MAKING SENSE IN CONVERSATIONS ABOUT LEARNING DISABILITIES

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This article describes an integrative, multisystem clinical approach to the psychological and relational problems that develop around learning disabilities. Positioned in relationships with children, families, and schools, the therapist addresses the emotions, interpersonal conflicts, and problematic beliefs that contribute to problems. Using clinical skills to contain and relieve painful emotions, the therapist soothes "inflammation at the boundaries" of relationships among children, families, and schools, depolarizing conflicts within and between systems. Familiar with developmental and educational psychology and developmental neurobiology, the therapist makes this specialized knowledge intelligible to children, families, and teachers. This article describes two specific methods, the chart of strengths and weaknesses and the map of learning functions, which facilitate communication of specialized knowledge about children with learning disabilities. The therapist uses expert knowledge to help members of the treatment system transform blaming, helpless, or hopeless interpretations of the problem into more hopeful constructions, which support healthy development.

Educational success for children with learning disabilities, including Attention Deficit Hyperactivity Disorder (ADHD), requires that parents, schools, and children understand individual learning styles. When education succeeds, learning-disabled children develop into adults who understand how they learn, who rely on their strengths, and who have mitigated their weaknesses through disciplined practice. They negotiate for the accommodations they need and find occupational and personal life settings that optimally fit their neurobiological styles. Family therapists can help families and schools achieve success by addressing the problematic interactions among emotional, behavioral, interpersonal, and institutional processes that interfere with educational success for the learning disabled (Abrams & Kaslow, 1976; Adamson & Adamson, 1978; Fine & Carlson, 1992; Kaslow & Cooper, 1978; Ryan, Adams, Gullotta, Weissberg, & Hampton, 1995; Sherman, Shumsky, & Rountree, 1994; Walker & Shimmerlik, 1994).

The approach described in this article integrates ideas from and beyond family and systems therapy, including social network intervention (Atteave, 1969; Boyd-Franklin, 1989; Gatti & Colman, 1976; Kliman & Trimble, 1983), collaborative therapy (Anderson, 1997), social constructionism (Gergen, 1985), narrative therapy (White & Epston, 1990), psychodynamic psychotherapy (Kohut, 1977; Rako & Mazer, 1983; Winnicott, 1965), neuropsychology, developmental psychology, and educational psychology (Levine, 1994). This approach is similar to other integrative practices in its emphasis on compassionate engagement with everyone in the treatment system, its case-specific treatment strategies, which incorporate individual, family, and larger system phenomena in a biopsychosocial perspective, and its attention to the therapist’s multiple positioning in relationships with individuals, families, and schools. It is distinguished by the use it makes of specialized knowledge from developmental neurobiology.

Paradoxically, although narrative therapy emerged from postmodern thought, this approach incorporates a narrative practice that employs modernist scientific knowledge. As problems develop,

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members of networks troubled by children’s difficulties with learning disabilities make sense of situations using explanations, beliefs, and interpretations that amplify distress and helplessness. The therapist’s command of expert knowledge is a powerful instrument for collaborating with networks to generate alternative ideas that support constructive action. Negative, pessimistic explanations, including children’s self-defeating beliefs and shaming, blaming constructions that reverberate among children, families, and schools, generate and sustain problems around learning disabilities. When a therapist is connected in respectful relationships and is credible by virtue of demonstrated caring, understanding, knowledge, and utility, s/he is situated to address the problematic beliefs that undermine successful learning. With persistence, it is possible to collaborate with all involved to construct alternative ways of making sense that embody hope and support successful learning.

Managing Painful Emotions: Reducing “Inflammation at the Boundaries”

Learning disabilities generate feelings of frustration, anger, helplessness, and sorrow, as children struggle to learn, parents struggle to support them, and teachers struggle to teach them. These emotions often exacerbate learning disabilities and disrupt relationships at home and school. Their persistence perniciously influences mood and emotional regulation. Tangles of confusion and pain develop as children, families, and teachers organize themselves around learning disabilities as problem-determined systems (Anderson, Goolishian, & Winderman, 1986). Some may try to manage their painful feelings by using shaming and blaming attributions of laziness, lack of motivation, or “not caring.” Teachers may believe that children would succeed if only their families provided better support or standards, whereas parents may believe that their children would do better if only teachers were doing their job.

Learning disabilities involve uneven patterns of ability. Parents and teachers may demand that learning-disordered children perform consistently at the level of their greatest strengths, generating frustration for adults and children alike. For example, adults may expect a verbally expressive child with significant auditory processing limitations to understand instruction and directions as competently as she speaks up in a classroom discussion. The difficulties children with ADHD have focusing on material they do not find stimulating or intrinsically interesting (Hallowell & Ratey, 1994) may be misinterpreted as a lack of moral fiber: “If Johnny can organize himself and pay attention when he is doing something he likes, that means he is capable of doing work. If he avoids work he doesn’t like, it’s not because he can’t do it; it’s because he won’t.” Children tend to internalize these mistaken adult attributions, thereby developing painfully negative self-concepts that fail to explain or help them overcome their difficulties. They may see themselves as stupid or lazy, rather than as capable in some areas and struggling in others. These negative identities as learners contribute to their creating strategies for avoiding the painful enterprise of learning: They may lie about what homework is due, or whether or not they did it. They may rush through assignments, satisfying themselves with the sparsest of productions. They may create diversions (e.g., misbehavior in domains seemingly unrelated to school) that distract parents and teachers from attending to their problems with learning. Frustration, anxiety, and misunderstanding accumulate at interfaces among child, family, and school. I call this process “inflammation at the boundaries.”

