THE WORLD OF THE LEARNING DISABLED

A child who has a mild or moderate learning disability may, in many ways, suffer more emotional stress, than a child with a severe handicap because there is the constant comparison with normal children their age and especially by the practice of attempting to “normalize” them by mixing them in schools with healthy children of their own age. This can and should be done, but only under the supervision of highly skilled teachers, which unfortunately are too few in number.

There is a tendency for schools that are funded for special classes and teachers to work with the mildly and moderately learning disabled to group students according to disability. Most disabled children resent being corralled into groups with other disabled children and feel that the mere process of "grouping" ignores their individuality. The prevailing attitude is to view the disabled as the mentally retarded, or the cerebral palsied or the mentally ill.

This global-type labeling compartmentalizes the disabled as a homogeneous group when in fact the disabled are a heterogeneous group of individuals with differing handicapping conditions. Secondly, the practice of diagnosing or labeling presents a problem for the professional: What is meant by the diagnosis or label? Many characteristics of the mildly retarded could be described as schizophrenic-like in that they may have similar problems in rigidity of thinking and reasoning.

Why, then, the label? How can I, as a professional, use the diagnosis to prescribe a treatment plan? The answer is that it is unlikely that any label, in and of itself, can point the way to an effective treatment plan.

The mere fact that a person is disabled presupposes that his/her life has been handicapped by the labeling as much as by the disability. It behooves the professional

to look beyond the diagnosis to the individual, from the general to the specific, to pass through the surface impression to find what lies hidden beneath.

The environmental atmosphere often contributes to inhibiting normal functioning and this should be a major emphasis in attempting to prescribe remediation and treatment. It is for this reason that many mothers choose to do home schooling of their child until their teens. However peer socializing is still likely to be a missing ingredient unless there are neighborhood children who have been taught to occasionally babysit and otherwise relate respectfully to a younger child with a handicap.

I. Normalization

Perhaps the biggest barrier to normalization for the disabled is lack of exposure to learning situations and socialization experiences. A person's self-image is formed through both formal and informal learning experiences. Each individual learns to assess their strengths and weaknesses by participating with other children. Unavoidably, the poor learner or mildly handicapped child is deselected from those growth experiences that give to him a healthy identity by being placed in special classes, made fun of in gym class, ignored in conversations, by-passed in dating, and left out of group activities.

As a result, they hear only about their weaknesses: "You're awkward." “You're not good looking.” “You don’t belong with normal people.” “You’re stupid.” “You're a loser.” For this reason, many disabled children are home-schooled today.

The mildly disabled person who eventually makes it to a community-based setting has often learned to cover-up the depression and the bitterness of being left out by laughing and cracking jokes - by "acting" happy. One of the tools for survival and acceptance is the disabled person's ability to be easily placated, compliant and accept scapegoating.

A teacher must explore the student's past areas of mastery and develop these more fully, accentuating his strengths so that the weaknesses may be strengthened. Look past the complacent smile, the sarcastic joke, the compliant attitude and acknowledge the anger, the hostility and the despair. In other words, their student must be taken seriously even when he refuses to take himself seriously.

II. Object Relationships

Because disabled children have usually been denied experiences necessary to develop a positive self-image, they develop poor object relationships. Assuming that an "object" is both a "person" or a "thing", this handicap has wide implications for the disabled person in a treatment program.

1. Learning disabled children and young adults generally do not relate well to other children, and as a result have few close friends. They are often inaccessible to others - retreating to the comfortable fringe of a group where their disability can go unnoticed. They have learned not to participate. Or else their behavior may keep others at a distance. They may laugh inappropriately or change the topic of a conversation without notice. They usually have tics, quirks, speech impediments or strange ways of talking that prompt other children to make them an object of ridicule.

2. The "non-disabled" child is generally unable to relate appropriately to disabled children with obvious handicaps and may tend to reject them cruelly as a way to deny any defects in themselves. Lastly, the disabled person is not always open to making friends with other disabled persons. Embarrassed by the handicap, the flaw, and the defect of others

accentuates their own disability and makes them even more self-conscious.

