children. Symptoms include extreme distress from either anticipating or actually being away from home or separated from a parent or other loved one, extreme worry about losing or about possible harm befalling a loved one, intense worry about getting lost, being kidnapped, or otherwise separated from loved ones, and/or refusal to go to school or to sleep away from home. When faced with separation from loved ones, a child may also experience increased physical symptoms such as headache, stomach ache, or vomiting.

WHY IS ANXIETY AND ITS MANAGEMENT IMPORTANT FOR MANY STUDENTS AFTER TBI?

Both children and their families experience a wide range of emotional reactions, including significant anxiety, during the initial few months after onset of a brain injury. Initially there is anxiety about whether a child will survive the injury. Early recovery of physical abilities often inspires hope that the child will be able to return to normal day-to-day activities in the near future. For many students and their families, there is a gradual realization that some changes in thinking and behavior may persist. These changes can result in increased anxiety in both the child and her parent.

Anxiety symptoms can also intensify once a child is back home and attempts to return to school. The older the child at time of brain injury, the more aware and more self-critical she may be of these brain injury related losses. Self-critical statements fuel anxiety. At the same time, the student may begin experiencing academic difficulties, losing friendships, and becoming more isolated, all situations that will increase anxiety reactions. Thus, students with brain injury are at increased risk of an anxiety disorder. Unless treated, the anxiety symptoms can worsen, creating further functional decline for the student, which in turn will lead to depression. **(See Tutorial on Depression.)**

Research has shown that younger children are more apt to experience GAD, specific phobias, or separation anxiety disorders after brain injury. Children who experienced brain injury as a result of a “near death” experience (e.g., a car accident) and those who are anxious during hospitalization are at increased risk of developing a PTSD after hospital discharge. OCD behaviors after brain injury (e.g., making extensive lists) are more likely to occur in adolescents who attempt to compensate for new onset thinking difficulties with OCD behaviors. Students with a prior history of anxiety symptoms are at greater risk of developing an anxiety disorder post injury. Finally, anxiety disorders after brain injury are in part due to specific damage to part of the brain that modulates emotional responses – the bottom sides of the prefrontal parts of the brain. Thus, there is a neurological basis for development of anxiety disorders post injury as well.

WHAT ARE THE CLINICAL SUPPORTS AND INTERVENTIONS NEEDED FOR STUDENTS WITH BRAIN INJURY WHO ARE ANXIOUS?

Supports for students to address and limit anxiety symptoms include timely identification of the problem, accurate diagnosis, implementation of mental health services, medications if warranted, and support from both school personnel and family members.

1. Identification of the student’s anxiety: The initial step in dealing with anxiety is to recognize that the child is anxious. The first step in identifying an anxiety disorder is to ensure that it is truly anxiety that is the problem. Parents and school staff are keen observers of a child’s behaviors and often the “front line” identifiers of the child’s anxiety symptoms. Consultation with parents, the school psychologist, and teachers may be helpful to determine if the student presents as anxious in all or only select settings. For example, a young child may be presenting with separation anxiety only at home but is quite calm during the school day; an adolescent may be nervous and avoiding specific activities involving friends at school but not at home. These behaviors would suggest situation-specific anxiety issues rather than a sign of an anxiety disorder.

2. Timely assessment of the student’s anxiety: Referral to a physician or other mental health professional to assess the severity and scope of the child’s anxiety is the next step in obtaining needed treatment. In

younger children, the diagnosis of an anxiety disorder is more difficult, because younger children may lack words to describe their thoughts and feelings. Clinicians often must rely on parents, teachers, and other professionals to assess possible physical manifestations of anxiety (e.g., headaches, stomach aches) as well as behavioral change in younger students.

3. Starting needed medications or therapy: Management of anxiety disorders depends on the severity and symptoms presented by each student. Interventions typically are supportive in nature with anxiety medications added if symptoms are significantly affecting the student's day-to-day activities.

Psychological intervention or "talk therapy" is typically the first approach to anxiety management. In older children, therapy can be done individually, with family members, or in structured group settings. Most psychotherapy approaches use a cognitive behavioral therapy (CBT) model in which a child is taught how to alter faulty (or negative) self-thoughts that are maintaining anxiety. Stress management, biofeedback, hypnosis, relaxation training, desensitization, and exposure treatments are alternative approaches. In younger children, play therapy may be utilized in lieu of talk therapy.

