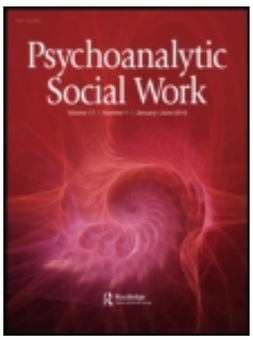

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The Therapeutic Process with Children with Learning Disorders

Joseph Palombo

SUMMARY. Clinicians who work with children and adolescents with learning disorders must be aware of the relationship between the learning disorder and the psychopathology the children present. This article offers a conceptual framework, based on psychoanalytic self psychology, to understand the modifications that are necessary in the treatment of this population. The author suggests that, in contrast to other approaches, it is not possible to conceptualize the treatment of these children as having a beginning, a middle, and an end. Rather, the therapeutic process is open-ended and conceived as occurring during a series of moments. The moments may be categorized as concordant, complementary, or disjunctive. During concordant moments a holding environment is created; during complementary moments the transference and countertransference is addressed; and during disjunctive moments the ruptures that inevitably occur during treatment are dealt with.

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In some respects, all children are alike, yet in other respects each child is unique and different from every other child. In this article, the focus is on the *differences* between children rather than on their similarities. Specifically, it is on the differences that result from having a learning disorder and on the way these differences influence the treatment process. By a learning disorder, I mean a neuropsychological deficit or weakness in one or more of the domains of perception, attention, memory, executive function, verbal and nonverbal language, affect regulation, or social functioning.

The profile of an individual child's neuropsychological strengths and weaknesses is analogous to the topography of a landscape. For some children, the terrain is fairly flat; that is, their competencies are evenly distributed. Other children's profiles look like a terrain filled with prominent peaks. These children are gifted in multiple areas. Yet the valleys between the ridges indicate that their gifts are rarely uniformly distributed across the entire terrain. Gifted children may also have learning disorders (Vail, 1989). For children with learning disorders, the terrain is highly variable. There are peaks and valleys that are notable for the contrast they present. The valleys between the peaks are much deeper than one would expect, indicating a great disparity between the areas of strength and those of weakness.

Some children appear unaffected by their learning disorders. In fact, the presence of a deficit may remain undetected, either because the child has learned to compensate for it or because the environment has not placed a demand on her[1] to demonstrate competence in that area. However, for those children who manifest symptoms, the learning disorder produces academic underachievement, psychological disturbances, or both. I refer to these psychological disturbances as disorders of the self. Such disorders of the self may manifest as failures to attain or maintain a sense of self-cohesion or as an inability to construct a coherent self-narrative or both.

A disorder of the self may manifest as dysfunctional behaviors or emotional problems, or may appear in combination. The dysfunctional behaviors may range from the absence of motivation to perform academically to disruptive behaviors at home and in the classroom. The children's emotional problems may present as low self-esteem, depression, anxiety, or difficulties in affect regulation. Dysfunctional behaviors may manifest as an inability to cope with the environment or an impairment in the ability to form positive relationships to caregivers, to respond appropriately to peers, or to function in school settings. For some children the emotional problems manifest as intense shame,

because they feel that they cannot be as successful as they want to be. They realize that they are smart but find themselves unable to demonstrate their competence in academic work. Their self-image is deeply affected. The net result of these dysfunctional behaviors and emotional problems is that these children's development takes a different course than it would have taken had they not been impaired. The extent to which children are affected, as I will discuss, depends on many factors. Among these is the severity of the learning disorder, the demands and expectations made of the child, the child's capacity to compensate for the disorder, opportunities and resources available to the child for the remediation of the disorder, and the parents' responses to the problems the child presents, which in circular fashion affect how the child will react and respond.

Learning disorders do not occur in a vacuum. Children with learning disorders exist in an environment that has a significant impact on their functioning. I refer to that environment as the *context* in which the child is found. My preference for the term "context" instead of "environment" grows out of my desire to emphasize the child's social and emotional milieu rather than simply the physical location in which the child is raised. Caregivers, as well as other aspects of the context, provide psychological nurture that is as important as the physical care the child receives. This context may complement deficits in endowment by providing protective factors, which may explain how the context can, at times, mitigate the impact of deficits in endowment (Cohler, 1987). At the other extreme, the context may amplify the effects of a deficit and overwhelm the child. While endowment may help overcome the deprivations that exist in some contexts, endowment can also act as a constraint that limits the child's development in a way for which no context can compensate.

The relationship between learning disorders and disorders of the self is complex. Disorders of the self may interfere with the acquisition of knowledge, but they do not cause learning disorders, since the latter are neurologically based. The impression derived from clinical experience is that children with learning disorders appear to suffer psychologically more than their peers who do not have learning disorders. As many children do not display psychological symptoms, their suffering cannot be measured through manifest symptoms alone. Epidemiological data, which look at overt symptoms, do not deal with the children's subjective responses to their learning disorder. Most of the children seen clinically seem to suffer at a minimum from self-esteem problems, anxiety, or depression. Some have, in addition, psychiatric problems–comorbid conditions such as mood disorders, anxiety disorders, obsessive-compulsive disorders, and adjustment problems. But no single pattern of problems is associated with all learning disorders. Some subtypes of learning disorders produce specific identifiable configurations of behavioral

and emotional problems, while others do not seem to be associated with any pattern of such problems (Brown, 2000; Rourke & Furerst, 1991).

The complex interplay among the neuropsychological deficits or strengths and weaknesses, the context, and the compensations a child utilizes lead to a variety of outcomes. While it is probable that no one is totally unaffected by the presence of a learning disorder, the manifestation of the impairment in the form of successful or unsuccessful adaptation or functioning can range from mild to severe. In the milder cases, the mark left may take the form of personality traits that uniquely identify the person. In the middle range, the combination of factors may lead to self-esteem problems or to narcissistic vulnerabilities to particular situations. In the severe cases, the child's functioning can be seriously impaired. (See also Palombo, 1979; Palombo, 1985a, 1985b; Palombo, 1987; Palombo, 1991; Palombo, 1992; Palombo, 1993; Palombo, 1994; Palombo & Feigon, 1984.)

