**Camp Counselor Training**

 **For Children with Neurological Disorders – Part II**

**Learning Objectives:**

* Dealing with behaviors that children with neurological disorders may exhibit
* Responding to the triggers that lead to emotional meltdowns for children with neurological disorders

**What’s next?**

In the first module of this course, you learned how to detect the warning signs of an emotional meltdown. Regardless of the preventive measures you take, however, a child in your cabin with neurological disorders can still have a full scale meltdown, complete with rages and tantrums. How long the meltdown lasts, and the impact that it has on you, the child and the other children in your cabin depend greatly on how you react and respond to it.

In this module, we will focus attention on how to deal with meltdowns, rages and tantrums, as well as the following:

* Stuck thinking and obsessions
* Fears
* Peer relations and social skills
* Dealing swearing
* Daily routines
* Self-esteem building
* Camp activities
* When to seek professional help

**Tantrums, Rages and Meltdowns**

Watching a child with neurological disorders as stress builds up is much like watching a storm front move in. The sky darkens, the clouds begin to churn and you can see that some nasty weather is headed your way! The good news is that if you see all of this happening while the potential storm is still just rumbling, you can seek shelter and make it through the storm high and dry! During a child’s “rumbling” stage, you can also see signs that indicate an emotional storm is brewing. The child may exhibit any combination of signs, such as:

* Biting nails and/or lips
* Speaking in a raised/lowered voice
* Tense muscles
* Foot tapping
* Grimacing
* Increased physical movements
* Lowering of the head and “shutting down”

Even though the child may not realize it, the storm will be arriving soon. What’s important is that you as the Camp Counselor realize it. However, even the most experienced Camp Counselors will sometimes miss the signs. When that occurs, the storm will hit full force and you experience the “rage stage.”

**The Perfect Storm**

In a real storm, when the thunder begins to peal, you know the lighting flash is not too far behind. When a child with emotional disorders goes into meltdown mode, you are that lightning rod! All of the anger that has built up during the “rumbling” is focused on you.

There are Camp Counselors who swear that behavior like this just “comes out of the blue.” What has probably happened is that for the particular child they’re commenting about has a shorter fuse than some other child might. Not all children will exhibit all of the signs mentioned on the previous page, nor will they all exhibit them over the same amount of time.

One thing that does seem to stay consistent, however, is the pattern for each child. For example, if one child builds up to the rage stage over a 5-7 minute time frame, he or she will be likely to do that every time. This is an important thing to know, because you will be able to identify the characteristics for your particular camper and know at approximately what point in the process they occur. With this knowledge, you can pick up on the signs at any point during the process and have a fairly good idea of how much time you have left before you’re faced with the meltdown.

**What Not to Do**

The best thing to do when an emotional storm is approaching is to divert it (some actions you can take to divert an impending meltdown were discussed in the first module of this course under “proactive steps”). There are also things that you don’t want to do, and we’ve listed some of them below. Engaging in any of these actions will likely bring the meltdown upon you sooner:

* Raising your voice
* Using put-downs
* Saying, “This is my cabin and you will obey the rules!”
* Backing the child into a corner (both literally and figuratively)
* Insisting on the last word
* Pleading or bribing
* Tense body language
* Nagging
* Using sarcasm
* Mimicking
* Comparing the child to other children

If you examine this list, you’ll realize that none of these techniques are really ever effective, even with neurotypical children. With a child who has neurological disorders, however, it isn’t just a case of ineffectiveness; it will hasten the arrival of the “storm.”

**Maintaining Emotional Control**

Since children with neurological disorders often have problems keeping their emotions in check, you must keep your emotions under control. “Stay calm at all times” sounds like an oversimplification, but that in fact is what your goal should be. Four things you should focus on to make sure this goal is achieved include the following:

* **Prior preparation** –This is why you create a plan in the first place. Actions like incorporating some of the diversionary tactics mentioned previously, mentally reviewing your strategies and entering the cabin with a calm mindset will help you be up to the challenges that face you.
* **Certainty of belief regarding the neurological process** – When the “storm” approaches, if you don’t sincerely believe in the concepts addressed in this course, i.e. the child’s actions being primarily because of the disorder and not just acting out, you’re not going to remain calm. You have to believe, or else you will find yourself drawn into a battle of wills, and the deeper you dig in your heels, the bigger the storm is going to grow, and the longer the meltdown is going to last.