Anxiety medications are likely to be used when the student's anxiety is interfering with day-to-day activities. Typically, antidepressants (usually a serotonin reuptake inhibitor (SSRI), or anti-anxiety medications are prescribed. Family and school staff need to ensure that the student complies with prescribed medications, as well as monitor the benefits of the prescribed medications in helping the student control anxiety on a day-to-day basis.

4. Helping students manage their own anxiety: There are many ways that teachers and parents can help the student manage and/or minimize anxiety:

Limit comparisons of before and after injury: A student with brain injury has potentially experienced "real" losses in thinking, physical abilities, and emotional/behavioral abilities. The older the child at the time of onset of injury, the more aware she is of potential differences before and after the injury. These discrepancies often fuel the student's anxiety. Parents and teachers can contribute to the student's self-esteem by helping her minimize negative comparisons which serve to increase anxiety. For example, the student might become anxious before an examination and say "I was really good at spelling before, but now I will probably fail this test"; the parent/teacher could reframe the same statement to a less critical response such as "You didn't do a bad job on the spelling test yesterday and your average is higher than it was last week, so there are clear signs that your spelling abilities are getting stronger."

Limit situations that trigger anxiety: Teachers and parents should be aware of situations, people, or events (triggers) that typically provoke anxiety reactions (e.g., perceived rejection by others, withdrawal of friends, over-crowded rooms). For example, if a student gets anxious in over-crowded environments, moving her gym activities to a smaller room with fewer student would help decrease her anxiety and allow her to participate more fully in the gym activity. Whenever possible, attempts should be made to remove triggers proactively from the student's daily routines. As the student becomes aware of what these "triggers" are, she should be empowered to remove herself from these events.

Help the student re-interpret social cues: Students with brain injury often have decreased ability to correctly "read" social situations and the intent of others' behavior. When social cues are misread – for example, a student misperceives someone making an insulting remark when none was intended – the student will feel rejected or demeaned. This reaction is magnified by the anxious student and serves to reinforce her sense of social failure. Parents and teachers can help the student reframe a misinterpreted social interaction and offer ways for the student to rethink the situation in a less critical fashion. This reframing will help to limit the negative emotional response by the student. [See Tutorial on [Social Perception](#).]

Ensure that strategies are in place to enhance a student's self-esteem and self-concept. Anxious students develop a reduced sense of self, which includes a strong sense of failure and futility. The student tends to think of self in negative terms of "failure", "helpless" or "hopeless". For these students, it is essential that they be provided ample opportunities to be successful and contribute to helping others, thus rebuilding

optimism about their own abilities, enhancing their self-esteem, and minimizing their "learned helplessness". Anxiety can further reduce a student's already taxed cognitive abilities after brain injury. Teachers should ensure that the student is given academic tasks within her current abilities to ensure feelings of mastery, minimize anxiety symptoms, and slowly rebuild self-esteem. **[See Tutorials on Instructional Routines; Apprenticeship Teaching; Sense of Self.]**

Help the student learn to “reframe” critical self-statements: Overly critical and negative self-statements make an anxious student more anxious. The student typically internalizes and believes these self-statements, thus maintaining her anxiety. Similarly, the student frequently “catastrophizes”, that is makes small concerns into major problems without realizing that she is doing this. Alternatively, the student may use extreme terminology when describing her situation, “I never get a chance to answer questions in class” “She always makes fun of me” “I never do anything right” and so on. In such situations, adults can model “reframing” of negative self-statements into a less critical response. For example, a less critical reframe might be, “While you often stay silent and let others answer questions, when you volunteer a response, it usually turns out ok”. With modeling, the student can learn to reframe critical self-statements into less critical and more positive messages to self.

Help the student learn to identify anxious feelings: Young children and older students with significant brain injury may experience physical symptoms of anxiety without knowing what the emotions underlying these symptoms are. These feelings are simply nameless feelings that lead to negative and regressive behaviors. These students need help in identifying anxiety feelings, giving these feelings a name, and understanding that these symptoms can be addressed in order to gain control of their anxiety. For example, when a young child suddenly withdraws from an activity, the teacher may ask her to think about what she is feeling inside (bodily symptom) that made her remove herself from the activity. Often providing suggestions of possible reasons (e.g., tightness in your stomach, fear or sense of something bad happening) will help the child associate words with the feeling.