Therapy with children and adolescents with learning disorders is, in some respects, no different from therapy with any child. In other respects it is quite different. The major difference is that the therapist brings to the process a perspective that is informed by the contributions the context and the child's competencies make to the child's psychodynamics. In this article, I do not undertake to develop a model of the therapeutic process. A model implies a set of standard techniques that are applicable to all patients. While such techniques may exist, the creative aspect of the therapeutic process cannot be captured by such an approach. This is especially true for work with children with learning disorders, where the modes of interaction involve play, drawing, fantasy games, and an entire repertoire of nonverbal modes of communication. In addition, treatment with these children necessitates work with their parents, their teachers, tutors, and other professionals who are closely involved with them.

The goal of the therapeutic process is twofold: (a) *To engage the child in an experience* in which she can either relive an old pattern of interaction and create a new pattern in which feelings are deeply engaged and made more meaningful, (b) *to cocreate a narrative with the child* that helps her understand her strengths and weaknesses, what happened to her historically, and how to use that knowledge in dealing with future situations. The first set of transactions is directed at strengthening the cohesiveness of the child's sense of self, while the second is intended to help her integrate past experiences into her self-narrative. Experience without understanding may be beneficial but is limited because it leaves the person in the dark as to what exactly occurred and what strategies to consciously bring to bear in future situations. Understanding without an experience in which to anchor the understanding is pure intellectual knowledge.

Such knowledge may be helpful, but it may not immunize the child from responding, both affectively and behaviorally, in old ways to current situations.

In the transference, the child unconsciously relives old patterns with little understanding of the motives for her conduct. As new experiences occur between the therapist and child, the therapist has an opportunity to reframe the child's understanding of her narrative and can help her create an entirely new self-narrative. Having an understanding for her conduct–that is, having a narrative interpretation that ties disparate events together–provides a road map that serves as a guide for the child. This is a necessary component of the therapeutic process. The therapist's interpretations or explanations serve to reveal the nature of the patterns and help the child begin to build new patterns for conduct. As the child informs the therapist of the narrative themes that shape the enactments, the therapist gains an understanding of the explanation the child has given to herself for her conduct.

In order to understand the treatment process with these children, I introduce the term *moments*[2] to describe nodal aspects of the process at different phases of the treatment. These moments consist of specific interactions in the dialogue between therapist and child. During this dialogue, feelings associated with past experiences and narrative themes emerge. These moments do not necessarily occur sequentially but arise episodically; they become organizing events that capture for the therapist the essence of the issues with which the child is struggling. As such, they present opportunities for the therapist to intervene through supportive statements, interpretations, or other interventions.

MOMENTS

The therapeutic dialogue with children with learning disorders may be deconstructed as series of moments (Pine, 1985) in which nodal occurrences are in the foreground of the interaction. By "foreground" I mean that the dialogue is experienced as having an ebb and flow during which attention gets focused on a particular set of affect-laden and meaningful interactions. Therapists often theorize that the therapeutic process unfolds in an orderly sequential way and that the movement is from one phase to another–from beginning to middle to termination phase. This sequential approach does not sufficiently appreciate the fluid, dynamic and untidy nature of the dialogue with a child with a learning disorder. In speaking of different *moments* it is possible to view the process as malleable, oscillating from one position to another. The three moments to which I will refer are *concordant moments, complementary moments,* and *disjunctive moments* (Palombo, 1985b; Racker, 1968).

Concordant moments are episodes that occur when the foreground issues are related to the therapist's efforts at maintaining a connection with the child and at creating an environment of safety and confidence. Under the concordant moments, I subsume those issues that have traditionally been classified as pertaining to the therapist's empathy for the child, the creation and maintenance of a holding environment, and the fostering of a working alliance between child and therapist.

Complementary moments are episodes that occur when the foreground is occupied by the *transference* or *non-transference* dimensions of the process. In those moments when the transference elements are activated, the themes of the child's narrative emerge to shape the interaction between the child and the therapist. The therapist must be open to experiencing those themes and understanding the impact they have had on the child's life. Themes from the therapist's narrative also arise within the therapist in response to the child's themes. These inevitably intrude into the process: they are part and parcel of the exchanges. They cannot be understood as undesirable; rather, it is through the interplay between the two sets of themes that a better understanding of the child's communications occurs. At times, nontransferential elements related to the child's neuropsychological deficits are activated. In those moments, the child may be seeking adjunctive functions from the therapist. Adjunctive functions are psychological or cognitive functions that reflect the child's neuropsychological weaknesses. The search for complementarity is motivated by the child's inability to function adequately without that assistance. The therapeutic dilemma for the therapist lies in how to respond to what the child perceives that she needs.

Disjunctive moments are episodes during which disruptions in the dialogue occur. The disruptions may be due to factors related to the therapist or the child. When such a disjunction occurs, the treatment is in crisis. It is essential that the therapist heal the rupture and reestablish the concordance between himself and the child. It is my view that, in those moments, the therapeutic process engages both child and therapist at the deepest levels of their senses of self. Countertransference reactions that stem from the therapist's own problems are subsumed under disjunctions; however, the concept is meant to include a much broader set of contributors to the disruptions that occur between child and therapist.

Concordant Moments: Immersion into the Child's Experience and Narrative

The therapeutic process begins with the establishment of concordant moments in which the therapist's efforts are directed at understanding either the child's psychic reality, or the meanings of what she reports. By becoming immersed in the child's view of the world and resonating with the child's experi-

ences, thoughts, feelings, and memories, the therapist enters that reality. The child must experience the therapist as being attuned to her feelings and responsively appreciative of their significance. Through his attuned responsiveness, the therapist begins to understand the meanings to the child of what she brings to the sessions. As the therapist experiences what the child experiences, he conveys, directly or indirectly, the assurance to the child that the clinical setting is a safe place in which no intentional harm will be inflicted.