Children who have learning problems often have difficulty maintaining a coherent conversation. They have not had an opportunity to learn the functional components of conversing, which includes input-feedback, listening to others and being listened to by others. They have learned that they have nothing interesting to say, that others do not understand them, that they will not like what they are going to be told. The disabled are always being talked at rather than talked to. They are not listening to and therefore do not know how to listen. They are not given an opportunity to provide input and therefore do not receive feedback.

The learning disabled are usually not able to respond to discriminative cues when making decisions concerning how to relate to a person by the expression on his face or the tone of his voice, although they generally are able to pick up on overt cues such as frowns and smiles and can respond accordingly. However, in situations where the cues arc more subtle they may respond inappropriately by bringing up topics at the wrong time or just spurting whatever happens to be on their mind. For example; A young adult may have just gotten a new pair of shoes and while a group is talking about something else, he suddenly remembers his shoes, holds them up for the group to see and begins on an entirely new topic. Although his new shoes might be a topic of discussion, it is raised at an inappropriate time.

The disabled child may often not be able to pick up on discriminative cues for another reason: they have learned to avoid eye contact because of the kind of cues they received in the past. Others may have look at them in a

"what's wrong with you?" way# curiously eyeing their deformity or focusing in an uncomplimentary way upon their face.

The egos of a child who feels that he or she is different will tend to close off and live in a protective envelope of ignorance and in which they may make themselves appear more retarded than they are. Some have learned that it is easier to act retarded so they don't have to think, interact, make decisions, or otherwise expose themselves. In doing this they disguise the fact that they are capable of being significantly significantly more aware.

4. Many disabled persons display either a flat affect or extreme mood swings. They easily become giddy or silly, break into tears, or become upset without apparent provocation. This may be the result of organic causes or the medication they are taking. Many learning disabled children are also neurologically as well as psychologically hypersensitive.

5. People with brain damage and physical disabilities may have metabolic imbalances such as being overweight or underweight, sluggish mental processes, or low energy. Low energy is also manifested during states of depression. Almost all disabled persons have some depression. They become depressed when they cannot solve their problems and become easily overwhelmed. They feel like losers. They are lonely and feel left out of the human race because they were never given an opportunity to learn and to grow. The disabled have learned to deny their depression and repress it, which often increases their flat affect - a lack of

animation in facial expression. It takes a lot of energy to continually repress and deny one's feelings. The disabled have little energy left to become involved in socializing activities, to apply themselves in learning situations. All of these - the flat affect, giddy or inappropriate behavior, and difficulty with their speech make them appear unapproachable to others.

6. The lack of having experiences in learning to problem-solve and to reason things out contributes to their simplistic, concrete pattern of thinking. The disabled are not prepared to think in complex, abstract patterns. They often do not perceive subtle changes, make associations or "fill in the missing pieces". They have difficulty visualizing alternatives. Another reason for faulty thinking patterns is that disabled persons often come from families where their parents do everything for them rather than expecting them to problem solve for themselves. Normally, a child attempts to figure things out for himself and consults the mother only when he cannot make any headway. Then, together they explore solutions and ways of thinking it over. Parents of the learning disabled too often tend to do everything for the child, thus exaggerating the disability and further handicapping their child by not teaching him how to think.

All children develop their self-concept by learning through graded frustrations. This means that an individual learns by conquering a task and then feeling confident enough to move on to another task equally or more difficult. When

tasks become too easy, children become bored and are only entertained by challenges that are more difficult and where they can achieve a sense of mastery.

The ideal parent gives a cliild self-help tasks that teach mastery - how to think and how to persevere to success. The disabled child is not tend to persevere; he tries once and then gives up. However, with the proper environmental help and a positive self-image, learning disabled adult might function very adequately in this society.

What are the prerequisites for an adequate rehabilitation or treatment plan?

Experience has shown that traditional individual and group counseling sessions are not appropriate experiences for the learning disabled to resolve interpersonal relationship conflicts or to develop interpersonal skills. Actual experiences in person social situations or staged experiences such as sharing books or special objects are important learning devices. The learning disabled require concrete exercises and do not respond well to abstractions.