Help the student to “self-motivate”: Anxious students often over-react to challenging situations, minor annoyances, or unexpected changes in their daily routines with increased anxiety and self-doubt, and as a result, often refuse to engage in the task or activity. Their refusal only fuels their feeling of failure and leads to further isolation. In such situations, it is helpful to provide the student with a "self-talk script", for example a series of questions that the student can ask herself in order to evaluate the relative merit and limitations of a task or activity, thus encouraging her to think more flexibly about the specific task and her actual abilities. For example, the student can ask “Is this really a big deal or a little deal to do the activity?” or “If I start this task, will there be any benefit to me?” or “What will be the down side of not doing this activity?” These self-regulation scripts can be practiced by the student across a variety of tasks, allowing her to gradually internalize the self-talk script, thus minimizing rejection, failure and isolation. **[See Tutorial on Self-Regulation Scripts.]**

Written by Mary Hibbard, Ph.D. with the assistance of Mark Ylvisaker, Ph.D.

Tutorial: Depression and Depression Management

WHAT IS DEPRESSION?

Depression is the most common mental health disorder in both adults and children/adolescents. A depressed person experiences intense emotional distress for a period of days, weeks, months or years. There are differing severities of depression with differing psychiatric diagnoses given to each:

- An *Adjustment Disorder* is the most common type of depressed mood. A person admits to depressed feelings. These feelings are short lived (less than 6 months) and usually occur in response to some negative experience, such as rejection, a let down or a loss.
- A *Major Depression* is a serious depressive disorder in which a person experiences a severely depressed mood for periods as long as 7-9 months or greater. Depressive symptoms are similar for both adults and older children and include a sense of intense sadness, a loss of interest in formerly pleasurable activities, self-criticism, feelings of pessimism, a sense of hopelessness, increased fatigue, difficulty with concentration, impaired decision-making skills, lack of energy or motivation, and altered sleep patterns. Anxiety symptoms may be present. In more severe depression, the individual might think life is not worth living and/or have suicidal thoughts. In younger children, anxiety and depression symptoms are often seen as increased fears of separation, reluctance to meet new people, vague physical complaints such as general aches and pains, stomachaches, headaches, and acting-out behaviors. It is not uncommon to have repeat bouts of major depression. The younger the age of a child at the time of the first depressive episode, the greater the risk of repeat bouts of depression as the child matures.
- In *Dysthymia*, a person has fewer and less severe depressive symptoms than in a major depression; however the depression last longer, sometimes years. Children and adolescents often experience dysthymia, with the child depressed for most of the day, on most days, with symptoms continuing for several years. Because of its persistent nature, dysthymia is especially likely to interfere with normal adjustment.
- In a *Bipolar Disorder*, a person has dramatic changes in mood which alternate between spans of hyperactivity, or mania, and depression. Symptoms of mania are very different from depression. During a manic episode, a person feels overly energetic, confident and “special” and may report racing thoughts. During these hyperactive states, the person may do tasks too quickly and in a disorganized chaotic fashion; numerous projects may be started but few completed. Typically, the person has difficulty sleeping but denies feeling tired, and often has pressured or loud speech. Finally, the person may have exaggerated ideas about actual capabilities, may become “fresh” and uninhibited with others, and engage in reckless, risky or promiscuous behaviors. This mood disorder typically starts during adolescence with the onset of a depression; the hyperactive or manic symptoms typically do not occur until many months or years after the depression has resolved.

WHY IS DEPRESSION AND ITS MANAGEMENT IMPORTANT FOR MANY STUDENTS AFTER TBI?

Children and their families often experience a wide range of emotional reactions during the initial few months after a brain injury. Initially, there is relief that a child has survived. Early recovery of physical abilities often inspires hope that the student will be fine with a return to normal day-to-day activities in the near future. For many students and their families, there is a gradual realization that some changes in thinking and behaviors may indeed persist. These changes often occur in the larger context of the students mourning their very real and potentially permanent losses in their thinking, physical abilities, and behaviors. A student needs to mourn these losses; sometimes, this mourning leads to depression. This is particularly the case when mourning is experienced at the same time as the student is experiencing academic difficulties, losing friendships, and becoming more isolated. Thus, all students with brain injury are at increased risk of an adjustment disorder with a gradual onset over the months post injury. Unless treated, the adjustment disorder can worsen into a major depression or a dysthymia.