EMPATHY

Kohut defined empathy as the tool through which we vicariously introspect our way into a patient's experience (Kohut, 1959). Stern enlarged the definition to include the experience of affect attunement (Stern, 1984). Stolorow emphasized the more cognitive aspect of understanding the meaning of an experience to a patient (Stolorow, Brandchaft, & Atwood, 1987). Each of these definitions underscores the role of nonverbal communication in the clinical process. When we attune ourselves to patients or resonate with their emotional state, we use nonverbal clues to guide us in our understanding of their experience. We listen to patients' verbalizations, but we also note their facial expressions, the direction of their gaze, their prosody, body posture, and other cues that enhance our capacity to enter into their experience. We form impressions of the child's self state through reading these nonverbal cues and respond to them with appropriate verbal and nonverbal interventions.

Empathy, as a tool for gathering data about the child's experience, is used to read nonverbal communications while experiencing with the child what she feels. We do not need to translate the child's nonverbal feelings into words for us to understand what the child is communicating. Through empathy we can tap into areas of the personality to which the child's verbalization may not give us access. Understanding a child's experience occurs through an understanding of the personal and shared meanings she derived from those experiences.

An important step in the empathic process is that of matching affective states. The concepts of attunement, alignment, and resonance describe a process by which caregivers attempt to match the affective state of an infant. This capacity to grasp or to understand is rooted not simply in cognition, but also in the contextual relations experienced by the child, and affective states evoked in her. One determinant of the meaning of an utterance is the context. The therapist's alignment with the child's affect state while grasping the meaning of the experience to the child defines an act of empathy.

The reliability of any information acquired through empathic observation is constrained by the limits of the therapist's capacity to be attuned to and under-

stand another person's experiences. Therapists face a difficult problem in their attempts to empathize with the experience of a child with a neuropsychological deficit. If the therapist has no knowledge of learning disorders, he may grasp intuitively the source of some of the child's struggles but will not understand their origins as related to neuropsychological deficits.

During the decades when psychodynamically oriented therapists had no knowledge of neuropsychological deficits, much good therapeutic work occurred. However, the work was incomplete because the paradigm did not account for these deficits. A detailed understanding of the nature of those deficits is essential to gaining an empathic understanding of the child's struggles. Empathizing with the child who has dyslexia presents therapists with a very different experience from empathizing with the child who has Asperger's disorder. Neglecting to incorporate an understanding of each of those disorders will lead to a failure to understand the child.

I am reminded of an adolescent with severe dyslexia who was failing most of his high school subjects. He often came to sessions angry that he had to be in treatment for his problems. He would open the sessions with contemptuous remarks about my waiting room magazine selection, the office furniture, or even my car. He compared me to his father's therapist, who had a larger office, more expensive furniture, and an expensive car. It was hard for me not to feel annoyed and injured by these contemptuous remarks. The temptation to respond defensively or to retaliate because of the child's attacks was also hard to control. Only after I could take these assaults in stride could I point out to the adolescent how badly he must be feeling due to his failures and how he dealt with his disappointment in himself by directing his anger at me. The contrast he drew between his father's therapist and me paralleled how he felt. He felt that others were much better endowed and more competent than he was. Had I not known of his dyslexia, I might have interpreted his comments as motivated by other dynamics, such as oedipal competitiveness or narcissistic self-centeredness.

During concordant moments, the therapist seeks to establish an environment in which the child can feel safe and understood. A number of factors enter into the creation of such an environment. The therapist conveys a sense of caring and concern by his demeanor and attitude, as well as a readiness to be responsive and helpful. Such a stance is characteristic of the "holding environment" (Winnicott, 1965, p. 240). This position has also been described as a "working relationship" (Keith, 1975). By being nonjudgmental, by assuring the child of the confidentiality of all transactions, and by consistently trying to maintain a perspective that is from within the child's experience, the therapist establishes an alliance with the child. By being open and receptive to feelings, the therapist strives to permit the child to experience an optimal level of inti-

macy. The therapist's depth of understanding is related to his knowledge of the effects of the learning disorder on the child's development and personality and his ability to convey that understanding to the child. A therapist who lacks that knowledge is prevented from fully empathizing with the child and understanding her psychodynamics (Ornstein, 1976; Ornstein, 1981; Ornstein, 1986).

The atmosphere created in the clinical setting is always dictated by the standards of social propriety consistent with the cultural context in which the therapy is conducted. It assumes unqualified acceptance of and respect for the child. This demeanor is not just part of the empathic stance that is proper for the conduct of the therapy but also implied by the code of conduct to which society and the professional code of ethics subscribe. Deviations from such standards can, in more serious forms, represent a betrayal of the child's trust. At times minor deviations from social propriety, such as not acknowledging a significant event in the child's life or refusing to respond to questions but not explaining why, insert into the setting an element of artificiality that cannot help but bring discomfort or embarrassment or both to the child. The deviations may be perceived as reflective of the therapist's detachment or wish to exert power. Since the therapist owes the child safety and respect as a condition of therapy, these deviations should be explained to her. Failure to adhere to these standards may introduce an iatrogenic element that will add to the child's suffering.

Finally, maintaining a concordant position is at times equivalent to being available to share meaningful affective experiences. Such responses raise the hope in the child that the therapist will acknowledge and respond to her unsatisfied longings. For the therapist to allow himself to be so experienced requires the discipline of keeping his own longings into the background. This disciplined self-denial constitutes the essence of professional integrity.

CONCORDANT RESPONSES

It is possible to conceptualize a variety of *concordant responses* that constitute therapeutic interventions. These are primarily either supportive remarks, indicating to the child that the therapist understands, or remarks directed at the enhancement of the alliance. Most children with learning disorders begin treatment with some initial resistances that must be recognized and worked through. These resistances are often motivated by the fear that their problems will be dealt with much as they have been by others. The empathic atmosphere may raise children's hopes and transference expectations, although they are likely to remain wary that their fear will be realized. Time and acquaintance with the therapist can help work through some of these resistances. Articula-

tion of these resistances through interpretations that convey a general understanding of their source may speed the process along.