Taking field trips with the intention of observing specific situations or obtaining specific information and sharing these observations and information teach not only conversational skills, but observation as well. Exercises in describing objects, paintings, arts and crafts and even people are excellent beginning exercises for conversation

and observation. Experiences using the telephone are invaluable for learning how to. communicate. The telephone company is willing to lend out telecommunication sets with accompanying exercises and instructions.

Establishing problem solving experiences with tasks graded according to complexity will help the disabled to test out their capabilities. Graded frustration leads to mastery. By setting tasks in steps from simplest to most complex, the frustration level will be tolerable and the client will experience mastery. These tasks may be work tasks, academic learning situations, independent living skills training, arts and crafts projects, sensorimotor integration exercises or contrived or real socializing experiences.

The key is to ascertain where the client is now and where he is going in order to set appropriate goals with an individualized treatment plan to get him there. Presenting learning tasks of graded frustration levels is essential to building confidence. Often this necessitates a one-to-one relationship of instructor to student. Once students have progressed to near equal levels, group instruction can proceed.

3. Learning to think and thinking to learn can be approached from many angles. Sensorimotor integration is probably the most feasible starting point for the learning disabled. However, if a trained professional is not available, stretching exercises and relaxation training facilitate body awareness. Learning games that require body movement, perceptual communication, visual and auditory

perception exercises are available through educational supply centers, the public school districts, the special education department, public libraries, and college and university reference sections. Although many of the exercises are geared toward children, they can be modified for use with adults. Especially excellent are the Montessori books.

Good nutrition is especially important for the learning disabled. Neurological disabilities are aggravated by poor nutrition, especially large amounts or refined sugar and carbohydrates which tend to raise the blood sugar level temporarily and then plunges below the level needed for optimum mental and physical functioning. High protein diets with plenty of fresh fruits and vegetables, supplemented with vitamins, will help to reduce mood swings and somewhat counteract the side effects of medication. Substituting pure fruit juices such as apple juice or grape juice for sweet drinks and sodas greatly enhances the mental/physical functioning as well as fulfilling the sweet tooth urge. A good nutritional program requires reinforcement from the home environment.

III. Ego Defenses

We often judge the behavior of learning disabled so closely that everything they do appears stupid. Rather than looking at general behavior, we react to inappropriate behavior. Yet, outwardly behavior is not a good barometer of what is happening internally. I actually had the interesting experience of observing a group of learning disabled young adults and noticed that

the behavior of one young man was particularly peculiar. When he noticed that I was observing him, he came up to me and said, “I’m not as stupid as I act.” I felt like responding, “Who is!”

The learning disabled have been forced into roles of massive denial. Beneath the surface, and often beyond their erratic behavior, is an anxiety which triggers inappropriate behaviors. The disabled have no way to bind their anxiety. The "average" person has many avenues by which he can act out his anxiety such as make plans to go places with friends for entertainment and recreation. The disabled often have no such avenues. They must hold their anxiety inside. Sometimes the anxiety comes out impulsively - through silliness, or anger, or tears. They have primitive defenses such as, denial - pretending it's not happening, or projection - you made me do it, acting out by breaking things or yelling and shouting. Acting out is a common outlet for teenagers in general when their anxiety becomes too intense to suppress. Healthy adults are able to talk themselves out of their anxieties or talk to friends who will validate them. The learning disabled are not articulate or self-aware enough to approach others for validation of their feelings.

The learning disabled are also anxious because they lack control of their environment. They are not used to feeling in charge and are accustomed to feeling powerless. It appears to them that everyone else has power and control over them. This is anxiety provoking in itself because of their concerns, “Who will take care of me?” “How can I get

from here to there?" "Who will make my decisions for me? "Who will protect me from harm?"