Inflammation at the boundaries between subsystems of learning-disabled child, siblings, parents, and school is among the most serious problems surrounding learning disabilities. People’s reactions to their frustration over their own and others’ failed efforts to do their best, set off inflammatory interpersonal processes: A child avoids schoolwork that s/he perceives as overwhelming or even impossible. The teacher (or parent) who first discovers this avoidance becomes upset that it was apparently overlooked by the parent (or teacher). Hurt feelings, judgments, and pessimism disrupt home–school communication, as the explanation people construct in one setting blame the problem on shortcomings in the other setting. The child, angry at him/herself and at the school for “getting him in trouble with his parents,” becomes more defiant or avoidant. This behavior provokes still more school criticism of the child’s parents, who, in turn, get angrier at the school. Bright, learning-disabled children can distract everyone from the evidence that they are avoiding work by misrepresenting or omitting information in the tales they tell, thereby stirring up conflict between parents and school. Reactivity builds within and between subsystems, amplifying already intense emotions. As sequences of misunderstanding and confrontation persist, the threshold for reactivity is lowered. People’s actions and narratives become more rigid and stereotyped. In their efforts to
manage feelings of rage, shame, confusion, or powerlessness, participants may create crises or engage in sabotage, antagonism, or defeatism. The flaring emotional reactivity that characterizes ADHD, along with the mood problems that often accompany it, may also contribute to the intensity of these inflamed situations.

Reducing inflammation at the boundaries often has priority when treatment starts. In individual psychotherapy, parent consultation, family therapy, and school consultation, the therapist reduces polarization and soothes inflamed emotions by listening carefully, respectfully, empathetically, and compassionately to all parties. By staying connected while tolerating high levels of emotion, the therapist helps to calm conversations down. In crisis situations, a therapist may cool off inflamed exchanges by placing herself as the temporary interlocutor concerning overheated issues between parents and school, or between parents and children. It is sometimes helpful to suggest that parents let school deal with certain issues, or that teachers disengage from fruitless struggles over homework by reporting regularly to parents about unfinished assignments. If the option is available, e-mail correspondence can improve communication between parents and teachers. With the parties' permission, the therapist may describe his/her separate conversations with a child or with a family to the teacher or vice versa. Sharing the experiences of parties locked in polarized conflict with each other can restore belief that everyone is trying to do his or her best. Appreciation for each other's efforts—and for the obstacles to be overcome—generates collaboration and mutual support.

Reducing inflammation at the boundaries involves trial and error. A child may avoid schoolwork without being detected for long intervals that are punctuated by eruptions of anger and recrimination when the avoidance is discovered. In such cases, it is useful to encourage tighter linkages between home and school. In contrast, some parents, at their wits' end over fruitless conflict with their children, can overload teachers with strident demands and complaints. One mother of an angry and uncooperative daughter constantly engaged the school, even accosting teachers in public places. I tried to reduce the emotional inflammation of face-to-face encounters by suggesting that the mother, the special education teacher, and I be in regular e-mail correspondence. This plan backfired when the mother copiously broadcast emotionally laden material, including detailed accounts of family arguments and raw criticisms of her daughter, which overwhelmed the teacher. I responded to the teacher's distress by helping mother to distinguish between what was appropriate for conversations in therapy and what belonged in communication with teachers. In the long run, the mother learned to temper her communications with school. As she and I reviewed her e-mails together, she came to recognize the impact of her rhetoric on her daughter's feelings about her mother and herself.

Case Examples

Mary. Seventh-grader Mary had ADHD and other learning disabilities; she was also vulnerable to painful episodes of depression. Weaknesses in sound–symbol association and visual sequencing had made it difficult for her to learn to read in the earlier grades: It was hard for her to associate specific sounds with particular letters, and to track letters from left to right across a page. Expressive language difficulties affected both her speech and her writing. Although her reading ability now tested near grade level, she was averse to reading anything. Her white, working-class family was uncomfortable communicating with the school. In family sessions, Robert, Mary's father, told his daughter for the first time about his own pain and confusion as a learning-disabled child in school. His tears over Mary's pain brought father and daughter closer. Despite this gain in treatment, he was unable to overcome the pain over his own experiences of failure enough to begin communicating with the school. He continued to leave the primary responsibility for dealing with their children's education to his wife, Elaine. Elaine, who had weathered frightening bouts of Mary's depression, was reluctant to push her to do the reading necessary for her schoolwork. She often read aloud to Mary to help her complete her assignments. There was a history of destructive conflict between the school staff and Elaine, whom teachers saw as an uncooperative and hostile parent whose overprotectiveness was handicapping Mary educationally. The teachers saw themselves as acting on Mary's behalf, advocating for firmer performance demands that would develop Mary's strengths and assure her an adequate education.