Occasionally interpretations of a child's resistance to the establishment of a concordant position might also be made. Adolescents, for example, are often resistive to the process itself, experiencing the therapist's attempt to be empathic with their experience as intrusive. They seem to actively repel any effort at being understood. Such patients drag their heels into treatment, resentfully complying with caregivers' wishes. Their engagement is initially quite difficult. Rather than responding to these patients in an adversarial way, therapists might think of them as one would of children who are burn victims and require physical therapy in order to be rehabilitated. The therapeutic process itself is agonizingly painful and may even appear to be traumatizing. Keeping their distress in mind makes it easier to respond with gentle firmness, rather than harshly and punitively. The resistance must be addressed with the utmost sensitivity. General interpretations consisting of no more than a comment about the distrust of adults may be more effective than other means.

Once these initial resistances are addressed, the process may unfold. Some of the archaic selfobject needs begin to surface as the transference develops, and what Ornstein call the "curative fantasy" (1981, 1983, 1986) becomes activated. This fantasy, which is often unconscious, embodies within it the unfulfilled longings contained within the deficient self. Another way to think of this fantasy is to understand it as the activation of the child's hope for self-restoration. The hope is that, at last, relief from the chronic suffering is in sight–something will change things radically for the better.

Complementary Moments

Complementary functions are psychological functions children with learning disorders use to maintain a sense of self-cohesion. I refer to selfobject as well as adjunctive functions. In the context of the treatment process, I return to the construct of complementarity and extend its meaning to describe part of what occurs between the child and the therapist. The application of this construct to the therapeutic process highlights the parallels between therapy and the functions that parents perform to enhance the child's growth and development. It also sheds light on the replication of those patterns in the transference.

A complementary moment may be said to occur when the therapist replicates the childhood context as the child experienced it. One set of complementary moments is related to the *transference of self-object functions and narrative themes*; the other is related to the performance of adjunctive functions by the therapist, which I designate as a *nontransference reaction.* Let me first discuss those moments that are related to the transference dimension, and

then deal with those that are related to the nontransference dimension or the search for adjunctive functions.

SELFOBJECT TRANSFERENCES AND NARRATIVE THEMES

Broadly speaking, transference is the perception of the present from a particular perspective in the past. It is the arena in which the child reenacts, and reexperiences old selfobject needs and themes from his narrative.

With regard to selfobject needs, if we were to contrast Kohut's view with Freud's, we might say that Freud understood patients as wanting something forbidden in the transference (the oedipal object), while Kohut saw them as wanting something they needed (selfobject functions). Selfobject transference then is the evocation of the early experiences that resulted from the frustration of selfobject needs. The revival is the reawakening of the uncompleted developmental sequence, not the reemergence or reenactment of an unresolved conflict.

What is recreated is not the selfobject deficit itself–it would make no sense to speak of the rearousal of something that does not exist–but the desire for particular kinds of responses or the disavowed feelings related to the deficit. The positive transference produces an expectation that the new relationship will in some magical fashion provide the patient with the longed-for selfobject functions, that the current relationship will provide what was missed or will repair the injury produced by past events. The negative transference is the expectation that the therapist will respond as others had responded in the past. The child will then be retraumatized. I will deal with this aspect of the transference in the section on disjunctive moments.

From the perspective of the child's self-narrative, the transference represents the enactment of the themes that have organized her experiences. The form the enactment takes reflects the way in which the incoherences in the narrative organized the child's life historically. The clinical setting is, then, a microcosm of the child's current life. It reflects the child's organizing themes in the here-and-now. Those dynamics reflect the unintegrated personal meanings the child has retained. Enactments often represent the best integration the child has made of her experiences. They represent the psychic reality or the narrative interpretation of the child's past. In this sense the historical reality may not have been distorted, because the experience was integrated within the cognitive-affective givens of the child. What makes these experiences problematic now is not that they are fantasies, but rather that they represent a view of reality that has remained walled off from the rest of the child's system of meanings and so has not been integrated with them into a coherent view. The walling-off

itself may have been due to an attempt at either repression or of disavowal of the affects associated with the experiences.

Two particular narrative themes I have frequently encountered in the transferences of children with learning disorders are emplotment and conventionalization.

EMPLOTMENT

The concept of emplotment (Kerby, 1991) is used in narrative theory to delineate the ways in which patients become characters in other people's narratives or become engulfed by their own expectations of how their self-narrative ought to unfold. Children can become emploted in their caregivers' narratives when they try to conform to their expectations. They may take on the themes of the narratives of those they wish to please. Caregivers' self-narratives include the meaning the child has for them as well as the role the child is to play in their lives. In effect, the parents experience their infant as a character in their own plot. If the child appropriates these attitudes and behaviors and includes them as subplots within her narrative, she thus becomes emploted into the caregivers' narrative characterizations of her.

Emplotments occur when the child finds it necessary to conform to the narrative themes of others in her context. Children with learning disorders have a great need for others to complement their deficits. At times, the price they have to pay is high; not only must they perform selfobject functions for others, but they must also conform to their expectations. While it is true that many children resist such expectations by rebelling against those who require them, some collapse into compliant conformity. Those who rebel come to the notice of adults more frequently because of their noisy protests. But the compliant ones often fade into the background and are written off as lazy, unmotivated, or simply not bright enough to perform the tasks demanded of them. These children accommodate to their context by trying to become as invisible as possible.

Not all emplotments involve such withdrawals. Some children act out a parent's unconscious assignment of a particular role. A parent may identify the child with a sibling who died young or was a childhood rival. The child's behavior then appears to mimic that of the assigned surrogate.