Research has shown that the majority of children with severe brain injuries, and a considerable minority of children with less severe injuries, are at risk of developing a new and significant depression post injury. Research also suggests that males injured before the age of 15, children with emotional problems prior to their brain injury, and children in families who are having difficulty coping with the brain injury are at increased risk of developing a depression. Finally, depressive disorders post brain injury are, in part, due to specific damage to part of the brain that controls our emotional responses – the bottom sides of the prefrontal parts of the brain. Thus, there is a neurological basis to post brain injury depression.

WHAT ARE THE CLINICAL SUPPORTS AND INSTRUCTION NEEDED FOR STUDENTS WITH BRAIN INJURY WHO ARE DEPRESSED?

Supports for students to address depression include timely identification of the problem, accurate diagnosis of the depression and implementation of mental health and medication as well as support in the school and home. Each of these areas is addressed below:

Identification of Depression

The initial step in dealing with depression is to recognize that a child is depressed. The first step in identifying depression is to ensure that it is truly depression that we are dealing with. Parents and school staff are keen observers of a child's behaviors and often the "front line" identifiers of the child's depressed mood. Consultation with parents, the school psychologist and teachers may be helpful to determine if the student presents as depressed in all settings. For example, a young child may be acting out or an adolescent may be increasingly irritable in the home setting but not the classroom or with friends. These behaviors would suggest situation specific issues rather than a sign of depression in the student.

Timely Assessment of the Student's Mood

Referral to a physician or other mental health professional to assess the severity of a child's depression is the next step in obtaining needed treatment. In children, the diagnosis of depression is more difficult, since younger children may be unable to verbalize thoughts and feelings. Clinicians by necessity need to rely on parents, teachers, and other professionals to assess mood and behavior change particularly in younger students.

Starting Needed Medications or Therapy

Management of depression depends on the severity and type of depressive disorder. Typical management includes mood medications prescribed by a physician and/or supportive therapy offered alone or in combination.

- Mood medications are likely to be used when a child has either a major depression or a bipolar disorder. Typically, antidepressants (usually serotonin reuptake inhibitors (SSRI) or mood stabilizers) are selected. Family and school staff will need to ensure that the student complies with prescribed medications.
- Psychological interventions or "talk therapy" is considered for older children either by themselves, with family members or in structured group settings. Most psychotherapy approaches use a cognitive behavioral therapy (CBT) model in which a child is taught how to alter faulty (or negative) self-thoughts that are maintaining their depression and to learn new coping and problem solving skills. In younger children, play therapy may be utilized instead of talk therapy.

Helping students manage their own depression

There are many ways that teachers and parents can help students handle and or minimize their depression:

a. Limit comparisons of before and after injury: A student with brain injury has experienced real losses in his/her thinking, physical and behavioral abilities. The older the child at time of onset of injury, the more aware the student is of these difference before and after injury; this discrepancy often fuels depression and anxiety. Parents and teachers can help the student by modeling less critical statements about a student's abilities, with the goal of minimizing negative comparisons which serve to maintain the student's depressed mood. For example, the student might describe his current abilities as "I was really good at spelling before, but now I am really dumb"; the parent/teacher could reframe the same statement to a less critical response such as "You didn't do a bad job on the spelling test today, and your grade was higher than last week"

b. Limit situations that trigger depressive thoughts: Teachers and parents should be aware of situations, people, or events (triggers) that typically provoke depressive reactions (crying, irritability, or withdrawal) in the student. For example, modifying gym class activities so the student is not confronted with current physical limitations, or matching a student with a new student for an assignment rather than a former friend who knew the student's former abilities. Whenever possible, attempts should be made to remove triggers proactively from the student's daily routines. As the student becomes aware of what these "triggers" are, the student should be empowered to removal himself from these events.