Elaine's story emerged as soon as she decided that I was committed to working on her behalf, rather than acting as an agent of the referring school. She saw the school as unconcerned about what she knew about her daughter and as unaware of Mary's pain. Feeling silenced and dismissed by the school did not
make Elaine particularly interested in providing what the school was asking of her. Each side of this polarized argument had important information that the other side needed to hear. For Mary to maintain her emotional health and to develop her potential as a learner, she needed her parents and school to collaborate with each other. To facilitate this collaboration, I needed to help reduce inflammation at the boundary between home and school.

Mary taught me to “talk in multiple choice.” Children with expressive language disabilities are frustrated by the gap between the rich ideas they want to express and their sparse utterances. They are hungry to be understood and, given a flexible partner, are willing to collaborate in finding language that best fits their intended meanings. Mary never spoke for more than 1.5 min in our 50-min sessions. At first, she seldom spoke more than 10 words. She was willing to communicate, but her expressive language difficulties and her history of chronic failure in conversations with adults left her reluctant to use her voice. Therefore, I learned to supply much of the language for our sessions. I would tell her about my conversations with her teachers, her guidance counselor, and her mother, speculating aloud about the meanings of events in her life. I would offer a set of alternative hypotheses or descriptions and ask her to choose which alternative best fit her understanding (always including the equivalent of “none of the above,” which allowed for a new round of alternative possibilities). This approach established a conversational flow in which I supplied most of the spoken words, and she directed me in shaping the flow. I found myself using my long-neglected Ericksonian training, not for hypnotherapy, but to read the micromovements of her body as indicators of whether or not my words were on track. I worked to distinguish the voice I used in “multiple choice” to explore her experience from the voice I used to express my own experience.

At first, it seemed that Mary’s mother Elaine had no trouble putting her experience into words. She was forthright, indignant, and eloquent in criticizing the school for mistreating her daughter. Soon, however, I noticed a striking conversational pattern: Elaine would present an utterance, then stop. Interpreting her stopping as punctuation, I would then take my conversational turn. As soon as I started talking, however, Elaine would resume her utterance. I would feel embarrassed for interrupting her, and become distracted and confused about what either of us was trying to say. In time, I realized that Elaine, like her daughter, had an expressive language disorder for which she had learned to compensate by carefully processing her utterances internally before voicing them. It took tremendous internal work for her to form her rich and complex utterances. Her apparent “stops” were not punctuation intended for the listener, but, rather, intra-personal pauses intended for her own internal process of generating more spoken words. Once I began waiting longer to speak, thus eliminating my disruptive interruptions, our conversations became more fluent and productive.

Bringing this story about my conversations with Elaine back to the school offered an alternative to their view of Elaine as hostile and uncooperative, and helped me offer the staff specific, practical suggestions for improving their relationship with her. By telling the story about myself, I revealed my own frustration at communicating with Elaine, gently introducing the idea that she was easily misunderstood at the same time that I joined with the teachers’ frustrations trying to communicate with her. Attributing the conversational disruption to Elaine’s hard work at overcoming the same kind of language disorder that constricted Mary helped teachers see Elaine as trying to do her best. This new narrative offered a concrete, practical implication for reducing conflict and misunderstanding: School staff could pause deliberately before taking their turns in conversations with Elaine. Their imaginations captured, staff began following my suggestion for managing the conversational pace and started reporting easier, more productive conversations with Elaine.

In this case, the boundary was inflamed between school staff and Mary’s mother. Once the school staff could see Elaine as a caring parent struggling with her own learning disabilities, they could treat her differently. To see her differently, they had to feel differently about her. Their emotions shifted when they felt my respectful, empathetic appreciation for their commitment to Mary while I shared my initial frustration and emerging enthusiasm communicating with Elaine. Sustaining connection with both sides of the polarized conflict, I provided an explanation that reduced the staff’s reactivity, which subsided further as they used my advice to communicate more productively with Elaine. Productive communication with the school was, in turn, soothing for Elaine, making it easier for her to collaborate.

As complicated as the problems surrounding learning disabilities may be, sometimes the most
powerful interventions involve attending to simple truths of the human heart. Therapeutic conversations bring healing when parents and I come together to understand, acknowledge, and bear the frustration, ambiguity, and pain of having a child who is particularly difficult to raise. In the following case, this type of conversation soothed inflammation at the boundary between parents and child.