The sources of these behaviors are often obscured by the fact that they are subtly shaped by the caregivers' unconscious expectations. For example, an eight-year-old child with dyslexia whose testing placed him within the average range of intelligence was referred because his school performance was so much lower than his capacities. His second grade teacher thought he was re-

tarded. During an extended evaluation, the mother revealed that she had a younger brother who had Down Syndrome. This brother had required much attention from her parents, who were determined to give him every opportunity to feel valued. My patient's mother interpreted their behavior as disinterest in her and a sign that the parents favored her brother. Her resentment toward her brother, however, was fraught with guilt. When she was assigned duties for his care, she felt both responsible to act as a caring older sister and deeply resentful that she had to give of herself to this rival for her parents' attention.

When her son was born, she was unambivalent in her love for him. But as developmental deficits emerged and he required more and more of her, her old ambivalent feelings toward her brother began to surface. She struggled against these feelings with increasing guilt; in spite of her best efforts, however, she began to treat her child as she had treated her retarded brother. For the boy's part, he needed his mother to fulfill complementary functions, and the only way he felt he could stay connected to her was through close compliance with what he perceived to be her expectations. The net result was that he became emploted in his mother's narrative by representing his mother's brother, whom he unconsciously mimicked by presenting himself as less smart than he actually was.

In the transference, this child seemed desperate to find a role he could play in the therapist's life. He persistently asked for details about the therapist's family. When given a few facts, he tried to fit himself into the family constellation. He imagined that my other patients were my children and that he was their sibling. He would ask me if I prefer them to him, and were they smarter than he. My responses were that he wished he could be as loved by his mother as he imagined me to love my other patients. I also pointed out that he could not imagine himself to be smarter than my other patients, a comment that he met with disbelief. It was only after his parents could integrate the fact that the dyslexia stood in the way of his accomplishing more academically that their perceptions of him changed. He was then able to integrate the understanding of having a reading problem as not being equated with being retarded. As the family dynamics shifted, his self-perception changed, and he could begin to use tutorial help to learn to read.

CONVENTIONALIZATION

Society presents each individual with a set of "predesigned" narrative themes and expects its members to embrace them. Each patient must integrate some social norms, expectations, and behaviors into her self-narrative or suffer some consequence for defying. Children feel pressured to conventionalize

their narratives by making them approximate the normative narrative, that is, the canonical narrative of the social/cultural milieu (Bruner, 1990). The child is confronted with the task of integrating the shared meanings of the context into her self-narrative. In order to maintain selfobject ties to the members of the larger social group, she must embrace or reject the values that the group maintains. She must modify her narrative to bring it closer to the expectations of those whose opinions are valued.

The issue of conventionalization is closely related to alter-ego selfobject functions. Children with learning disorders often feel themselves to be foreigners in the context in which they are raised; yet they desperately wish to be part of the peer group. They see acceptance by the group as minimizing their sense of strangeness. The desire to conventionalize their narratives leads them to try to be as others expect them to be. There are numerous ways in which children manifest the desire to conventionalize their narratives. By conforming to how others dress, how they talk, the activities in which they engage, or even the drugs they use, they try to join a group of peers that is considered "cool." Acceptance by that group erases the sense of difference and normalizes their behavior.

CASE ILLUSTRATION: JIM

Jim was an obese high school freshman who had a history of receptive language problems and impairments in auditory memory and auditory processing. His ability to understand verbal communications was impaired, as was his ability to extract information from reading, although he did not have dyslexia. While he heard clearly what was said to him and could process simple verbal communications, he had difficulty fully understanding other people's spoken words if they were not couched in simple sentences. Even with the assistance of a tutor, he struggled to get C's in courses that involved listening to teachers' lectures. In math, or in subjects that did not involve reading, he consistently got high grades. His perception of himself, in his high-achieving family, was that of someone who would never attain the level of success reached by his parents and siblings. Consequently, he was chronically depressed and had lapsed into a passive stance in which he took no initiative in any activity. His preferred form of entertainment was playing video games, at which he had become quite expert. In addition, he had resorted to eating as a way to comfort himself and was unable to control his food intake. He was more than 60 lbs. overweight, although his large frame masked his obesity so that he looked like an ideal football player.

Jim's father, who had a similar physique, came from a large family in which he had to fend for himself. He was able to become highly successful by being aggressively competitive. While he intellectually understood his son's problems, he felt utterly frustrated by Jim's passivity. He would become enraged whenever he saw Jim watching TV, munching on snacks, or playing video games. To him, Jim was a lazy slug who would never amount to much. He developed the approach of "motivating" Jim by berating him, presenting him with the image of failure unless he did something with himself now to become like other kids. He constantly compared Jim with his high-achieving siblings, tried to restrict his food intake and TV watching, and pushed him to engage in sports. Jim inevitably responded by increasing his food intake and putting even less effort into homework than usual.

When Jim entered high school, his father decided that the solution to the problem was for Jim to try out for football. He felt that participation in football would not only involve him in a healthy athletic program but also encourage him to become more assertive. Jim hated the idea. Being fearful of body contact and not well coordinated, he saw only failure and humiliation ahead of him. However, he felt caught between his own desire to remain regressed and his desire to please his father and gain his approval and affection. For his part, his father dangled the prospect of more fun times together should Jim comply; he threatened to withdraw altogether from Jim if he did not. Finally, Jim's resistance was overcome by the gains he felt he would be making in pleasing his father.

Football turned out to be a painful but bearable experience for Jim. The coach was impressed by Jim's size and saw him as a promising linebacker who could contribute to the team's success. He took a great interest in Jim's training, praised him for the efforts he made, and rewarded him by publicly recognizing any success on the field. The rest of the team became equally invested in Jim's success since they needed him; they made him an integral part of the group and accepted him as one of their own. Jim began to make efforts to be like the others. He saw his salvation as lying in the direction of conventionalizing his behavior so that he appeared to be more "normal." He began to daydream of being a star on the football team, thereby shaping his identity into one that would conform to others' expectations of him.

