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ABSTRACT

Learning disability is seen to be a dissociative disorder (school shock) similar to shell shock in wartime. The shell shock model is explained to focus diagnosis and treatment of learning disabilities around the dynamics of the predisposing unconscious conflict, the dynamics in the environment, the mechanism which allows these two conditions to produce symptoms, the rationale of symptom choice, the collaborative application of psychotherapy and educational remediation, and the use of therapy techniques proven to be successful with shell shock and hysteria. (Author/DB)

School Shock: A Psychodynamic View of Learning Disability

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Running head: School Shock: A Psychodynamic View

Footnote

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ABSTRACT

Organic-sensory-neurological teaching strategies strongly influence special education while psychodynamic theory has faded from the school scene. A comparison of the problem of learning disabilities with the condition of wartime shell shock may prove helpful in explaining the dynamics of learning disabilities, especially of dyslexia. Shell shock soldiers often manifest symptoms which fit the nosology of conversion and disscciative reactions. Dissociation is the psychophysiological mechanism which underlies these hysterical reactions and may also be the essential mechanism of learning disabilities. The shell shock model would focus diagnosis and treatment around (1) the dynamics of the predisposing unconscious conflict; (2, the dynamics in the environment; (3) the mechanism which allows these two conditions to produce symptoms; (4) the rationale of symptom choice; (5) the collaborative application of psychotherapy and educational remediation; (6) the use of therapy techniques proven to be successful with shell shock and hysteria.

Movement toward organic explanations of learning disability has been greatly accelerated in recent years by the invention of the concept of "minimal brain damage" in neurology. It is no longer necessary to find hard signs of organic deficit and thus almost anyone can hypothesize that neurological or perceptual impairment exists. Optometrists who are expert in visual acuity, not perception, now function as educational consultants in perceptual training programs. Attempts at pseudo-neurological expertise are explained by one author (Hewett, 1968) as "indicative of the educator's strong need to bring order out of the educational chaos created by children with unexplained learning and emotional problems".

Some order can be brought to the perplexing problem of learning disability by adapting knowledge gained from our experience with the phenomena of wartime shell shock. Soldiers and school children must make an adjustment to a new and stressful environment. When individuals fail in this task they may develop "incomprehensible" symptoms.

The shell-shocked solder may become deaf, dumb or blind or have convulsions or become paralyzed. He may manifest more complex behavioral disorders such as amnesia, startle reaction to noises, nightmares, sleepwalking, aimless flight or panic. These are reactions of an hysterical nature and, in modern psychiatric terms, are called conversion or dissociative reactions depending on whether the body or the mind is the symptom target. Incidentally, it was the Swiss-American Meyer who influenced psychiatry to change behavior categories from fixed diagnostic notions to the transient idea of reactions.

When shell shock was first recognized as a major military problem, Army doctors believed the conditions to result from concussive effects on the brain. Medicine and psychology eventually came to understand the symptoms as psychological reactions which had the effect of disablement and which were the result of an interaction between an unconscious conflict or predisposition and a traumatizing environmental event or series of events. Rest and psychotherapy became the treatments of choice. Hospitalization was de-emphasized and many men improved dramatically after a few days relaxation and sympathetic encouragement. Men whose symptoms did not quickly abate received psychotherapy often utilizing hypnotic techniques.

When finally understood in terms of psychodynamic forces the problem of shell shock was well on its way to being solved.

Most children experience school as a growth-enhancing social institution. Those who enter this new way of life unprepared in their emotional development may find it more like combat. They may experience in more or less child-like forms the same symptoms we enumerated for shell shock. While a soldier's arms jerk in choreic movements, a child's hand tremors when attempting to write or to draw a diamond. The soldier with amnesia will have forgotten most of his identity while the learning disabled child forgets what he learned the day before. The soldier panics and runs through a barrage of bursting shells while the child becomes hyperactive and "climbs the walls" of the classroom.

The threatening aspects of schooling do not compare in severity to the actual survival threats of war however, if we borrow from the organic theorists their concept of minimal dysfunction then a large number of cases of learning and conduct disorders will rather easily fit the shell-shock model. For example, dyslexia, traditionally defined as word blindness, may be a pure instance of dissociative reaction while the more common degrees of reading disability in which some reading skill is acquired may lie somewhere in the continuum between total disablement and normalcy and might best be considered as conditions of MINIMAL DISSOCIATIVE REACTION (MDR).

Semantic support for the hypothesis that reading disability is a dissociative reaction is easily found. West (1965) defines dissociation as a special instance of a general psychophysiological adaptive mechanism for dealing with information. The mechanism "is responsible simultaneously and continuously for (1) scanning and screening incoming information; (2) processing both new and old information in such a way as to modulate the state and content of conscious awareness; (3) integrating or associating new information with previously stored information; and (4) controlling information output in the form of behavioral responses".

This is a good definition of the process of reading.

West defines a clinical dissociative reaction as a pathological exercise of the normal functions of dissociation.... "a state of experience or behavior wherein dissociation produces a discernible alteration in a person's thoughts, feelings

or actions, so that for a period of time certain information is not associated or integrated with other information as it normally or logically would be".

This is a good definition of reading disability.