George. Eight year-old George was born with hyperacute perceptual sensitivities, a restless and impulsive temperament, extraordinary intelligence, and specific cognitive weaknesses that became apparent as he learned to speak. He had trouble coordinating his strong language-based thinking with his intuitive grasp of situations, because of poor functional integration between right and left cerebral hemispheres. He did not have an ear for the “music” of conversation—the nonverbal tones, gestures, and pauses that help people coordinate their utterances with each other. Word-finding difficulty further impeded his efforts to communicate. George could be loving and considerate, but was prone to mood fluctuations. When frustrated, he tended toward dramatic displays of emotion. Most of the time, these outbursts subsided as rapidly as they flared. When he was in a bad mood, however, these emotional flares triggered hour-long tantrums in which he screamed, hit, and said hurtful and frightening things that deeply injured him and his loving family. The extremity of these tantrums evoked an image of George as the Biblical captive Sampson, who pulled on the chains binding him to the pillars of the Syrian temple, bringing down ruin on everyone, including himself.

George’s parents quickly learned that such tantrums required special measures. To avoid escalating a crisis, they deferred disciplinary measures. When George started to go into a “fit,” his parents provided firm direction and soothing support to settle him down. Later, they talked with George about the tantrum and its apparent antecedents, allowing him his voice while holding him accountable for his behavior and providing appropriate consequences. Other times, at moments of everyday misbehavior, their calm, firm, and consistent responses reduced the risk of escalation. They were competent parents who had learned to distinguish between conduct and temperament, and to respond appropriately to each (Turecki, 1989).

George learned to observe and plan his actions as he developed his capacity for internal reflective language. Noticing that his parents were more lenient when he had tantrums, he experimented with pretending. He began to perform the opening moves of a tantrum, with the intention of getting his parents to give him some slack. Like the Sorcerer’s Apprentice, George found trouble using his new powers. Sometimes, his performances worked. At other times, his parents called his game, and gave him consequences. Getting away with pretend tantrums was less fun than expected. It frightened him to realize that his parents (whose help he needed for calming down when he really lost it) could be so easily tricked. Faking tantrums made it harder to resist the “real” ones. And sometimes, during a real tantrum, his parents responded as if he were faking. At those moments, his rage, pain, and terror at feeling betrayed took those tantrums to new levels of destructiveness. Parental discovery of a fake tantrum might set off a real one, which, he despairingly realized, they would not recognize as real until things got very bad. When his parents disengaged in frustration over their repeated failures to manage these incidents, George sensed their emotional withdrawal. His feelings of abandonment made him even more vulnerable to losing self-control.

I see many children like George. There are things we can do to make things better: I can help parents understand how this pattern operates. Although some parents often already understand such patterns quite well, they do appreciate that someone else can see them. From my perspective outside the despairing and overloaded family, I witness parents’ knowledge and competence as they succeed most of the time at helping their children to manage themselves. My witnessing encourages parents to persist in what they already do well. Sharing knowledge about the comorbidity of ADHD and depression helps families develop strategies for living with these temperamental qualities. Sometimes, medication (for ADHD and/or depression) or improved behavioral management reduces the frequency and intensity of tantrums. I let parents know that I recognize how they feel judged by school and network members (as overly lenient, inconsistent, or “spoiling”) for their adaptive, creative, and even heroic responses to their children’s fluctuating states. I tell my colleagues at school about families’ struggles to do their best in extremely challenging circumstances, thereby working to alleviate blaming and isolation between families and schools.

These interventions, although useful, may be less powerful than simply holding family pain in compassionate, collaborative conversations in which we develop mutual understanding of their difficult situations. I use words like this to acknowledge parents’ experience: You cannot avoid making consequential mistakes.
Because no one can read another person’s mind, sometimes you will misread a pretend tantrum as real, and easing up on parental demands will have negative implications for your child’s developing conscience. Sometimes you will misread a real tantrum as pretend, making the tantrum worse and damaging the relationship of trust between you. Even if you could always distinguish real from pretend, your response to pretend tantrums can sometimes set off real ones, further disrupting the relationship.

Rather than plunging parents deeper into despair, acknowledging their dilemma buoys them as they feel understood and supported. Acknowledgment helps them to recognize and accept their limitations and encourages persistence in doing their best, knowing that their best will sometimes fall short of what they want for their child and themselves. They are then less likely to disengage from their child out of frustration and are more likely to work on restoring connection.

**Multisystem Intervention**

Most of my clients come from the community of 60,000 where I have lived and worked for nearly 20 years. In my community practice, I have cultivated collegial relationships with teachers, learning specialists, guidance counselors, and administrators in many elementary schools and in the town’s one high school, where for years I did group work with high-risk students. These relationships extend into community activism, collaborating with high school students to address issues of race and advocating on behalf of teachers and of children with special needs. I see children and families in my office and visit schools regularly to consult with my clients’ teachers, guidance counselors, and educational specialists. Well-established relationships with school personnel help me operate at multiple system levels on behalf of my clients. Because I am situated at the interfaces between children, their family members, and their schools, I can mobilize support, address problematic patterns of interaction, and collaborate with families and school staff to develop hopeful constructions that replace pessimism, misunderstanding, and disagreement.

