Managing Challenging Behaviors in the Classroom
By Ronald C. Savage and Helen McDonald

Introduction
The success of students in school is built around academic achievement and social behavior. The educational programs for students with brain injuries may be helping them achieve academically, but the real success in school is often measured by how well they behave and socialize. Students with cognitive challenges (e.g., attention, memory, speaking, thinking) or movement challenges (e.g., walking, fine motor skills, sensory integration) are often better tolerated than students with unwanted behaviors (e.g., inappropriate language, aggressiveness, difficulty with peers). After sustaining brain injuries, many students fail to succeed in school and their transition into adult life.

This article presents information to help students with challenging behavioral tasks related to success in school, improving medical management, making classroom accommodations and developing clinical systems.

Common Behavioral Tasks
After a brain injury, teachers may begin to notice changes in the student such as: ability to handle stress and confusion, response to adults and peers, ability to handle transitions and changes in personality. These and other behavioral changes may impact on how well the student “behaves” in the classroom and around school. The common behavioral tasks from a developmental and functional school perspective that students need to succeed are outlined in Table 1:

| 1. Displays appropriate restraint regarding self-stimulation |
| 2. Uses non-aggressive words or actions |
| 3. Accepts unexpected changes in routine |
| 4. Refrains from provoking others |
| 5. Hears constructive criticism without losing temper |
| 6. Uses words rather than physical actions to respond when provoked or angry at others |
| 7. Seeks adult assistance, if necessary, when experiencing peer conflict, especially conflicts involving violence |
| 8. Responds to/handles teasing in a constructive way |
| 9. Handles frustration when experiencing difficulties with school tasks/activities |
| 10. Shows common sense in words and actions around bullies, gangs, or strangers |
| 11. Maintains behavioral control in large groups of children (e.g., cafeteria assemblies) |
| 12. Resolves ordinary peer conflict or problems adequately on his/her own without requesting teacher assistance. |
Without this set of common behavioral tasks, students will find themselves floundering in school. Unwanted behaviors will continue to escalate as the student meets with more and more failure. In order to maximize teaching these behaviors to students with brain injuries, we need to work through an interdisciplinary model that incorporates medical, environmental and clinical strategies.

Managing Medical and Health Issues
Educators need to remember that students with brain injuries still may have complicated medical and health needs. Many times, changes in behavior are related to health care issues (i.e., decreased sleep, increased lethargy, increased tantrum behavior). Students often exhibit increased behaviors during times of illness or alterations in medical status, due to infection, seizure activity, fluctuations in hormone levels, etc. Working with the school nurse and the student’s primary care physician can help educators understand the impact of changes in health status upon students’ behaviors.

For example, many students with brain injuries take medications (e.g., seizure management, mood stability, anxiety, attention and arousal). While these medications are prescribed by physicians for particular reasons, all medications do have side effects. Some medications can make the student more drowsy or fatigued; others may slow the student’s thinking and ability to handle multiple pieces of information. Even common cold or allergy medicines can cause students to be more irritable and less able to self-monitor mood swings. Knowing what the medication is used for and its side effects can help educators plan accordingly. If a student becomes very restless and inattentive before the next dosage, this needs to be incorporated in the fully planning for that student.

A student’s brain is a developing organ. Sometimes, as the student gets older, new seizures appear even years after the brain injury. Other students may have chronic pain from injuries sustained in their accidents that cause them to be irritable or less attentive. Physical and occupational therapies or recreational activities, for example, may exacerbate chronic pain and decrease ability to maintain positive behavioral functioning. For example, students with brain injuries often complain of nagging headaches that could interfere with attention and concentration and lead to frustration and agitation. By working closely with the students’ primary care physicians, teachers and school nurses can inform the students’ physicians of any new of changing medical problems.

Making Classroom Accommodations
Students with brain injuries often need to work in environments that many adults with brain injuries could not tolerate. Classrooms that are overly stimulating (high activity levels, lots of noise and bright light) with continually shifting cognitive tasks (reading, writing, mathematics, social studies, science, lunch, recess) are the norm in most schools.

As more and more students with special needs are included in the mainstream of school to help social integration, students with brain injuries may find these schools and classrooms intensify unwanted behavioral responses. Students with attention and concentration problems, difficulty processing information effectively and quickly, or
problems making transitions may find themselves becoming frustrated, angry, and out of control.

Students will function much better in a “brain injury friendly environment” that is predictable, organized, devoid of over-stimulation and following consistent routines. Educators should consult with allied health professionals (physical therapist, occupational therapist, speech language pathologist) for recommendations about how to structure the classroom to make learning easier and thereby reduce frustration, confusion and other unwanted behaviors. Table 2 outlines critical environmental concerns for students with brain injuries.

Table 2

**Classroom Organization**
- Do classroom schedules consist of regular, predictable routines?
- Is the classroom organized for student capacity and appropriate work/study areas?
- Does the classroom have physical barriers that impede student movement?
- Is there a “quiet area” in the classroom that the student can use to calm down and refocus?