The school shock model of learning disability would focus diagnosis and treatment around the following parameters:

1. The dynamics of the predisposing unconscious conflict.

2. The dynamics in the environment.

3. The mechanism which allows these two conditions to produce symptoms.

4. The rationale of symptom choice.

5. The collaborative application of psychotherapy and educational remediation.

6. The use of therapy techniques proven to be successful with shell shock and hysteria.

Much research and experimentation needs to be organized around these factors; however, certain observations and implications based upon documented studies and clinical judgment can be briefly noted here.

1. Predisposing factors: The historical medical foundations of shell shock lie in the age-old condition known as hysteria. Freud made this his special field of interest in his early work and he concluded that hysterical symptoms are specifically associated with oedipal sexual drives. Many researchers since Freud have implicated disturbed family interrelationships and oedipal strivings in the problem of under-

achievement (Buxbaum, 1965; Grunebaum et al, 1962; Hellman, 1954; Morrow & Wilson, 1961; Proctor, 1958, 1967; Rubenstein et al, 1959; Sperry et al, 1958.)

2. The environment: There is evidence that suggests that the pairing of a pupil with an opposite-sex teacher is related to school failure. In the U.S. where most elementary teachers are female there is a high incidence of school failure among boys. In Germany where male teachers are in the majority the incidence of failure is highest among girls (Spache & Spache, 1969).

3. The mechanism of dissociation: When an emotionally immature child who enters the school environment with unresolved oedipal strivings experiences close interation with an opposite-sex teacher, painful anxiety arises which is then dissociated from awareness taking along with it any activity that may be going on at the time (very often a reading lesson). Contrary to general opinion, the poor reader is often anxiety-free and exhibits la belle indifference toward his problem. It is not valid to take such a child from the classroom to save him from further harm.

4. Symptom choice: Not all dissociative reactions lead to learning disability. The child may become aggressive, withdrawn, school phobic, psychosomatically ill or some combination of any of these behaviors. Symptom choice is undoubtedly a function of identification with parents and is also influenced by the culture which places increasing emphasis on intellectual accomplishment as the focal point of an individual's

worth. Such attention makes intellect a target for disability. It is possible that the decreasing incidence of conversion reactions in the adult population is related to the increasing incidence of learning disturbances. This would suggest that symptom substitution may be a factor to contend with in education.

5. Collaborative therapy and educational programs: It has been evident for sometime that academic intervention alone is only marginally effective in remediating learning disability.

6. Therapy techniques: Hypnosis was very often used successfully as an adjunctive therapy for shell shock and for hysteria. A basic therapeutic component of hypnosis is the tension release effected by the induction procedures and by the emotionally charged abreactions which often occur. These two opposites, profound rest and strenuous muscular and emotional activity not only reduce tension but also release cognitive processes which may lead to insight or be utilized in problem solving. It seems likely that classroom learning would be facilitated for many children by scheduling of rest and/or exercise closely and more or less continuously with academic lessons. If there are more opportunities for normal anxiety reduction activities integrated with learning tasks, there should be a lesser need for disability-prone children to dissociate the curriculum from awareness.

Scheduling of rest and exercise probably merits as much research attention as has been devoted to reinforcement schedules in behavior modification and to perceptual-neurological training activities and materials.

In conclusion, it is possible to define the reading process as a special instance of the psychodynamic mechanism of dissociation. Following this, it may be stated that dyslexia is a pathological exercise of the normal functions of dissociation. Such a view will hopefully suggest new approaches and solutions to the problems of children with specific learning disabilities.

REFERENCES

Buxbaum, E. The parents' role in the etiology of learning disabilities. Psychoanalytic Study of the Child, 1964, 19, 421-447.

Grunebaum, M.G., Hurwitz, I., Prentice, N.J., & Sperry, B.M. Fathers of sons with primary neurotic learning inhibitions. American Journal of Orthopsychiatry, 1962, 32, 462-472.

Hellman, I. Some observations on mothers of children with intellectual inhibitions. Psychoanalytic Study of the Child, 1954, 9, 259-273.

Hewett, F.M. The Emotionally Disturbed Child in the Classroom. Boston: Allyn and Bacon, Inc. 1968.

Morrow, W., & Wilson, R. Family relations of bright high-achieving and underachieving high school boys. Child Development, 1961, 32, 501-510.

Proctor, J.T. Hysteria in childhood. American Journal of Orthopsychiatry, 1958, 28, 394-407.

Proctor, J.T. The treatment of hysteria in childhood. In M. Hammer & A.M. Kaplan (Eds.), The Practice of Psychotherapy with Children, Homewood, Ill.: Dorsey Press, 1967, 121-151.

Rubenstein, B.O., et al. Learning problems. 2. Learning impotence: A suggested diagnostic category. American Journal of Orthopsychiatry, 1959, 29, 315-323.

Spache, G.B. & Spache, E.B. Reading in the Elementary School, Boston: Allyn and Bacon, Inc., 1969.

Sperry, B., et al. Renunciation and denial in learning difficulties. American Journal of Orthopsychiatry, 1958, 28, 98-111.

REFERENCES (contd)

West, L.J. Dissociative reaction. In A.M.Freedman & H.I. Kaplan (Eds.), Comprehensive Textbook of Psychiatry, Baltimore: The Williams & Wilkins Company, 1967.