**Case Example**

Holly. When I began working with her, misunderstandings and hurt feelings reverberated among Holly, her sole parent Louise, and her fifth-grade teacher. Holly struggled mightily with her mother over doing her homework. Louise wanted to help Holly succeed. Because of her own painful history of learning disabilities and school failure, Louise distrusted teachers even more than she distrusted her own ability to help her daughter. Nonetheless, Holly and Louise had worked out a routine in which Holly put in 2 solid hours a day doing homework. Unfortunately, Holly spent most of this time wrestling with arithmetic, the subject in which she was weakest and needed the most specialized assistance, which her mother could not provide. As a result, Holly was barely passing in arithmetic and often did not complete her work in other subjects. Holly’s teacher was troubled that this apparently bright child was not producing as well as expected, and was frustrated at the distancing and avoidance she encountered when she tried to collaborate with Holly’s mother. Louise felt blamed by the teacher, and Holly was upset with everyone, particularly herself.

Louise brought Holly to me because of her increasing depression. Because I recognized signs of problems around learning disabilities, I helped arrange for Holly to get a neuropsychological evaluation, which found that Holly had ADHD and weakness in nonverbal, visual–spatial cognition. Using the evaluation findings, I could help the teacher revise her image of an unmotivated, irresponsible child and uncooperative mother. She became open to hearing how hard Holly was working, and how hard Louise was working to support Holly’s learning. She welcomed my suggestions for collaborating with Louise to redirect Holly’s homework, so that she was not spending all her time at home on her weakest academic subject. As I told Holly and Louise how the teacher appreciated their efforts, and what good ideas the teacher had for making Holly’s homework time more productive, both of them became better disposed to collaborating with the teacher. As Holly became more successful as a student, she became less depressed and more accepting of herself.

**Making Sense of Expert Knowledge**

A wide variety of disciplines, including neurology, neuropsychology, educational psychology, educational specialties, occupational therapy, and so on, bring their particular perspectives to work with learning disabilities. Within and among these professions, there is no consensus as to how to describe,
**FIGURE 1**
Chart of Strengths and Weaknesses: Joey Wilson DOB 9/10/86

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
</tr>
</thead>
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| **Clinic Report, 2/2/96, Grade 3, Age 9-5**  
- Oral reading: Read quickly at 3rd and 4th grade levels. Unable to summarize content.  
- Spelling SS 105; high 4th grade level.  
- Math SS 103; early 4th grade level. | • Parents describe as kind, generous, caring, thoughtful, bright, healthy, funny, good company.  
• Visual, temporal sequencing.  
• Large group of friends.  
• Very attentive to tasks.  
• Excellent fine and gross motor skills; good eye-hand coordination. | • Mother notes he often seems not to hear her.  
• Confrontation naming and rapid word retrieval.  
• Intense, easily frustrated on language tasks; performance improved with visual cues.  
• Did not ask for clarification of instructions ... nonresponse, then laconic, nonelaborated answers to reading comprehension questions.  
• Strong-willed; can “dig in his heels” over inconsequential issues. Difficulty “choosing his battles” and communicating goals or concerns once he is involved in adversarial interaction. |
| **Specialist report, 5/31/96, Grade 3, 9-8**  
- Solved 4th grade word problems with no difficulty. | • Writing sample: correct grammar, punctuation, capitalization; no spelling errors. Maintained meaningful sentences; varied sentence structure. | • In answering structured questions at fourth grade level (relevant for his competitive school), he faltered with sequence, inference, and vocabulary. |
| **School report, 6/96, Grade 3, 9-9**  
- Computation skills: Proficient.  
- Use of place value rules: Proficient. | • Excellent word attack skills; factual and critical thinking skills.  
• Steady progress, good foundation in mathematics. | • Needs to improve his inference thinking skills: He expects information to be explained to him in a straightforward manner. |
| **School report, 10/96, Grade 4, 10-1**  
- Benefits from repeated instruction and from getting help to interpret written directions. | • Good progress in math: Tentative and uncertain at first with new concepts and strategies, then gains confidence for independent work. | • May have some subtle difficulties reaching abstract levels of thinking. |
| **School report, 12/96, Grade 4, 10-3**  
- Generally does well with math problem-solving. | | • At times, has expressed reluctance to read aloud; benefits from advance notice his turn is coming. |
| **School report, 2/97, Grade 4, 10-5**  
- When reading aloud, usually careful to decode unfamiliar words. | • Writing mechanics. | • When conflicts arise, he often needs a teacher to intervene in order to help Joey express his frustrations.  
• Math: Can be overwhelmed if peers or teachers move at fast pace during verbal discussions or demonstrations. |

**Note:** These are excerpts from nine pages, selected to highlight the evidence for Joey's particular pattern of strengths and weaknesses.
explain, or measure learning disabilities (Green, 1992). I rely on Levine's (1994) comprehensive phenomenological descriptive system, which addresses the implications of neurobiological differences for difficulties with learning. For therapeutic work, I find it most helpful to construct learning disabilities as variations in human neurobiology, forms of temperament that become problematic when there is poor "fit" between organism and environment (Jensen et al., 1997; Thomas, Chess, & Birch, 1968). This construction encourages normalizing conversations about differences, locating problems in the relational space between child and context, rather than entirely within the child himself. People with ADHD, for example, alternate between two attentional states. In a state of unfocused, nondiscriminating responsiveness to everything in their environments, they pay attention to nothing in particular and react to whatever happens to strike their attention at the moment. In a state of hyperfocused, persistent responsiveness to a novel, attractive, or stimulating situation, they become fixated and absorbed and cannot be interrupted or distracted from their single-minded pursuits. This same style, which is obviously problematic for students who are expected to sit quietly and listen attentively to their teachers, may prove well-suited to the challenges and opportunities of high-pressure securities trading or athletic competition.