They have learned to see the world as uncaring and threatening, a place where they expect to be ridiculed and abused. Unless they have been taught to think through basic problems and situations, they cannot cope with a new situations and may become easily frightened. They live in a space of ambiguity where no one thinks to tell them what is going on. "Significant others" are always making plans for them. Parents, counselors, teachers and doctors have meetings in which they are most often not invited. They are not accustomed to being asked for input into their feelings, desires, and expectations. As a result they often give the artificial answer, "I don't know."

The learning disabled may have primitive ego defenses including a thin line between reality and fantasy or between emotion and reality. The professional teacher within a treatment setting may often see their student swing from unrealistic desires of wanting to become a great surgeon or a movie star to believing they cannot achieve anything at all and that someone else must do their thinking for them. They swing from one end of the spectrum to the other because they lack a well-grounded self-image.

However, the disabled need their fantasy world and in some cases it would be cruel to take it away from them. For example they may believe that certain members of the opposite sex really like them despite their behavior to the contrary. Those who do not live with their parents might believe that their parents really miss them. I have talked to young

adults in residential centers who were rejected by their parents and fabricate excuses or reasons for not being with them or even speak positively of attaining independence. Denial is a common defense against hurt and anger.

The learning disabled, in general, have poor conscious control of their mental processes. They do not concentrate well and cannot attend to monotonous tasks for a long period of time. One defense is to ignore or avoid a task that appears too difficult for them. They have had too many past experiences of being put down and blamed for failure. To avoid blame they may reject the task at hand in any way possible. Avoidance of failure may take many forms, including engaging in annoying behavior or talking excessively in order to avoid the task presented.

The learning disabled tend to regress easily and act childlike and immature. This represents a reverting to previous childlike behavior rather than risk experiencing another failure of using their intellectual capacities. They may regress to such a point that they become restricted and withdraw within themselves. This is the type of client the professional often forgets about, the one who is not acting out and is therefore of little trouble to the staff. At the same time, this client is not progressing or growing, but is being reinforced to withdraw, to be unseen and unheard.

There are many ways to handle these primitive defenses.

1. Take them seriously. Rather than react to their inappropriate or immature behavior guide them through crisis situations. Respond to the client's need to be heard and understood, to express what lies beneath the outward manifestation.

2. Use guided imagery to solve inter-personal conflicts and to build a positive self-image. Guided imagery, or story telling, can be used therapeutically to give the client a means to express feelings of anger, hostility, pain, sorrow and resentment.

The disabled talk to themselves in much the same way that they have been talked at - negatively. By bringing them in touch with their "mind chatter," they can be taught to reverse their negative thinking to positives affirmation. Autogenic training can be helpful in this regard. They can learn to center themselves and thus be more open to receiving positive reinforcement.

3. Reinforce their ability to act intelligently. Set up experiential situations of solving real life problems. Role-playing situations should be of graded levels. Then they can move from role playing to real situations such as ordering lunch, taking a bus, etc. Most importantly, ask the client for input, respond to their input and give appropriate feedback. Help them to establish their self-worth by involving them in decision making, being sure to establish the validity of their opinion even when the input may not be the best solution. Offer alternatives and discuss the ramifications of various decisions.

4. Ground the client "in the reality of the situation in which you are working with him. For example, it is perfectly valid to bring the client out of talking about a fantasy and back to the task at hand. Help them to move past failure by explaining that it is a necessary step to learning mastery.

5. Attending to the task at hand rather than avoiding it goes hand-in-hand with number 4 above. Psychologist, Marc Gold, has performed task analysis of routine-repetitive jobs and has developed an effective technique for reinforcing clients to attend to the task at hand. Essentially, this program plan necessitates the staff member refraining from eye contact with the client, verbally instructing the client or in any way allowing the client's attention to focus on anything except the task. It is an effective method for re-programming, and although simplistically presented here is as much involved with re-programming the staff! This technique is invaluable when attempting to remediate sensori-motor difficulties. The client's full attention must be on his body or he will ignore the input he is receiving, just as he has done previously. Much learning is avoided by the disabled because they have so effectively learned to manipulate authority figures away from teaching them what they need to learn.