**Positioning in the classroom**
- Is the student distracted by sights and sounds near doorways, windows, and/or learning stations?
- Does sitting next to certain students increase unwanted behaviors?
- Are desks, chairs, and tables at appropriate heights?

**Visual attention**
- Do classroom walls have too much visual stimuli?
- Is information posted on walls and bulletin boards contrasted with bold/colored markings to make understanding easier?
- Are classroom and individual schedules posted?
- Are behavior contracts written and placed so the student can refer to and self-monitor?
- Are cabinets, closets, and bookshelves covered by curtains/doors when not in use?
- Are clear pathways maintained?
- Are classroom rules presented positively and posted for the students to see?

**Auditory attention**
- Is the classroom noise level slightly below conversation level unless otherwise recommended for hearing?
- Are teachers and peers first getting the student’s attention by establishing eye contact and using a prompt phrase?
- Are students with hearing losses positioned close to the teacher? Can extraneous auditory stimulation be decreased?
Many new students with brain injuries also display difficulties with learning new information, remembering old information, communicating, maintaining socially appropriate behavior and tolerating a multi-sensory environment, as well as physically participating in activities with ease.

Allied health professionals can provide useful information in these areas as well. For example, to enhance successful interactions, the speech language pathologist, along with the occupational therapist, may be able to provide strategies to improve effective communication, such as:

- Securing eye contact
- Considering the speed of verbal interactions
- Considering the amount of verbal information
- Considering the processing ability/time of the student
- Considering the expressive ability/time of the student

Another example of the allied health team’s ability in providing strategies to enhance the student’s behavior if looking at the student’s skills within the environment, such as his/her abilities in the area(s) of:

- Body awareness
- Auditory discrimination/modulation
- Visual discrimination/modulation
- Visual perception
- Motor planning/coordination of movement

When considering the surroundings that can facilitate or discourage adaptive behavior, it is important to remember that common impairments in brain injury are exacerbated by the environments in which students are expected to function. Their neurological and cognitive systems are often unable to cope with typical surroundings that developing students experience daily. Attending to, understanding, interpreting, and acting on input received from the visual and auditory systems may be particularly overwhelming for many students with brain injuries, especially when placed in typical school settings. By establishing more “brain injury-friendly environments,” educators will be able to better manage behaviors before they become barriers to student success.

**Developing Clinical Systems**

Along with good medical management and environmental accommodations, educators need well-developed clinical support systems to support students with brain injuries. Knowledge of brain-behavior relationships is critical in developing an effective clinical program for students as part of their educational plans. For students with frontal and temporal lobe injuries, many behaviors are the result of changes in the brain as well as diminished capacity to use cognitive strategies to help self-monitor behaviors. Educators may find students with frontal lobe injuries to be impulsive and haphazard, while students with temporal lobe injuries may become explosive and demonstrate rage-like behaviors. All these behaviors and more need to be addressed in a well-developed behavior management plan.
The A-B-C model
The management of behavior is often thought of using the traditional model of A-B-C, where A = antecedent, B = behavior, and C = consequence. While many educators receive training about behavior management, much of this training is often focused more on consequential management rather than antecedent management. Educators may try to manage the behavior through the use of consequences AFTER the behavior has occurred by using discipline, timeout, punishment, and other “consequential” management strategies. While consequential management techniques work for many of us, for individuals with brain injuries, “consequential” management often fails miserably. Students can’t remember the rules, no alternative behaviors are taught, or damage to particular areas of the brain, especially the frontal lobes, inhibits their ability to learn from consequences.

Many professionals find that “consequential behavior management” does not work well because:
- It was not proactive in design
- The student viewed the consequence as a punishment
- The student was not taught adaptive skills
- The teacher had “control” over the student
- It produced short-term effects but not long term results

Many professionals find that “antecedent behavior management” is more successful with students with brain injuries. Quite simply, the time and effort put into antecedent management follows a prevention model. That is, more time and effort are put into managing things before they happen. By looking at antecedents that may cause the student to have unwanted behaviors, educators can design behavior programs that focus on avoiding those antecedents and/or teach students strategies to help them control their behaviors. The traditional A-B-C linear model now becomes a reallocation of time and effort. The triangle model of A-B-C that follows exemplifies the antecedent based model.

The “antecedent behavior management” model works well because:
- It is proactive in design
- It helps the student learn adaptive skills
- It replaces challenging behaviors with adaptive skills
- It transitions control to the student

By using an antecedent-based model, teachers will also find it useful if they follow a five-step strategy when creating the behavior plan for a student:

1. **Identify changes in behavior**
   - Know how the student behaved prior to the brain injury
   - Identify changes in behavior after the brain injury

2. **Define the behavior**
   - Specify what to watch for or observe
   - Measure the behavior (how long, how often, when)
   - Limit and prioritize how many behaviors to change
3. **Assess the behavior**
   - Determine why the behavior occurs and focus on antecedents instead of consequences
   - Identify the strategy that will be most successful
   - Consistently follow the strategy

4. **Evaluate regularly and often**
   - Focus on adaptive skills and on compensatory strategies
   - Consider any cultural and/or language differences and family preferences
   - Review the effectiveness of strategies

5. **Make strategies successful**
   - Involve the student and family in developing the behavior plan
   - Focus on strengths, needs, and preferences of the student/family
   - Fit the strategies to the learning style of the student
   - Set up the environment to help the student learn/behave
   - Plan events and activities so the student knows what is expected and can predict what happens next

**Identifying and implementing successful strategies**

After identifying a pattern of antecedents to the student’s behavior, the process of identifying and implementing successful strategies can begin. It is important to determine and analyze the strengths, needs, and preferences of the student. The table on page 30 outlines behavioral interventions and strategies that teachers can use in the classroom.