My understanding of temperament does not imply that neurobiological variations are immutable characteristics given at birth. Organism and environment are in continuous, recursive formative interaction over the course of development (Lerner, 1989; Pellegrini & Horvat, 1995; Schore, 1994). The research of Green and his colleagues (Green, 1995; Shields, Green, Cooper, & Ditton, 1995) demonstrates that family patterns known to affect school achievement negatively may amplify neurobiological weaknesses. Multisystem intervention can mitigate the pernicious effects of destructively poor fit between organism and environment.
FIGURE 3
Levels of Compatibility

FIGURE 4
Spherical map of Domains

Attention

Memory

children make sense of experts’ reports. First, the therapist can develop a chart of strengths and weaknesses from reports obtained from parents, schools, and specialists (Figure 1). The chart organizes data into columns summarizing testing data and descriptive information (Findings), strengths, and weaknesses. Construction of a chart requires from 1 to 3 hours, depending on the number and complexity of available reports. Charts can be updated readily with new information. I usually share charts of strengths and weaknesses with children and parents, and sometimes with teachers or other specialists. In my own files, they provide a ready reference to remind me what the assembled documents can tell me about the child.

Charts summarize information, expose contradictions between reports, and highlight patterns. They are problematic, however, in that they incorporate the forbidding jargon of the specialists whose reports they summarize. For some clients, particularly those who prefer visual imagery over language to make sense of complex information, I offer a map of learning functions. Figure 2 shows how Levine’s (1997) phenomenological catalog of cognitive functions is organized into the four functional domains of seeing, hearing, speaking, and writing, as quadrants in a circle. Functions are arrayed spatially (Figure 3), with the simplest at the periphery (representing the most direct interface with the environment) and the most complex at the core (representing brain integrative activity). As attention and memory apply across all domains, they are represented as hemispheres above and below the circular map, as in Figure 4. In discussing a particular child’s learning style, the therapist can literally point to areas of strengths and weakness on the map, as in the case of Joey, described below (See Figure 5).

Children with learning disabilities need to make their own sense of their learning styles. Understanding helps prepare them for lifelong practices of self-advocacy. Levine’s story book for children, All Kinds of Minds (1993), and manual for adolescents, Keeping a Head in School (1990) help them to see themselves as whole and unique, rather than as defective. Levine (1993) argues that there are all kinds of minds; no one has a perfect brain, and everyone has a unique pattern of strengths and weaknesses. Understanding their strengths helps children take responsibility for dealing with, working around, or strengthening their areas of weakness. Reading aloud in session from Levine’s storybook is a useful way to engage with preadolescent environment, or, if applied early enough in the course of development, may even prevent them.

Translating expert knowledge into language that is intelligible to children, parents, and teachers is critical for effective therapeutic conversations about learning disabilities. Children with learning disabilities accumulate reams of paperwork over the years: Report cards, academic skills evaluations, neurological and neuropsychological evaluations, diagnostic reports from speech and language pathologists, school achievement tests, and so on. Most of these documents emphasize problems rather than strengths. They vary in clarity, intelligibility, accessibility of writing, and in the quality of their observations, conclusions, and recommendations. Even the most educated parents can despair of making sense of these ever-growing piles of paper. Helping them to understand these documents reduces confusion and allows parents and children to become informed advocates for themselves.

I have developed some devices to help parents and children make sense of experts’ reports. First, the therapist can develop a chart of strengths and weaknesses from reports obtained from parents, schools, and specialists (Figure 1). The chart organizes data into columns summarizing testing data and descriptive information (Findings), strengths, and weaknesses. Construction of a chart requires from 1 to 3 hours, depending on the number and complexity of available reports. Charts can be updated readily with new information. I usually share charts of strengths and weaknesses with children and parents, and sometimes with teachers or other specialists. In my own files, they provide a ready reference to remind me what the assembled documents can tell me about the child.

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and younger children in conversation about their learning styles.

For some children, it may be necessary to go beyond charts, diagrams, and/or readings from Levine’s books. Therapist and client may coauthor a client’s self-statement of personal qualities, strengths, and weaknesses. Such a document serves to remind a child, in his/her own words, about his/her own kind of mind. It can also serve as a tool to advocate with teachers for appropriate accommodations and to guide teachers as to where it may be appropriate to demand more from a child.