6. We have been impressed with how even moderately retarded adults were able to cope well on field trips downtown into a city setting when they were taught to improve their facial expressions and their grooming. They had to be taught to improve their

posture, stand up straight, wear their clothing appropriately, keep their tongues in their mouth and to hold a slight smile on their faces.

7. I cannot overemphasize the value of inculcating a strong spiritual belief and a caring God who understands and is watching over them. (Avoid all organized religions that believe in guilt, sin and punishment.) Teaching them to pray is not only therapeutic but has actually been proven to work!

OTHER APPROACHES TO REMEDIATION

A "disability" is a mental or physical condition that usually "handicaps" a person from normal social functioning. Some cultures much more accepting than others. So the nature of the social structure plays an important role in emphasizing a disability. Most disabilities are amenable to remediation that will to a greater or lesser degree enable satisfying social interactions. Obtaining specific information about the disability may suggest a mode of remediation.

Perhaps a client has been diagnosed as "brain-damaged", and therefore is unable to handle integral data coming into his brain or is unable to process information as fast as non-brain damaged individuals. He may be slower catching on to things, but once he "gets" the basic concepts he may do almost as well as a non-brain damaged individual. He can learn new ways of processing or integrating information and putting it together that is meaningful for him. This individual may be considered handicapped only because he needs more patience and more time.

However, without help, he may soon develops the more serious handicap of low self-esteem, and with it the belief that he cannot perform any complicated task. He may come to believe that everyone else knows how to do things automatically without having to seriously thinking about it. What happens, then, is that they may stop trying to think. If they don't know the answer right away they don't bother to attempt to problem solve. An ingrained defeatist attitude must be addressed and avoided before any progress can be made. They need to realize that everyone needs practice at problem solving and that a little patience is all they need if they are a little slower than others.

In addition he has been deprived in another important area, the area of social contact with his peers. It takes consistent contact with other people to maintain adequate interpersonal relationship skills. An example of how easily we can lose interpersonal relationship skills is that men who who have spent a long time in a war zone may require a period of orientation to get back to the level of interpersonal relationship skills that he had attained prior to going into the service.

The most common question that I get from learning disabled individuals who want to relate to other people is "What do I talk about". Eric Berne has written a book about this, explaining that most conversations are extremely superficial and idle. They just provide a way of mingling. Learning to ask simple questions and then listening is a good start.

Handicapping conditions also limit normal opportunities for learning during the various phases of growing up. An individual

who is not handicapped is given a certain amount of freedom to socialize and to learn things on his own. These are social things that we "just know", things that you can't put down on a piece of paper because they are learned unconsciously through experience. The language that we speak, and almost everything that we do "naturally" we learned from exposure. This is called experiential learning. This is despite the fact that we have forgotten 80% of the things that we learn academically in school.

Academic learning is not real learning. This is one of the reasons why our education system is inadequate. However, one of the things that we do learn in school is to exercise our minds. Exercising the mind is important. If you have been out of school for any length of time and then return to a school setting it is difficult to get into the swing of things initially and to compete with the younger students who have been constantly in the academic setting. The mind needs exercise just like the muscles of the body. With the disabled client who is handicapped by a lack of educational training which would enable him to learn to use his mind, we find there is a lack of memory skills or understanding written material, even shortly after been read to him. Putting facts together, and remembering things in sequence are parts of the thinking process which the handicapped individual has not had sufficient experience with.

Most of the brain is not developed at birth. Researchers have discovered that the brain forms according to the experiences one has. Thus a child who is born in Afghanistan has a different brain than one born in Texas, for example. Something that our diplomats should be aware of.

Another example is if a child does not use his eyes by age six he may develop permanent blindness. The "wandering" eye will go blind, but can be remediated if the good eye is patched, forcing the child to use the "wandering" eye. The same phenomena is true in all areas of mental functioning. Let us take speech. If speech is not encouraged it will not develop along a normal pattern.

There were studies done with prostitutes in Europe after World War II whose children were born healthy, but were put in a back room and not much attention given to them. These children, when found at the age of 8 or 9, were healthy children physically but were unable to communicate and could never be brought up to their chronological age level. They had missed the critical age for learning speech and language. This had led to the theory that there are critical periods in the development of a child. The learning process can be speeded up, but if the critical period is passed by and the skill has not been learned, the child has difficulty in ever attaining his full potential in that area.