**Maintaining Emotional Control (Continued)**

The other two things you should focus on include:

* **The ability to disengage yourself from the process** – If you disengage, you don’t take the child’s words and actions personally and that will help you to keep from being drawn into the storm emotionally. When the child seems to be attacking you personally, the ability to see the comments and behavior as neurologically induced will help you to maintain your poise.
* **Successful experiences in diverting prior storms** – If you’ve experienced success, you’ll be more inclined to trust the process. Success breeds confidence, and confidence is what will get you through the worst of these events.

**Negotiating and Compromising**

While the child is still in the “rumbling” stage, he or she is still capable of thinking and reasoning to some degree. As the storm intensifies, however, emotions take over and clear thinking is less likely to occur. If you pick up on the “sparks” and “triggers” early enough, there’s still a chance that you can engage the child in some compromising and negotiation (discussed in module one of this course).

**Use of a Home Base or Safe Place**

A home base or safe place is simply a place the child can go when stress, excitement or overstimulation build up and you are witnessing signs of an impending meltdown. It is not a punitive action; in fact, typically it is a place that you and the Camp Therapist have agreed upon. It could be some extra room in the camp or the nurse’s office. It should be equipped with things that will help the child relax. For example, if the child relaxes by drawing, there should be art materials accessible. If the child enjoys music, having an MP3 player available would be helpful.

Have a plan so that the child can leave the room gracefully. In most cases, the child will not be aware of what’s happening to them (if they could self-soothe, they would, preventing the meltdowns), so it’s important to have some kind of signal you can give to the child that it’s time to go to “home base.” Once you are headed that way, keep talking to a minimum, even if the child is trying to talk you out of leaving the room. As with any episode of “sparks” and “triggers,” you don’t want to make matters worse by debating with the child. The less you say, the better off both you and the child will be.

Trust your instincts; if you think a meltdown is on the way, a trip to the safe place prevent it could help.

**The Rage Stage**

The rage stage begins with an emotional lightning flash. The child may lash out verbally and/or physically against objects or people. If the anger isn’t diverted during the rumbling stage, and the rage has an opportunity to begin, you likely cannot stop the rage until it has run its course. In fact, some children will even say, “I don’t want to do this” in the middle of a rage. However, at this point they are running strictly on emotion; there is no thinking involved. During this stage they may:

* Scream
* Bite
* Hit
* Kick
* Destroy property
* Engage in self-injury

The Camp Counselor’s role at this point is simply to prevent the child from harming themselves, others and property. Talking, discipline or correction can come later.

**The Recovery Stage**

Following his or her rage, a child with neurological disorders will often have contrite feelings about the event, even though he or she sometimes cannot completely remember everything that happened during that time. Some children will become sullen and withdrawn, even denying that any kind of inappropriate behavior has occurred. Others will be so physically exhausted that they will want to sleep, but don’t let them.

The child will be very emotionally fragile during this stage. In fact, some children with neurological disorders will actually re-enter the rage cycle from this stage because they have little stamina left for stress or over-stimulation. Others may have rage cycles that can come in waves over the period of an hour. Be aware, and when the rumblings occur, you can once again use diversionary techniques to fend off another rage.

Ease the child back into his or her routine, possibly with easier tasks and fewer demands to allow the sufficient time to recover completely. For some children, this may only take 10-20 minutes. Others may be later in the day and in some instances, it may even be the next day before they are fully back to the all-clear stage.

**The “All Clear” Stage**

The beginning of the all clear stage is the time to focus on instruction and discipline, since for many children with neurological disorders, this is a “warm-fuzzy” time when they are most open to instruction on how better to cope with their next rage. In some cases, the child may tell you what’s been troubling him or her, and could even have suggestions about what he or she could do to decrease the rages. For others, however, this type of thinking will be difficult, primarily for three reasons:

* They are not yet able to understand the series of social interactions that lead up to the storm.
* They do not understand any part they may have played in bringing about the event.
* They are unable to make sound judgments on what they should do next to keep the event from occurring.