c. Help the student re-interpret social cues: Students with brain injury often have decreased ability to correctly "read" social situations and the intent of others behavior. For example, when social cues are misread – for example, a student perceives someone making insulting remarks when none was intended – the student will feel rejected based on this incorrect interpretation. This rejection is magnified when a student is depressed, resulting in an increase in the depression and further social withdrawal. Parents and teachers can help the student reframe the social interaction and rethink the social situation in a less critical fashion. This reframing will help to limit the negative emotional response by the student. **[See Tutorial on Social Perception.]**

d. Ensure that strategies are in place to enhance a student's self-esteem and self-concept: Depressed students develop a sense of self that includes a strong sense of failure and futility. The student tends to think of self in terms of "failure", "helpless" or "hopeless". For these students, it is essential that they be provided ample opportunities to contribute to helping others, thus rebuilding optimism about their own abilities rather than continued focus on enhancing and maintaining "learned helplessness". Depression can also reduce a student's already taxed cognitive abilities. Parents and teachers should ensure that the students is provided academic tasks within his current abilities to ensure feelings of mastery and allow for a slow rebuilding of self esteem. **[See Tutorials on Instructional Routines; Apprenticeship Teaching; Sense of Self.]**

e. Help the student learn to "reframe" critical self-statements: Overly critical and negative self-statements make a depressed student further distance himself from his peers. The student typically internalizes and believes these self-statements, thus maintaining his depression. Similarly, the student frequently "catastrophizes", that is, makes small issues into major problems without realizing that he is doing this. Alternatively, the student may use extreme terminology when describing his situation, "I never get a chance" "She always makes fun of me" "I never do anything right" and so on. In such situations, adults can model "reframing" a negative self-statement into a less critical response. With modeling, the student can learn to reframe critical self-statements into less critical and more positive messages to self.

f. Help the student learning to identify depressive feelings: Young children and older students with significant brain injuries may experience bodily symptoms of depression without knowing what the emotion underlying these symptoms is. The feelings are simply nameless feelings that lead to negative and regressive behaviors. These students need help in identifying depressive feelings, giving these feelings a name, and understand that these symptoms can be addressed in order to regain better control of their mood. For example, when a young child suddenly withdraws from an activity, the teacher may ask the child to think about what she is feeling inside (bodily symptom) that made her remove herself from the activity. Often providing suggestions of possible reasons (e.g., fear, a sense of doom, rejection, failure, etc.) will help the child associate words with the feelings.

g. Help the student to “self-motivate”: Depressed students often over-react to challenging situations, minor annoyances or unexpected changes in their daily routines with immediate refusal to engagement in a task or activity. Their refusal only fuels their feeling of failure and leads to further isolation. In such situations, it is helpful to provide the student with a “self-script”, a series of questions that the he can ask himself in order to evaluate the relative merit and limitations of a task or activity, thus encouraging the him to think more flexibly about the specific task. For example, the student can ask “Is this really a big deal or a little deal to do the activity?” or “If I start this task, will there be any benefit to me?” or “What will be the down side of not doing this activity?” These self-regulation scripts can be practiced by the student across a variety of tasks, allowing the student to gradually internalize the self-script, thus minimizing rejection, failure, and isolation. [See [Self-Regulation Scripts](#)]

EVIDENCE SUPPORTING THE USE OF INTERVENTION APPROACHES FOR CHILDREN AND ADOLESCENTS WHO EXPERIENCE DEPRESSION AFTER TBI

This summary of evidence is written for teachers, mental health clinicians, and others who may be required to support their intervention practices with evidence from the research literature or who may simply be curious about the state of the evidence. This summary was written in early 2008. Evidence continues to accumulate.

The research literature contains no reports of studies of the effectiveness of intervention specifically for children or adolescents who experience depression after TBI. Findings from studies of other populations are relevant in making evidence-based clinical decisions, but should be interpreted with caution. In particular, the memory problems, difficulty with abstract reasoning, and self-regulatory impairments of many students with TBI may require modification of clinical approaches validated with other populations.

Carr (2008) reviewed several reviews of evidence based on studies of alternative approaches to intervention for depression in varied populations of children and adolescents. Causes of depression that Carr considered in the review include genetic factors (e.g., neurobiologic factors that control relevant neurotransmitter systems) and environmental factors (e.g., loss of important relationships, injuries, illnesses, disruptive life transitions, and experiences of failure and bullying). Non-optimal parenting received special attention.

Psychological therapies that have been studied in children and adolescents with depression include cognitive behavior therapy (CBT), psychodynamic therapy, interpersonal therapy, and family therapy. One review and two meta-analyses have demonstrated the effectiveness of CBT with these populations. The effect sizes in the two meta-analyses (focused on adolescents) were both large (1.27 and 1.02). In one comparative trial, outcome following cognitive behavior therapy was superior to that following family therapy or supportive therapy. These results support several of the practical suggestions offered in this tutorial.