Case Examples

Joey. Joey was a pleasant 11-year-old from a white, upper-middle-class family. He was having trouble learning and was getting into fights at home and school. When his mother called for an appointment, I requested copies of school and diagnostic reports, so I could begin forming hypotheses about Joey’s neurobiological style and how it might contribute to his difficulties. The documents included psychoeducational and behavioral medical workups, scores from standardized achievement tests, and several years of detailed narrative school progress reports. As I prepared Joey’s chart of strengths and weaknesses (See Figure 5), I found the teacher reports more useful than the ambiguous clinical workups. As clear, coherent, and compelling as they were, however, the school reports were framed in the discourse of teaching, not of neurobiological description. The best I could do with the collected works was to frame a working hypothesis: Joey seemed to have difficulties with expressive and receptive language. He seemed to have trouble making sense of what he heard and read, as well as with speaking.

When I first met Joey and his highly educated parents, I saw him struggle to keep up with our conversation about his troubles. He focused intently on his parents’ long, structurally complex, and conceptually dense utterances. Although I could not tell how well he understood, he did not appear distracted, nor did he
seem to shut down as his parents spoke. When they expected him to answer their questions or to take his turn in the conversation, however, Joey would slump in his seat and turn away, appearing to shut down. He either avoided speaking, or spoke in sparse phrases that communicated little.

I saw Joey alone in the next session and, sitting alongside him, read aloud the first chapter of Levine’s *All Kinds of Minds* (1993). At the end of its first chapter is a list of nine kinds of “mind work,” as follows: Concentrating, building up skills, remembering, getting things in the right order, understanding things that you see, understanding and using words and sentences, making muscles work, having ideas and solving problems, and making and keeping friends. Each item is briefly and clearly explained. I told Joey that I wanted to know what he thought his greatest strength was, and what he thought was the most difficult for him. I said that I would read through the list once, then ask him to think about what he was strongest at and what the most difficult for him, then I would read it one more time, and then I would ask him to answer the question. (This approach helps compensate for problems with receptive and expressive language.) When I finally asked Joey, he said he was best at making and keeping friends, and he had the most difficulty with understanding and using words and sentences.

Joey’s response illustrates the complexity of language-based learning disabilities. Recognizing his weakness in managing language required deep and accurate reflection on his own experience. Reflection on experience is intrinsically a function of language (Maturana, 1978). Joey’s ability to use language internally, in reflective communication with himself, was strong, in clear contrast to his weak use of language to communicate with others. Language functioning at the surface, at the boundary with the rest of the world (See Figures 2 and 3), was weak, whereas deep language functioning was strong.

When I met later with his parents, his mother told a story that further confirmed the picture of relative strength in reflective language processing. A few days after the session in which he had chosen his greatest strength and weakness, Joey and his mother had a conversation about having two playmates for a sleepover. She pointed out that these two friends could be difficult, and having both of them overnight could be hard to manage. Earnestly, Joey responded, “But Mom, making and keeping friends is one of my strengths. I can handle it!” Joey had internalized the language from our session, and was able to access and transform it for use in a later conversation.

I reviewed the available information and my diagnostic impressions with his parents, using Joey’s chart (Figure 1) and his map of learning functions (Figure 5). Joey’s map highlighted his visual–spatial strengths, his strengths in the domain of writing, and his core reasoning strengths. It also illuminated his weaknesses in receptive and expressive language. The map made immediate intuitive sense to his parents. Sorrowfully, they recognized the frustration and sadness that Joey felt at thinking deep thoughts that he could not bring out in conversation. His parents’ narrative of Joey as willfully misbehaving in conflicts at home and school began to change as they took into account Joey’s frustration and confusion as he struggled to express himself to other people. Joey’s parents agreed to arrange a new neuropsychological evaluation, which confirmed the diagnostic impression of language-based learning disabilities. A speech and language therapist began to work with him on his language skills, and Joey began to do better in school, on the playground, and in conversations in my office.

In the case of Joey, and in the case of Nancy, which follows, offering parents a different lens with which to see their children helped parents to overcome their frustrations, to be more compassionate about their children’s struggles, and to take concrete steps to address the learning disabilities at the center of those struggles.

**Nancy.** Nancy, a 10-year-old with fluent conversational language and with a vast fund of information that she had gathered with passionate curiosity and stored efficiently using her strong memory, nonetheless struggled with school work. Despite specialist assistance in the school learning center, Nancy hated to read and write. She had learned to apply her creativity to devise strategies to avoid those onerous tasks. Her parents came to me baffled over her avoidance of reading and writing assignments, and angry that she had been lying about schoolwork. They saw her as having poor moral habits and as needing to be pushed to “buckle down and do the work.” Going over Nancy’s specialist evaluation reports together, we developed the picture of a talented child with severely limited abilities to associate sounds with letters or to organize letters sequentially across the page. Her hand had such low muscle tone that it cramped painfully as she tried to control the pencil when she wrote. When I collaborated with them to make sense of this expert knowledge
about their daughter. Nancy’s parents better understood her challenges, and revised their beliefs about her. They realized that, rather than not working hard enough, Nancy actually worked harder than her peers, struggling to produce in the face of her limitations. Changing their perspective helped her parents handle their understandable frustration when Nancy did not perform as they hoped. They were able to provide compassionate support, to sustain reasonable expectations, and to collaborate more productively with learning specialists so that Nancy could master the challenges of learning to read and write.