By embracing a conventionalized theme, that of the heroic football player, Jim was able to find an avenue of success that helped restore a measure of self-esteem in an activity into which he had been pushed. While the initial impetus for his trying out for football was a desire to please his father, his involvement was transformed by the responses he got from his coach and teammates. The desire to be like others and to be accepted as part of the group

became a powerful force for his continued involvement in football, in spite of his initial fearfulness and his lack of aggressiveness.

Jim was desperate to attain a conventionalized self-narrative. This included an adamant refusal to involve himself in therapy, because that would have accentuated his sense of difference.

We might speculate as to the type of transference that would have developed had Jim become engaged in treatment. We would expect that Jim's resistance would be in the forefront of the initial work. He would need to be engaged at a level that was acceptable to him. The first priority would be to establish an alliance with him in which he could see the therapist as understanding and supportive. One way such a relationship could have been achieved would have been by focusing on the difficulties Jim was having in his academic work. In this connection, it would be important to find out how well he understood the limitation his learning disorder imposed on his capacity to achieve. Addressing this issue would be complicated by his receptive language problem. Care would be needed in communicating with him verbally, to make sure he understood what was said.

In time, it might have been possible to develop an alliance. The hard work would come with the unfolding of the transference. Expecting the therapist to be as critical and deprecating of him as his father had been, Jim would be acutely sensitive to any negative overtones he might pick up from the therapist's interventions. At the same time, he would be wondering what he needed to do to please the therapist so as to be perceived as a "normal kid."

In the positive transference, the therapist would be responding to Jim's desire to "not have any problems." The issue would be engaged around the meaning Jim attached to having a learning disorder. If he could come to accept that, could he then feel that it did not detract from who he was, and could he feel himself to be different from others without seeing that as a stigma? If those questions could be answered positively, he would escape from the need to seek acceptance by conventionalizing his self-narrative and be freed to find his own path in life.

NONTRANSFERENCES

Not all conduct by a child in the clinical setting is motivated by unconscious factors. Some conduct is the product of the child's neuropsychological deficit. In treating children with learning disorders, therapists confront a major confounding factor, that of making a distinction between a child's responses based on transference and those based on the child's search for adjunctive functions. While sharp differentiations cannot be made, some distinctions are possible

that will help therapists in making interventions. These children have emotional *and* learning disorders. They suffer from two types of deficits that often cannot be distinguished: selfobject deficits and neurocognitive deficits. Each has its own history and its own associated set of symptoms. Each leads the child to look to others to fill in these deficits. Neurocognitive deficits do not result from disruption in relationships but from the child's endowment or innate givens. Selfobject deficits arise from the complex interplay between what the child brings to the relationship and the responses of significant others to what they experience the child as expressing. In addition, the child, through her innate givens, contributes significantly to the shape of the relationship with caregivers. Unaware of the child's deficits, caregivers respond to her from the belief that their responses address what the child requires. The failure in the dialogue results in the child's experiencing the parents as unempathic. The therapist must be attuned to the subtle or not so subtle miscommunications that inevitably arise in the transference and that replicate these patterns.

Since, as therapists, our focus is always on the transference, the question can be posed as follows: Can we as therapists distinguish between behaviors that are "brain driven" (hence, unmotivated) from behaviors that are motivated by conscious or unconscious factors and, hence, will manifest as transference reactions? If we were able to answer this question, we would be well on our way to defining appropriate interventions and gaining a better understanding of these children.

At times therapists modify their techniques to respond to specific needs of children with learning disorders. A dilemma is created for the therapist when the child's request requires a departure from what is considered acceptable. For example, a child with a handwriting problem may bring her homework to the session and wish to dictate her work to the therapist. Or, a child may ask that the therapist write a note excusing her from a gym activity that is particularly embarrassing because the child feels exposed and humiliated. The response to these requests must take into account the child's struggles and the issues being addressed. It is not inappropriate to comply with such demands if they serve to demonstrate to the child that the therapist understands the difficulties she is facing.

The child has little or no awareness of her own deficits; therefore, the burden falls upon the therapist to make the distinction and to make a response based on the child's needs. Problems arise less at the extremes than in the middle ground. When a child clearly transfers onto the therapist attitudes that were not invoked by the therapist and manifests patterns of interaction that occurred with significant others, such episodes bear the clear imprint of transference. But when a child asks the therapist to accompany her to the bathroom door because the corridors the child has to negotiate to get to the destination are totally

disorienting, it is an injustice to the child to attribute such a request to regressive motives or transference. The request does have meanings to the child based on past interactions, but in most situations these meanings are not clear-cut. The therapist's focus and the context must help determine the proper intervention. Ultimately, observing the results of the interpretations of such behaviors permits the therapist to differentiate between transference and nontransference requests. An interpretation may attenuate the effects of selfobject deficits, but it cannot modify the cognitive deficits–only compensations or new skills can do that.

Disjunctive Moments

A disjunction may be said to occur when the child ceases to feel understood by the therapist. The therapist may also feel that he does not understand the child. The situation need not be symmetrical. At such points the child may withdraw, become enraged, express disillusionment with the progress of the therapy, or actively seek to reengage the therapist in the process. For the therapist, these indicators are flags that something is seriously amiss in the dialogue. While the reactions may be part of the larger transference, they cannot be ignored. The repair of the disruption must take precedence over the reconstruction of the pattern of response. (See also Atwood & Stolorow, 1984, p. 47 on *intersubjective disjunctions*.)

Several factors contribute to the creation of disjunctions or derailments in the dialogue. These may emanate from three sources:

1. *Negative transference reactions* result from the nature of the child's dynamics and recreate experiences in the child's past.
2. *Transferences of the therapist to the child* are the traditional countertransferences that have been discussed at length in the literature and which I will address in relation to the special problems that occur in the treatment of children with learning disorders.
3. *Nontransferential areas of the therapist's functioning* are disruptions created by the therapist's theoretical orientation, lack of experience, interferences due to supervision, personal life events, neuropsychological strengths and weaknesses, and other factors.