Again, if the brain is denied critical experiences in early live points it may have permanent learning disabilities. This is why it is so important to get handicapped children into experiential learning experiences at a very young age. Most of the adult clients we are working with were corralled into groups for "the handicapped" and were essentially allowed to do whatever they desired to do. They were not taught at the critical periods of learning to use whatever mental faculties they still had intact.

This particular way of dealing with the handicapped in their early years of life fits the phenomena of "self-fulfilling prophecy". We viewed the handicapped as never being able to learn to read or write and *therefore gave up on him and often felt it a waste to teach him survival skills or independent living skills. Much research has been done in this area.

One group of researchers took a group of children who were in an orphanage and who had very little one-to-one human contact and put them with mentally retarded girls who would play with them continually and expose them to all types of stimuli and experiences. These children's I.Q.'s jumped as a result.

Various other things such as interesting mobiles were introduced into the situation to enrich the environment and continued to improve I.Q. functioning. On the contrary, if you would take a normal individual and give him the life experiences that a retardate has had, that so called "normal" individual would soon appear retarded. If you are not given the opportunity to use the facilities that you have then you loose the ability to use those facilities. It is for this reason that Down's children who, we consistently found are capable of reaching at least 100 IQ, when placed in institutions were considered to be "Mongoloid idiots."

So what have the experiences of the handicapped been? Most have been protected and not allowed to do much at all on their own. They have a poor self-image socially. Their social skills are minimal and as a result they feel alienated from society. They prefer to be alone. A handicapped individual who has a yearning for social contact and acceptance on the one hand

avoids it because he is afraid of rejection and humiliation on the other hand.

What is needed for this population is more workshops of graded levels. Perhaps the best goal that we could achieve in vocational rehabilitation with these particular type of clients is to move them into sheltered employment rather than pushing them into competitive employment until we have developed their social skills. The work of Dr. Mark Gold has shown that it is relatively easy, when using the proper techniques, to train an individual to do assembly work that is routine and repetitive. You can program people to put motors together and to do assembly line work.

However, we are concerned about human beings in a total social context. Are they happy? What are these people doing on the weekends?. Do they have any social life at all? Do they have boyfriends or girlfriends? What is their mental attitude? What is their physical health like? These are the important things that we must look at, not just how many nuts and bolts they can put together. It is important to look at the total picture of a fulfilling life.

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In the past, the total picture has not been looked at adequately. We know from experience that work for every person is not the answer. Good general physical and mental health and social activities outside of work are as important as the motivation to work. A person who has good ego strength is "happy" because he has a balanced life. If he does his job well, is able to have satisfying social contacts, has hobbies and entertainment he feels satisfied and fulfilled. This is also true of children. Children who come from a home life

which is satisfying to them do better in school. Activities outside of work or school give a person a sense of identity. It is often difficult for us to realize how little sense of identity the handicapped adult has. They have sensorimotor problems and difficulty in developing a kinesthetic sense of their bodies. When we give a young disabled child an exercise which give^ him a better tactile sense of his body, his whole behavior begins to improve. Whether the individual is handicapped or non-handicapped each person operates out of sense of personal identity. If we are able to change that person's sense of identity then we will modify his total behavior.

Counselors or teachers working with handicapped clients must remind themselves of the intrinsic value of every human being. The value of a human being is not determined by how fast he can run a mile or how well he can play football. What he does and how well he does it must be separated from his individual worth as a human being. Working with a handicapped individual is almost a sacred trust because that individual may either grow or stagnate depending upon the relationship that you develop with him or her. I remember a counselor who described his client as being "sullen and withdrawn, a person who answers laconically, and who seems lethargic" when in fact that is exactly the way the counselor was coming across to his client. An understanding of the counselor as a therapeutic tool is very important. We now know that an interest in school and the progress that all children make in a classroom is significantly dependent upon how much interest and caring that their teacher shows toward them.