Carr identified only two published reports of studies of psychodynamic therapy. Both had positive outcomes, offering preliminary support for that approach. Interpersonal therapy is supported by five studies with adolescents, four of which were controlled. Interpersonal therapy focuses on (1) grief associated with loss of a loved one, (2) role disputes among family and friends, (3) transitions within roles (e.g., new peer groups), (4) social skills, and (5) other relationship difficulties. The literature includes six studies of family therapy for this population (especially depressed adolescents). This literature supports the use of cognitive-behavioral approaches to family therapy.

In a comprehensive meta-analytic review of components of psychotherapeutic interventions for depressed and anxious children, Spielmanns and colleagues (2007) concluded that, although bona fide cognitive and behavioral treatments are superior to interventions that are not bona fide, evidence does not exist to support specific components of the successful interventions. Rather it is likely that nonspecific components, such as a strong therapeutic alliance, are most influential in determining the outcome of therapy. A similar conclusion about the importance of a therapeutic alliance was reached by Judd and Wilson (2005) in their review of psychotherapeutic interventions for adults with TBI.

Common themes in outcome and life after pediatric TBI make the procedures of CBT, relationship therapy, and family therapy worth recommending in many cases. As always, specific decisions about interventions and supports must be made on the basis of an analysis of the often complex factors in individual cases.

With respect to psychopharmacologic interventions, Carr cited one comprehensive review that showed that tricyclic antidepressants are ineffective, and two reviews that demonstrated positive effects of selective serotonin reuptake inhibitors (SSRIs) for children and adolescents with depression. However, SSRIs should be used with caution because of some evidence that they increase suicidal ideation.

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Judd, D., & Wilson, S.L. (2005). Psychotherapy with brain injury survivors: An investigation of the challenges encountered by clinicians and their modifications to therapeutic practice. *Brain Injury*, 19(6), 437-449.

Spielmanns, G.I., Paseka, L.F., & McFall, J.P. (2007). What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. *Clinical Psychology Review*, 27(5), 642-654.

Written by Mary Hibbard, Ph.D. with the assistance of Mark Ylvisaker, Ph.D.

Last revised: April 2008

Tutorial: Friendship and Peer Acceptance

WHAT ARE FRIENDSHIP AND PEER ACCEPTANCE?

As the term is used here, friendship implies a two-direction, mutual relationship of liking. By definition, then, there cannot be a one-sided friendship. When two children are friends, they like each other; there is some degree of mutual emotional connection. In addition, they tend to have shared interests and activities. Furthermore, in most friendships the two individuals are (roughly) equal in the relationship (symmetry) and they both bring something meaningful to the relationship (reciprocity). Friendships can be weak and short-lived, but they are often both intense and complex – and they are surely mutual. To say that friendships are symmetrical and reciprocal is not to say that two children of differing abilities cannot be friends. It is rather to say that they both bring something to the relationship and they both value what the other brings.

In a reciprocal relationship, friends seek each other out, both talk and both listen. They both support one another when challenged and remain loyal. They acknowledge and respect each others' perspectives. In these respects, friendships require attention and effort.

In contrast to friendship, peer acceptance and rejection can be one sided. For example, a child may like the group members and wish to be a member of a group, but the group may reject him. Similarly, a group may accept a child, but the child may choose not to associate with the group. Furthermore, acceptance implies a lower degree of emotional connection than is implied by friendship. And acceptance need not be symmetrical or reciprocal. That is, if one child brings very little to the relationship and is on a much different level than the other, mutual acceptance is possible but friendship is unlikely.

Both friendship and peer acceptance in childhood have long been known to influence the child's current life and also adult outcome – and in different ways. For example, peer rejection in childhood has been shown to be a predictor of problems in later school performance, adult vocational competence, aspiration level, and adult social participation. Lack of friends in pre-adolescence predicts depressive symptoms in adulthood. Peer rejection and lack of friendship in combination predict trouble with the law. Childhood friendships, in contrast, are strong predictors of strong family relationships in adulthood and adult sense of self-worth.

These are just a sample of findings in the research literature on friendship. The general point is that friendship and peer acceptance are both important for children and should be facilitated in the case of socially vulnerable children.