NEGATIVE TRANSFERENCES

Children tend to anticipate that a retraumatization will occur in the therapeutic relationship. The negative transference becomes activated when the child experiences the therapist as the embodiment of past negative relation-

ships. The conditions for such a reactivation are often found in a seed of reality in the interaction with the therapist, the result of some small, inadvertent responses on the part of the therapist. Such responses are experienced by the child as intentional or even maliciously inflicted injuries, the concrete manifestations of her fear of retraumatization.

In the complementary interplay, a nucleus of reality is embedded in the activity or the personality of the therapist, to which the child attaches great meaning. This sets off negative expectations. Since such incidents are an inevitable part of the process and reflect the child's dynamics, they provide an opportunity for therapeutic work. What is required is that the therapist acknowledge his contribution to the disjunction. This affirmation of the nucleus of reality in what occurred allows the empathic bridge to be rebuilt. Following that reconnection it may then be possible to comment to the child about the intensity of her response and its possible transference character. Usually what emerges is that the episode represents a reenactment of a segment of the child's past experience that is now available for possible interpretation. This ebb and flow in the process is one of the major components of the curative dimension. The therapist shifts from a disjunctive to a concordant position back to a complementary one. The shifts are an inevitable part of the treatment process. Healing the disjunction is essential to the treatment.

A disjunction may be triggered when the therapist is perceived as threatening, assaultive, or destructive. The therapist may experience the attribution of such feelings as threatening to his own sense of cohesion. The feelings are alien, not in keeping with the view the therapist has of himself. The therapist may then make a concerted effort to disabuse the child of her notions by pointing out the reality that the attributions are not correct. The child experiences these efforts as evidence that the therapist does not understand. The disjunctive gap widens. It is then not even necessary for the therapist to do anything that conforms to the child's expectations for the child to feel misunderstood.

CASE ILLUSTRATION: ASHLEY

A therapist came to consult me about a case with which he was having difficulty. He described Ashley as an attractive, angelic-looking eight-year-old child, who had been referred because of serious behavior problems at school, although her behavior at home seemed to be well within acceptable bounds. She was diagnosed with AD/HD. The parents had a terrible marital relationship; they had been feuding with each other for years. They seemed unable or unwilling to break the impasse by either working on their relationship or separating.

In the course of twice-a-week treatment, Ashley became more and more contemptuous of her therapist. She ordered him around like a slave, demeaning him by her humiliating insistence that the messes she created be cleaned up by him as she gleefully watched. She developed the disconcerting habit of walking into the office and greeting the therapist by giving him the finger and saying, "Hello, you f–." The therapist felt helpless and bewildered as to how to respond to the greeting and to the disrespect. If he did not comply with Ashley's wishes, she would throw a tantrum by screaming, kicking, and spiting in his face. Yet if he did comply he felt totally devastated at being placed in such an abject position. When at one point he complained about her name-calling, she responded that names are only words and can hurt no one. Wouldn't he rather be called names than be kicked or spat upon? While he recognized that Ashley was replicating with him what she probably witnessed at home, the therapist's rage at the constant injury suffered at the hands of this child mounted until he felt his therapeutic effectiveness was totally defeated. He eventually requested that treatment be terminated since he could not see how he could be of help to this child.

In consultation to discuss the impasse, we determined that the concordant position could not be maintained because the therapist's vulnerability to the assaults would not permit him to resolve the child's negative transference. As the consultant, I recommended that the case be transferred to another therapist. What the therapist discovered during the course of the consultation was that Ashley's assaultive behaviors brought up the teasing and taunting he himself had suffered from peers in grade school because of his poor coordination. He had never worked through his embarrassment or his rage at his peers for these assaults. Ashley's parents had dealt with her hyperactivity as misbehavior that required strong reprimands and punishment to control. In the therapy, she replicated the way she had been treated. Unfortunately, rather than responding therapeutically, the therapist became enraged and paralyzed in dealing with the negative transference.

COUNTERTRANSFERENCE

A different type of disjunction occurs when the child's own internal chaos produces a contagious anxiety in the therapist. The therapist may feel assaulted and overwhelmed. Because he feels alone and unable to help the child, he may cast about for measures other than those the relationship provides, such as medication, or possible hospitalization. It may not always be clear which, if any, of these measures are, in fact, indicated. What confuses the issue is the helplessness the therapist feels and the effect it has in clouding his therapeutic

judgment. Some therapists tend to respond with resentment and rage, as though the child is intentionally tormenting them and making them feel inadequate. Other therapists find their grandiosity stimulated and take charge of such situations with alacrity and zeal; they become directive and intrusive in the child's life. Obviously, in these instances the burden falls on the therapist to deal with the feelings the child has stimulated.

CASE ILLUSTRATION: KEVIN

Kevin was a sturdy seven-year-old boy who had been referred because of serious behavior problems. He was diagnosed with AD/HD, for which he was on Ritalin and in a special education class in his school. He was impulsive, disorganized, and, at times, intensely provocative. He seemed to know his therapist's vulnerabilities and had acquired the knack of provoking instantaneous rage reactions. At one point in the course of treatment, Kevin would walk by the therapist and then, unexpectedly, lunge toward him and hit him in the genitals. Although the therapist tried to anticipate these assaults, he was not always quick enough to fend them off or defend himself against them. He was repeatedly exposed to both humiliation and physical pain. On occasion he became so enraged at Kevin that he grabbed him and could feel himself almost enough out of control to have hit him. Fortunately, the therapist was able to observe the process closely enough to realize that these assaults were not totally unexpected. Instead, they occurred most often when the child felt on the verge of disintegrative anxiety caused by something that had occurred either in the prior session or in his environment. The complementary positions of the therapist were leading to disjunctive responses.

In consultation, the therapist realized that his own helplessness was reminiscent of physical abuse he had suffered as a child at the hands of an older brother. He became aware of his countertransference and was able to maintain a therapeutic stance. His realization led to an exploration of the management of Kevin's disruptive behavior at home. After several sessions with the parents, they were able to reveal that between the ages of two and five Kevin was cared for by a housekeeper while his mother was working. The parents began to suspect that she might be either physically or sexually abusing him when his behavior grew increasingly out of control. When they discovered a bruise on Kevin's arm, they immediately dismissed her. Kevin never talked or complained about her, which they surmised was because she might have threatened him if he reported what she did to him.