Developing Alternative Stories

Children, parents, and teachers often need help to revise rigid, constricted constructions of problems that develop around learning disabilities. They respond best when they feel supported emotionally and listened to with respect by a trustworthy therapist. Therapists gain trust as they are genuinely interested in people’s efforts to do their best in difficult situations, and as they help them make practical sense of complex expert information. In polarized situations, as people are encouraged to listen compassionately to each other’s stories as told by the therapist, they find themselves able to see through each other’s eyes. New possibilities emerge for making sense of problems, possibilities that are woven into hopeful narratives that support the collaboration between children, parents, and schools that is necessary for educational success.

Case Example

Jack. As his mother, Susan, saw things, her 13-year-old, Jack, was headed for serious trouble and was refusing to listen to her expressions of concern and alarm. Jack saw his mother as never leaving him alone and as constantly yelling at him. Jack had been diagnosed with learning disabilities involving expressive and receptive language. It was difficult for him to make sense of people when they talked to him, and difficult to form utterances in response. Disaffected from school, he was getting into trouble for defiance and misbehavior in and out of school. Susan, a sole parent, was increasingly distressed at the prospect of Jack’s attitude and behavior making him more vulnerable as a young, African-American male in a white-dominated society that was already prepared to judge him negatively. Traumatized by the death of her brother in a street confrontation with a stranger, Susan was terrified by Jack’s provocative conduct. She feared another violent death of a beloved family member. His misbehavior and her fears led to long mother-son conversations that escalated predictably into tears, screaming, and mutual recrimination. Their conversations in my office showed me a dilemma behind their escalating conflict: Susan had her own history of language-based learning disability and school failure. Like many people with strong core cognitive skills and weak expressive language skills, she used a compensating strategy that I call, “talking in first draft.” She formed complex utterances by starting with fairly awkward and sparse phrases, which she revised and elaborated as she emitted a long and uninterrupted stream of words. With patient listeners, people who talk in first draft can communicate in deep and complex ways, as they find their way through a series of revisions to get to words that carry their rich intended meanings. The underlying expressive and receptive language-based learning disabilities of mother and son were fundamentally similar. Susan’s strategy of talking in first draft, which compensated for her expressive difficulties, fit poorly with her son’s receptive difficulties. Susan had a great deal to say to her son. More mindful than Jack of his vulnerability, she dreaded the consequences of his not hearing her. Jack, however, could not take in other people’s long utterances, no matter how coherent and organized. He was particularly ill-suited to processing his mother’s rambling first-draft speech, and quickly tuned it out.

I invited them to look at their painful conversations through this neurobiological lens. As they grasped how each was experiencing the other, and how their misunderstandings were grounded in their shared difficulties managing language, they became more compassionate with each other. Susan worked to prepare her utterances more carefully. Jack worked to listen more patiently. They began to check in frequently on each other’s comprehension, and to collaborate toward mutual understanding. As they began to communicate more respectfully with each other, Jack gave his mother’s concerns a fair hearing, and demonstrated improved judgment. Mother and son could understand each other differently and cooperate more productively because our conversations illuminated the role of learning disabilities in their problems, and because each could feel the other’s respect.
Putting It All Together

Special education has developed methods to train most learning-disabled children to strengthen or to work around their weaknesses. Now that teachers have the tools to teach learning disabled children, it is important for therapists to help children, families, and schools overcome problems that undermine educational success. Multisystem intervention enables family therapists to mobilize systems to overcome these problems. For therapists, managing multiple roles at multiple system locations calls for a range of skills and knowledge. One needs to operate within multiple frames of reference, ranging from the relatively “hard” science of neurobiology to postmodern narrative work and social constructionism. One must be prepared to demystify all these realms of discourse with families and teachers. The practitioner has to tolerate considerable ambiguity and confusion. The challenges are invigorating and their complexity fascinating. One has to guard against the belief that it is possible to hold all the complexity of these problem situations within one’s individual conceptual grasp. I find it best for therapists not to try to hold the complexity, but to let the complexity hold them. A collaborative stance provides the best assurance against holding oneself to an impossible standard of knowing. Therapists can depend on the other participants in the problem-determined system to help make sense of what is going on. A “not-knowing” stance (Anderson, 1997) fosters this interdependency, and inspires open, respectful curiosity among one’s conversational partners. Developing fluency in multiple domains of discourse allows one to depend on members of the network—children, parents, teachers, guidance counselors, and educational specialists—to help make sense of what is going on.

As demanding as the work is, it is even more rewarding. When we recognize that everyone is trying to do their best, and when our efforts pay off, we witness a personal community mobilizing successfully to support healthy development. Children grow up, with healthy support from family and school, and everyone recognizes their own and each other’s contributions to the collective experience of success.

REFERENCES