**Discipline**

Any discipline decision must come from the Staff Therapist. No camper will be denied camp activities as a discipline measure.

**Planning Points**

Given the information you’ve learned at this point in the course, the first important points you need to consider for your plan are:

* Which of your campers have rages and meltdowns? How often? Where? With whom? Why?
* What are this child’s specific triggers?
* What is the typical pattern of the child’s rage cycle? What sparks do you see in the rumbling stage of the rage cycle?
* How long does the child remain in the rumbling stage before the full rage or meltdown occurs?
* What method of diversion helps the child avert the rage cycle?
* How are you able to maintain emotional control during the rumbling stage?
* Which of your own behaviors could escalate the behavior of the child during the rumbling stage? What can you do to reduce them?

**Stuck Thinking and Obsessions**

Obsession is a form of tunnel vision. When the child obsesses, he or she isn’t focusing so much as he or she is unable to think of anything but the object of his/her obsession. A child with neurological disorders can become so obsessed that at times you may not be able to discern whether the child is aware of what is going on around him/her. An obsessed child can have a conversation with you and an hour later have no recollection that the conversation ever took place!

Children who are obsessive can become stuck in rituals. They are convinced that a specific activity has to be done in a certain way, and they will do it over and over again until they get it “right.” If you attempt to interfere, they may tell you that they need to “start all over again”. Sometimes it’s helpful to give a child stuck in a ritual advanced notice that you will need to transition into another activity. Something like, “in ten minutes, we will be going to the next activity, and you need to be ready”, and then possibly another notification at five minutes can be helpful in getting the child to mentally shift gears. Be sure, however, to do it in a calm, relaxed manner so you don’t create additional stress for the child.

**Stuck Thinking and Obsessions (Continued)**

Sometimes, because of an inability to read their own internal signals, boredom or fatigue with a particular stuck activity can increase the child’s agitation and potentially lead to a meltdown. You need to be aware so that you can pick up on this and possibly divert the child to a new activity. It’s easier for the child to return to the activity if he or she has stopped it before a meltdown has occurred. Sometimes, children can become so infuriated over an activity that it can be difficult to ever get them to return to the activity.

Some suggestions for ways to help children transition includes:

* Let the campers know the daily schedule and how long an activity will last.
* Suggest other topics of discussion or actions that are also engaging to the child. This engaging activity could be any activity that moves the child away from whatever it is their locked on.

**Modifying Energy Levels**

Children with neurological disorders can have a difficult time transitioning from an energetic activity to a calm quiet activity. They don’t have the insights to either monitor their own internal energy levels nor the knowledge of how to make the modifications necessary to make the shift. They will need to rely on you to assist them.

In part, this can be accomplished by making them aware that a transition is going to be needed. For example, when returning to the cabin after an activity, you may want to remind him or her that “we’ll be going inside for a break, to play a card game, etc., so it will be important for you to be quiet and calm so that you can enjoy your time”.

**Obsession and Compulsion**

Obsession is “stuck thinking”. Compulsion is an act that is meant to “unstick” whatever it is the obsession might be. For example, if a child has an obsession about germs or about “being dirty”, the corresponding compulsion might be repetitive hand-washing. The problem for the child who is dealing with obsession and compulsion is that the relief is short-lived. Before long, the thought will be back in his or her mind, and the cycle repeats itself. Some common obsessions include:

* Fear of germs or disease
* Orderliness, symmetry and counting (i.e., counting cracks in the sidewalk, ceiling tiles, blocks on a wall, etc.)
* Sins, religious thought
* To hurt, or be hurt, by others
* Fairness vs. unfairness
* Having things “feel” right
* Obsessions with dangerous items

One of the biggest errors when working with a child wrestling with obsession and compulsion is trying to talk the child out of their obsession by using reason. In many cases, the child will realize that their obsession isn’t logical, but that doesn’t lessen its impact.