**Table 3**

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<tr>
<th>Behavior Intervention Strategies</th>
<th>Possible Instructional and Compensatory Strategies</th>
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| Secondary depression and withdrawal | • While students often have memory problems, they do not generally forget what they wanted “to be” before the injury. Hence, depression after a brain injury is common for many students as they adjust  
• Teachers need to help students recognize the things they can do rather than what they cannot do. Keep students involved with the “real world.”  
• Be an “active listener” for students who need to talk and focus on the positive feelings the student displays. Use caution when dealing with family matters or matters that are very sensitive. However, let the student’s counselor know of these situations so they can be addressed.  
• If a student becomes suicidal or expresses such thoughts, contact the school psychologist and/or counselor and the parents/guardian immediately. |
| Lack of insight/denial of disabilities | • Many students with right hemisphere injuries may not recognize their problems and hence deny that they have any  
• Speak to the student in terms of “strengths and needs” |
rather than just “see” his/her inabilities
- Find the student’s strongest learning modality (visual, auditory, tactile) and use this modality to help the student recognize his/her problem areas.

| Impulsive behavior/ lack of inhibition | Students with frontal love injuries often feel “out of control” and cannot effectively inhibit impulses
- Staff need to help students better manage their worlds by keeping activities organized and structured. Use calendars, schedules, time clocks, etc., to help students orient to the world around them.
- Key works/phrases help students track their behaviors and lessen impulsivity. Merely asking a student “why” he/she did something does not help the person control those actions.
- Have students write down their plans as much as possible. Check their daily journals and focus the students on routines to decrease “not knowing what to do next” behaviors. |

| Poor emotional control | The key to handling poor emotional control is to redirect behavior, change the subject/environment, and refocus the student’s attention on something positive
- Students are often very sensitive to negative criticism and often react strongly if they feel someone is making fun of them. Use humor positively and not as a way to ridicule/embarrass students
- Mood swings are common after a brain injury since the brain is having difficulty trying to inhibit impulses and respond properly to the emotions. Teachers need to reorient students to positive goals and have them recognize that normal recovery, like life, is full of “ups and downs”
- With some brain injuries, students may lose the ability to feel guilt and empathy. They may sue offensive language and become very critical of others. Teachers need to respond to students by saying, “What you talk like that it makes me very uncomfortable,” rather than reprimanding the student. Show the students how they might better state what they are feeling in a more positive tone. |

| Apathetic/not caring attitude | Give students a choice between doing one thing or another; do not give them a choice between doing something or nothing. Keep the students involved with each other; group interaction helps to reduce apathy.
- Help the student explore what it is he/she really wants. Proceed in small steps, set easy goals, and show the student he/she can succeed. |
- Structure practice situations so the student can practice perceiving the feelings of others or how to respond appropriately.

**Agitation and irritability**

- Agitation and irritability usually are not purposeful, but more often the result of something else—fatigue, frustration, “bad days”—which are often not recognized by the student. Help the student pinpoint what is wrong and then find ways to cope.
- When a student becomes agitated / irritated and has an outburst, redirect the student away from the source of the frustration. Do not dwell on the outburst or what the student did.
- During severe outbursts, redirect and reduce the stimulation or frustration by offering the student an alternative action. Take the student for a walk, to the gym, or have the student do something physical to work it off.

**Aggression**

- Students who become aggressive generally have been agitated for a period of time prior to an aggressive display. It is important to know your students well enough to redirect agitated behaviors by heading them off before the student explodes. Keep the student’s counselors informed of behaviors that you feel could become harmful.
- Speak very calmly and gently to a student who has become aggressive. Even if the student is screaming, raising your voice will only make matters worse. You need to act as a “role model” for the student—be calm, caring, and controlled.
- Use key phrases that are familiar to the student to help him/her gain control of the aggressive behaviors. If the student needs to work out physically, take him/her to a gym or some other safe place.
- If the student’s aggressive behavior cannot be controlled and/or threatens the safety of the staff or other clients, the teacher needs to follow the school’s emergency procedures. However, use a teaching model, not a punishment model.

**Conclusion**

For many students the most enduring and potentially disrupting effects of brain injuries are changes in their behaviors and how often others respond to those behaviors. By developing an interdisciplinary team model that integrates medical and health management, environmental accommodations, and sound clinical programming as part of the educational planning, students will have a better opportunity for success in school—academically and behaviorally.