WHY ARE FRIENDSHIP AND PEER ACCEPTANCE IMPORTANT FOR MANY STUDENTS AFTER TBI?

Outcome studies have shown that children and adolescents with TBI tend to have fewer friends than their uninjured peers. In one study, almost 40% of children with moderate-to-severe TBI had no friends or at most one friend, whereas all of the uninjured peers had more than one friend. Many children and adolescents with brain injury state that their most troubling concerns after the injury are the absence of meaningful, lasting friendships and the difficulty finding new friends. These children understandably feel socially isolated, a condition that can easily lead to depression. (See Tutorial on [Depression](#).)

There are many potential reasons why maintaining old friendships and gaining new friends are especially challenging for children and adolescents with TBI. In some cases, cognitive difficulties result in placement at a lower grade or in a new school, which interferes with maintenance of old friendships. Significantly weakened cognitive and academic performance can also result in difficulty maintaining the same interests as old friends and keeping up with social interaction. In one study, neuropsychological test performance did not predict number of friendships, but academic performance did; students who maintained their academic performance at reasonably high levels had more friends than those who did not. Physical impairments may also play a role in friendship by reducing the opportunities to engage in the same activities as old friends or

potential new friends, activities like sports, dancing, and other activities that require reasonable physical abilities.

Problems with behavioral self-regulation and social interaction are even more likely to interfere with maintenance of old friendships, creation of new friendships, and peer acceptance. Students who are impulsive, aggressive, egocentric, or socially awkward generally have difficulty making friends and being accepted by peers. **(See Tutorials on Behavior; Social Competence.)**

WHAT ARE THE MAIN THEMES IN INSTRUCTION AND SUPPORT FOR STUDENTS WHO HAVE DIFFICULTY WITH FRIENDSHIP AND PEER ACCEPTANCE (See also Tutorial on Social Competence)

Understanding the Problem

As always, the first task for parents and teachers is to correctly understand the problem. Because friendship is important and loss of friends common after brain injury, parents and teachers should anticipate the problem and do what they can to promote friendship and peer acceptance. Specifically they should try to understand why the student may be losing friends and then address those issues.

Environmental Compensations and Strategies

Nothing that parents and teachers do can guarantee that students with brain injury will maintain friendships or acquire new friends. However there are strategies that can be implemented to increase the likelihood of ongoing friendships.

While the child is hospitalized:

Two-Way Communication: In the event of extended hospitalization, communication between peers at school and the hospitalized student should be encouraged. Peers can send letters; they can also create video greetings, showing what they are working on at school and expressing enthusiasm for the student's recovery and quick return. Similarly, the hospitalized student can be encouraged to send mail or e-mail messages to friends and peers. Video messages, possibly illustrating hospital routines, might be used both to stay in touch and to demystify the hospitalization for peers.

Hospital Visits: When the student with brain injury is stable and able to interact with others, parents should encourage visits from friends and peers. Parents or hospital staff should be available to provide explanations to peers about unusual equipment and about the student's impairments. Furthermore, hospital staff should ensure that there are fun activities that the peers and the student with brain injury can engage in during the visit. The activities may require adaptations and coaching for peers so that the student with brain injury can be included. A simple example is a card holder so that a student with hemiplegia can play cards with peers.

When the child is out of the hospital:

Avoidance of Extended Home-Bound Instruction: Following discharge from the hospital, an extended period of home-bound instruction (e.g., several weeks or more) may have the effect of increasing the social anxiety in the student with brain injury. At the same time, the extended absence makes it more likely that alliances at school will have changed and that the student will therefore have greater difficulty re-entering his social network. Finally, the longer the student is away from school, the further he is likely to fall behind in academics. Therefore, if a period of homebound instruction is necessary, it should be as limited as possible.

When the child returns to school:

Classroom Placement: A variety of factors need to be considered in making decisions about classroom or grade-level placement after severe brain injury. In students with more severe injuries, the degree of cognitive and academic losses may rule out pre-injury classroom and grade-level placement. With less severe injuries, decision makers should balance social and academic considerations. Considerable support may be required to enable the student to benefit from the curriculum in a classroom with pre-injury peers. However, the value of meaningful social relationships is sufficiently powerful in many cases to justify the needed supports.