**Thought Blocking**

Distraction is one of the most effective ways for a child to cope with obsessive/compulsive thoughts. Some children have had success by thinking of their thoughts as something that is not even a part of them, going so far as to even give them a name, as if they were another person.

For others, thought blocking has proven to be an effective strategy. Some children found success repeating “It’s not me, it’s my OCD (Obsessive Compulsive Disorder)” repeatedly to themselves. Others simply repeat “no, no, no, no…” over and over.

**Replacing Bad Compulsions with Good Ones**

Some compulsions are relatively harmless. For example, children who feel a need to have the stuffed animals on their bed arranged in a certain way to feel safe and to sleep soundly find it comforting and it helps them get to sleep. This activity doesn’t really interfere with their lives. Some compulsions, however, can be dangerous. For example, some children feel a need to lick strange objects, avoid bathing or grooming, or conversely, feel a need to wash their hands so frequently that the skin chaps and bleeds. If you have a camper with these compulsions seek the advice of the Camp Therapist.

There are also compulsions that can be socially unacceptable, like children who feel compelled to swear. Acceptance is the key here. The child does not want to swear. Educating the cabin mates about specific symptoms will provide support for the camper.

**Coping with Fear**

Children with neurological disorders often develop fears of things like:

* Storms
* Darkness
* Closed spaces
* Being hurt
* Being embarrassed
* Bugs, spiders and snakes

Claustrophobia, in particular, occurs on a frequent basis. Instruct the campers on the importance of personal space. Before campers arrive check cabins for spiders and bugs around beds, ceiling corners, under beds, etc.

**Fear of Camp**

Arriving at camp can be one of the most stressful events of the day. If possible, have some type of fun activity that you can immediately involve the child in to serve as a distraction and reduce his or her stress.

It is also not uncommon for children with neurological disorders to be fearful about going to camp. This fear can be driven by:

* Being around other people
* Something bad happening at camp, like social disgrace, teasing, bullying or being physically harmed
* Irrational thoughts of something disastrous happening to parents if the child is not at home to prevent it, such as abandonment, a fire, physical harm to one of the parents or some other tragedy
* Fear of the unknown

Some children may be able to state their reasons; other’s may not. The Camp Therapist may be able to provide insight.

**Peer Relations and Social Skills**

Children with neurological disorders have a difficult time reading and reacting properly to the social cues of others. Even though it occurs almost instantaneously, picking up on the subtleties of another person’s facial expressions or remarks is a thinking process. It requires a person to:

* Receive clues from their environment
* Use thought to make out the meaning of the clues
* Draw from one’s own memory bank of information of other similar facts or events
* Learn from experience by modifying similar facts to fit the current situation
* Make a judgment about how to react
* “File” the new information in one’s memory bank for later retrieval

This inability to read and react can cause children with neurological disorders to respond inappropriately, causing issues between the child and his/her peers. You may need to intervene to help campers understand each other. Remember, you cannot rely on subtleties; you need to tell the child, or better yet, demonstrate what you want.

**Four Types of Processing Problems**

The problems with perception that children with neurological disorders have involve four specific types of processing problems:

* **Deficits in social perception** – Completely missing or misunderstanding social clues such as frowns, smiles, boredom and emotions, causing kids with neurological disorders to appear as if they are behaving in inappropriate ways without realizing they are being inappropriate.
* **Deficits in social cognition** – An inability to think clearly about their own behavior and internal feelings, as well as being unable to make assumptions about what others are feeling and thinking. For example, if the Camp Counselor frowns at a rowdy cabin, this is a sign that the Camp Counselor is displeased. The child with neurological disorders will be unable to make this connection.
* **Deficits in social judgments** – Because they are unable to make sound judgments about the people around them, children with neurological disorders tend to act impulsively and don’t think about the consequences of their actions.
* **Deficits in communication and social interaction** – Limited attention spans, limited ability to concentrate, and speaking too fast and too loudly.