After these revelations, the therapist was able to empathize with Kevin's victimization. Kevin was doing to the therapist what he experienced as having

been done to him. It was then possible for the therapist to share with Kevin his parents' suspicion and to have the parents also talk to Kevin, expressing their concern and sadness at what might have happened. While Kevin never could talk about any of this, the assaultive behavior stopped.

Trying to explain to the child the contribution of the learning disorder to the disruptive pattern without making the child feel that he is being blamed for what occurred requires considerable tact. In Kevin's case, there is no doubt that his overactivity made him a very difficult child to control. While this did not justify physical abuse, it raised the question of how to help him understand that his behavior had an impact on others and that others' responses were in part related to that impact.

The therapist began by explaining to Kevin that when he got out of control, bad things happened–people did not like it and could not be nice to him. Once he understood that, his therapist was able to discuss with him the internal disruption caused by his overactivity, that is, while he felt excited and stimulated when he got "hyper," it was difficult for him to settle down and feel good after that. Kevin could then acknowledge that it was difficult for him to stop himself, especially after the medication wore off. At that point, the therapist engaged him and his mother in a discussion of how she could intervene to stop things from escalating without his getting enraged at her. Since he could now accept her interventions without associating them with the physical assaults of the housekeeper, it became possible to restore a measure of calm to his life.

OTHER DISJUNCTIONS

Some authors have written about difficult patients (Groves, 1978; Martin, 1975; Winnicott, 1949) to illustrate the fact that some patients are capable of evoking exceptionally intense positive or negative feelings in therapists. With them the threat of a disjunctive response always seems imminent. These are patients whom therapists come to dislike or even hate. Some children produce anxiety at the prospect of their arrival: they are physically or verbally assaultive; they heap invectives and obscenities; they are obnoxious, contemptuous, and disrespectful. These children provoke, enrage, and push therapists to the limit of their tolerance. They also have the capacity to distort what occurs in the treatment and, adding insult to injury, report the distortions to their parents under the guise that the therapist is mistreating them. With these children, therapists find themselves trapped between desires to retaliate or to terminate the treatment.

When therapists attempt to treat such hostile or neglected children, they reach the very limits of their capacities for concordant responses. Serious rup-

tures inevitably occur, and the boundaries of what is usually considered appropriate are overstepped. It is as though therapists leave the safe confines of traditional technique and habitual responses and jump into the turbulent reality of the child's life, responding as others do in the child's life.

One question these cases raise is how much of the disjunction is caused by the child's difficult behaviors and how much results from the therapist's failure to understand the child, who in turn rages at the therapist. While this may not be true of all difficult patients, among several cases of children and adults referred to me because their therapy had failed, a common reason for the failure was that the therapists did not understand the nature of their patients' disorders. To those therapists, the patients were difficult, impossible to treat, or could not benefit from treatment. The therapists appeared to have little insight into the motives behind their patients' conduct. This is not to say that the patients did not have personality problems that made them difficult to treat. I only want to emphasize that when patients are not understood, they will, at times, respond with rage at the therapist and appear not amenable to treatment.

Child therapists who hold onto psychoanalytic theories that fail to take into account the effects of neuropsychological deficits on development often arrive at an impasse with their patients. They are handicapped by their incomplete understanding of the psychodynamics of their patients. The disjunctions that result are caused by an outdated or deficient paradigm.

As therapists, we must look not only at patients' contributions to the process, but also at our own. The sources of our contributions are not limited to our personalities but extend to our theoretical orientation, our belief system, and our self-narratives. Ignoring the significance of these factors in the therapeutic process is as detrimental to the process as ignoring the contribution of the context to the child's adjustment.

As therapists, we are imperfect beings, not unlike our patients. We have our share of difficulties, and some of us have learning disorders similar to those of our patients. The empathy we confer on patients ought also to be turned back onto ourselves. We, too, are in need of others to complement us and to serve as adjuncts. What we cannot do is turn to our patients for these.

Ruptures in the therapeutic process invariably occur. Once they occur and the child's rage is mobilized, the therapist must focus on the interventions that will bridge the chasm that has been created. The tasks of healing the rupture, of remaining available as a selfobject, and of restoring the capacity to listen to the child are crucial. Ultimately, the flow of empathy between the child and therapist must be reestablished if treatment is to continue.

In summary, in this article I have attempted to illustrate a perspective through which to understand the treatment process with children with learning disorders. Treatment is an encounter between a child whose personal narrative

inadequately organizes her responses to the world and a therapist who attempts to understand and modify the child's narrative. This goal is achieved through a process in which the child experiences being understood and has validation for her perceptions. Once there is a set of shared experiences, it becomes possible for the child to experience the differences between the therapist's responses and those of others. A set of shared meanings is created that helps the child reframe her understanding of the problems. Evidence for greater integration of the child's experiences is found in the greater coherence of her self-narrative. Themes that formerly reflected the assignment of personal meanings to some experiences now encompass shared meanings that have grown out of the child's maturation and experiences in therapy. The child's rehabilitation and restoration to better function can be credited to the combination of greater parental understanding, appropriate school programming, improved social functioning, and the therapist's educative, corrective, and interpretive efforts.

NOTES

1. Where the child's gender is unspecified, I refer to her as feminine. Since I was the therapist in most of these cases, I refer to therapist as male.
2. I borrowed the term *moments* from Pine (1985) (see his Chapter 4, Moments and Backgrounds in the Developmental Process, pp. 38-53), although I give the concept a different interpretation from his. The term is currently being used by the Process of Change Study Group, Boston, of which Daniel Stern and Louis Sander, among others, are members. This group (Sander, 1998) uses the term "moments of meeting." Their use of the term is different from either Pine's or mine.

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