Education for Peers: If the student returns to school with unusual equipment, physical impairments, unusual behavior, a marked change in personality, or other changes that may confuse or alarm peers, proactive explanations should be provided to them. In some cases it might be useful for a member of the rehabilitation hospital team to talk to peers at school. More often a respected teacher is chosen for this job, possibly with the assistance of hospital staff. In other situations, the student with brain injury can make a presentation to peers about his experiences and possible difficulties that he may face on returning to school. Creating this presentation could be facilitated by staff at the hospital before discharge. Ideally the student with brain injury is cast as a returning hero with an exciting story to tell. It is also helpful for the student to outline how peers can make the transition back to school easier for the “returning hero”.

Attractive Opportunities for Friends and Peers in the Home: To increase the likelihood that peers will enjoy spending time with the student with brain injury in his home, parents should try to have enticing activities for the peers. For example the latest video games might make visits enjoyable even if there are difficulties interacting with the student with brain injury.

Extra-Curricular Activities: The extra time needed to complete homework together with greater than normal fatigue might cause parents and teachers to overlook the importance of extra-curricular activities. However, it is often during such activities that friendships are formed. Extra-curricular activities might take place at school or in connection with activities at church or other organizations.

Peer Buddies: In selected cases, a volunteer peer buddy can at the same time help the student with brain injury and also provide valuable social interaction. Buddies might help the student navigate busy corridors, carry books and materials, and complete assignments as the student tries to make up school work. Peer buddies should be selected from a social set that is acceptable to the student with brain injury. In creating a peer buddy system, school staff should be sensitive to the possibility that the student might consider the system infantilizing. Knowing that true friendships are symmetrical and reciprocal, staff should also seek ways in which the student with brain injury can contribute to the buddies as opposed to simply receive assistance from them.

Schedules to Facilitate Positive Peer Interaction: In some cases, it is necessary for students with brain injury to have schedules that are quite different from their peers. These differences might include a variety of therapy sessions, rest periods, hallway navigation when the hallways are not busy, and others. These additions to and modifications of the schedule should be balanced against the social value of schedules that are more typical and allow for as much social interaction as possible. For example, the objectives of speech-language therapy might be achievable in choir, voice lessons, and drama class. The objectives of physical therapy might be achievable in physical education class, with appropriate adaptations. In these ways, educational planners can balance ongoing needs with normal social experiences.

Helping the Student Maintain or Acquire Friends:

Please see the Tutorial on Social Competence for additional suggestions.

Three Critical Social Skills for Young Children: Studies have shown that acceptance and popularity for young children with or without disability are associated with three critical social skills: (1) the ability to initiate social interaction or enter into ongoing social interaction (e.g., play, conversation); (2) the ability to maintain

that interaction; (3) the ability resolve conflicts effectively and peacefully. With this as background, school staff and parents should have scripts to preset the student prior to social times at school or home, and to coach the student in using these scripts during the activity itself. Presetting and coaching may be useful in helping the student with brain injury to incorporate these skills in everyday interaction. A variety of communication skills contribute to each of these three general social competencies. Creating scripts and organizing a program of context-sensitive social coaching is often the role of the school's speech-language pathologist. (See Tutorial on [Social Competence](#).)

Critical Social Skills for Older Children: Older children and adolescents have a similar list of critical social skills: (1) The capacity and interest to play or otherwise interact with one another frequently; (2) the ability to avoid fights; (3) the ability and motivation to advocate for one another. Once again, presetting and coaching may be useful in helping the student with brain injury to incorporate these skills in everyday interaction.

Alternative Sources of Potential Friends: In the case of adolescents whose abilities and domains of possible activities have been substantially altered by the injury, it may be inevitable that old friends drift away despite well-conceived efforts to maintain those friendships. Engagement in a variety of social activities might help the student acquire new friends. Some students with brain injury form new friendships in the rehabilitation hospital or in other ways come to know and like students who have similarly experienced a life-altering brain injury. Their shared experiences often create a bond that can support a deep friendship. Furthermore, the friendship attributes of symmetry and reciprocity may be more likely to be present in such relationships than in the case of relationships with pre-injury friends who now may have considerably different levels of functioning and domains of activity from the student with brain injury.

Written by Mark Ylvisaker, Ph.D. with the assistance of Mary Hibbard, Ph.D. and Timothy Feeney, Ph.D.