**Problems Created**

Because of the “processing” problems described, children with neurological disorders often exhibit:

* “Clueless” behavior
* Quick tempers
* Poor impulse control
* Disruptive behavior

These behaviors can create problems for these children developing relationships with their cabin mates. With repeated failure in the social arena, children with neurological disorders often experience emotional distress in the form of anxiety, withdrawal, isolation and low self-esteem.

**Dealing with Tics**

Tics are uncontrollable physical movements or vocal utterances and are most commonly associated with Tourette. They can involve any muscle group in the body, and verbal ticks may manifest in the form of snorting, coughing or saying certain words. The occurrence of tics may wax and wane, although periods of increased stress, excitement or fatigue will have a tendency to cause an increase in tics.

Some children are able to suppress tics for short periods of time, although doing so requires great concentration, which means it’s unlikely the child will be able to concentrate on anything else during that time. Sometimes, children with tics will have an uncontrollable urge to touch objects or people. The best thing to do about tics in the cabin is to ignore them.

**Dealing with Teasing, Bullying and Discrimination**

Children with neurological disorders because of their poor social skills and poor communication skills, as well as tics and other behaviors, are sometimes subject to teasing. In extreme cases, the teasing can escalate to a predatory level where there is a bully and a victim.

We are a bully-free camp. We do not allow staff or campers to engage in teasing, bullying and discrimination in any way, including discussion of sexual orientation jokes or activities.

It is the responsibility of the Cabin Counselor is take immediate action to eliminate teasing or inappropriate discussions. Any Camp Counselor who engages in in of these activities will be immediately dismissed.

**Following Daily Camp Routines**

Everybody has daily routines they follow. For children with neurological disorders, however, their routines can become obsessive compulsive issues. These children prefer routines, and for many, these routines begin as they prepare for camp. Getting dressed seems to be a routine that for many children with neurological disorders must be done “just right”. If dressing is not done in a particular manner or if an article of clothing doesn’t “feel right”, the child may have to start dressing all over again.

It is important that you have a morning routine for your cabin to follow that can help your campers transition into the camp day. What do you do first? Second? Third?

One way to help the child’s day start off right is to engage him or her as quickly as possible once he or she arrives at camp. Having the child responsible for some type of job in the cabin is one way to accomplish this. Keep it simple, and make sure that you don’t tell the child what to do; show him or her how to do it.

Organization is a struggle for most children with neurological disorders. Consequently, anytime the child starts a new task, you may find it necessary to help him or her get started, particularly if the task has multiple steps. Always be sure to focus on the positive things the child accomplishes. Finding fault will lower self-esteem, and usually cause an angry or stressful reaction.

**End of the Day Activities**

Just as checking the campers’ suitcases upon arrival at camp was necessary, so will making sure that campers have all of their supplies before leaving for home. Make sure at the end of each day all campers have placed dirty laundry in personal laundry bags and all of their supplies in their suitcase.

**Sleep Problems and Medications**

Communication with Camp Nurses will be important if you notice a child having problems staying awake. Some children with neurological disorders have difficulty sleeping, or in falling asleep. Often their mind will race as they lay in bed, sometimes to the point where the only reason they fall asleep is out of sheer exhaustion. Medications can often change a child’s sleeping patterns.

**Planning Points**

Important points you can consider for your Plan include:

* Do any of your campers have difficulty at the end of the day?
* What type of activities can you plan for the campers to help them be successful at this time?

**What We Have Learned in This Course**

There is more to the child with neurological disorders than simply managing meltdowns. Knowing how to see meltdowns coming and how to minimize their impact is no doubt important, but only if considered in the context of helping the child have a successful camp experience.

For children with neurological disorders, information is processed in a different way. The information in this course will help you to determine the best ways to reach them. Along with knowledge, you will also need empathy, patience and understanding. If you are successful in your efforts, you will find working with children with neurological disorders, while labor intensive, will be among your most rewarding experiences.

You have completed the online Camp Staff Training. We are excited to have you join us at camp. Please feel free to ask us any questions you might have during on-site training and during the camp program. Thank you for helping us change children’s lives.