Epilepsy A Guide for teachers

This information is addressed to those who teach children and young people who have some form of epilepsy. Because the vast majority will receive their education in mainstream schools, it is more than likely that every teacher will encounter epilepsy at some time in his or her career.

The parents will not always inform the school, and sometimes the teacher may be the first to realise that a child has epilepsy. In any event, the importance of the role of the teacher in helping the young person and members of the class to accept the condition sensibly cannot be over-stressed.

What is epilepsy?

Epilepsy is a tendency to brief disruptions in the normal electro-chemical activity of the brain, which can affect people of all ages, backgrounds and levels of intelligence. It is NOT a disease or illness, but it may be a symptom of some physical disorder. However, its cause -especially in the young- may have no precise medical explanation.

How does it affect a child?

It causes the child to have seizures. Apart from that, with sensible management at home and at school, having epilepsy need not affect a child in any way. If a seizure occurs, the teacher's calm reaction will largely determine the attitude of the class. Knowing how to cope with seizures eliminates fear and embarrassment. The type, number and severity of seizures
vary from child to child and each child needs individual understanding.

Can epilepsy damage, or change, the personality?

No, not in itself, but the underlying cause of the disorder may have this effect in some instances. Other factors that can affect the development of the child are rejection, misunderstanding, overprotection and over-expectation. It is not wise to pamper children with epilepsy in or out of school. They should receive the same handling from teachers as other children. Classroom discipline should not be lessened through fear of precipitating an attack, provided that the possibility of a seizure passing unnoticed is taken into account.

Medication

The medication is designed to build up chemically the resistance to stimuli that can trigger or precipitate a seizure. It takes the form of tablets, capsules, or in the case of small children, syrup. In the past, medication was administered three or four times a day, but improvements in methods of presentation now make it possible for many of the preparations to be taken night and morning only. This prevents the risk of embarrassment to the child of "taking pills" during school hours. Whatever the

prescription, it is essential that the child takes the correct dose at the right time. If it is necessary for the medication to be administered in school, a negative approach can damage the child's self image with the risk of subsequent under-achievement. If the child starts having an increased number of seizures, or appears drowsy, overactive or inattentive, it may be that the medication needs adjusting. An alert teacher recognising such behaviour is advised to discuss the matter with the parents and school health team.

Types of seizure

Tonic Clonic or Grand Mal seizure which can be very frightening when seen for the first time. The child may make a strange cry, (a physical effect that does not indicate fear or pain) and fall suddenly. Muscles first stiffen and then relax, and jerking or convulsive movements begin which can be quite vigorous. Saliva may appear round the mouth, occasionally blood-flecked if tongue or cheek have been bitten. The child may pass urine.

This type of seizure may last several minutes, after which the child will recover consciousness. The child may be dazed or confused - a feeling that can last for a few minutes to several hours and may want to sleep or rest quietly after the seizure. Although alarming to the onlooker, this type of seizure is not harmful to the child and is not a medical emergency unless one seizure follows another and consciousness is not regained. Should this happen, medical aid should be sought without delay. This condition is known as 'status epilepticus'

Complex partial seizures, sometimes called temporal lobe seizures, which occur when only a portion of the brain is affected by excessive electrical discharge. There may be involuntary movements, such as twitching, plucking at clothing or lip smacking, The child appears conscious, but may be unable to speak or respond during this form of seizure.

Absence or Petit Mal which may easily pass unnoticed by parents and teachers. The child may appear to daydream or stare blankly. There may be frequent blinking of the eyes, but otherwise none of the outward signs associated with tonic-clonic seizures. Though brief, these periods of clouded consciousness can be frequent. They can lead to a series of learning problem if not recognised and treated, because the child is totally unaware of his surroundings and receives neither visual nor aural messages during such a seizure.

Calm observation of any seizure may well provide vital information for the doctors, who rarely see the child having a seizure. Co-operation between teachers, parents school medical service personnel and the family doctor/paediatrician can prevent a child with epilepsy from becoming a handicapped adult.

Classroom First Aid

The reaction and competence of the teacher is the most important factor in any classroom acceptance of a seizure. In a non convulsive seizure, understanding and a matter of fact

approach are really all that is needed. A teacher should be aware of the possibility of mockery when the seizure has passed, and deal with it, if it arises, according to the age group concerned.

If the child has a tonic clonic seizure, classmates will respond to the calm behaviour of the teacher. Ensure that the child is out of harm's way, but move him only if there is danger from sharp or hot objects, or electrical appliances. Observe these simple rules and LET THE SEIZURE RUN ITS COURSE.

1. Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements.
2. DO NOT try to put anything at all between the teeth.
3. Loosen tight clothing around the neck, remembering that this might lighten a semi-conscious child and should be done with care.
4. Do not call an ambulance or doctor unless you suspect status epilepticus.
5. As soon as possible, turn the child to the side in the semi-prone position to aid breathing and general recovery. Wipe away saliva from around the mouth.
6. If possible stay with the child to offer reassurance during the confused period which often follows this type of seizures. It is not usually necessary for the child to be sent home, but each child is different. If the teacher feels that the period of disorientation is prolonged, it might be wise to contact the parents. Ideally a decision will have been taken in consultation with the parents, when the child's condition is first discussed, and a procedure established.
7. Always inform the parents if a child ahs a seizure.

School Activities.

Decisions should be taken after discussion with parents and medical advisers, but any restriction on the child with epilepsy with regard to school activities will serve to make the child feel and appear, different. With adequate supervision no activity need be barred, although it might be unwise to allow a child to climb ropes and wall bars if there is a history of frequent, unpredictable seizures. Swimming is to be encouraged and should cause no problems provided there is someone in the water to effect an immediate rescue should it be necessary. Many schools adopt the 'buddy' system for all children, which means that special attention need not be drawn to the youngster with epilepsy.

Some seizures can be triggered by TV and this should be borne in mind when lessons use this medium. Sitting at a distance is usually sufficient precaution.