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The Impact of Psychological Trauma on Learning and Functioning in Women wit Learning Disabilities: Looking at Classroom Trauma

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The Impact of Psychological Trauma on Learning and Functioning in Women with Learning Disabilities: Looking at Classroom Trauma

A DISSERTATION

submitted by

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In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

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This doctoral study is dedicated to
Gene, Brandon and Loryn, my best cheerleaders.

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Abstract

The Impact of Psychological Trauma on Learning and Functioning In Women with Learning Disabilities: Looking at Classroom Trauma

This qualitative study investigates the relationships between women with learning disabilities (LD/ADD) and psychological traumatic exposure, specifically classroom trauma. The researcher, from a feminist perspective, allows truths to emerge through the stories of 16 women. As a result of methodological triangulation, two central questions are addressed: 1.) does psychological trauma impact learning and functioning in women with learning disabilities, and 2.) is classroom trauma a psychological trauma ?

In order to create a comprehensive context from which to understand classroom trauma, the field of psychological trauma is explored from the cognitive, neurobiological and socio-emotional perspectives. The women's learning and functioning both in and out of the classroom environment is considered in conjunction with the physiological symptoms they experience when faced with new stressors which trigger memories of past psychological traumatic exposures.

Classroom trauma is defined as a result of the stories the women have told about their past educational experiences. Two central concerns and implications of this study emerge as truths: 1.) the need for undergraduate and graduate programs in education and psychology to offer coursework which will foster an understanding of the impact of psychological trauma on learning and functioning, emphasizing the very real phenomenon of classroom trauma, and 2.) the need for a treatment model in educational and therapeutic settings which integrates the cognitive, neurobiological and socio-emotional aspects of learning and functioning in children, adolescents and adults.

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Chapter I

INTRODUCTION

How did I get to this place?

Throughout my doctoral studies I have questioned myself about why I am pusuing the field(s) of study in which I am so deeply immersed and so unconditionally devoted. I found that through qualitative research, or interpretive paradigms, I came upon periods of time which left me in "data limbo"; everything looked intriguing, everything looked worthy of yet another perusal, but I kept losing sight of where I was headed. What was my original plan? How did I get to this place?

I have only begun to share my personal experiences about school over the past several years, close to the time when I decided to embark upon doctoral studies. Over the past six or seven years I have been frequently questioned by women with learning disabilities whom I have facilitated in group support and educative settings as to whether or not I have a learning disability. I found myself beginning to struggle with the notion, stammering for a clear explanation, having a deep sense of *knowing* who I was, yet experiencing a fear about disclosing how I felt about who I knew to be *me.*

It wasn't until nine years ago when I completed a course in the administration and interpretation of the Wechsler intelligence scales that I began to understand a portion of who I was. I discovered that despite my competencies, I was internally disorganized. Indeed, I do spend a great deal of time creating structures and parameters for myself in almost every task I endeavor; organization is the key to my academic and personal success. On vacations, I must practice relaxing without imposing a structure on my time. Unstructured time feels as if I am on a flying trapeze without a safety net. To move fluidly and without stress through a period of time which has no deadlines, self-imposed or otherwise, takes practice for me. Each time I am faced with "free" time, I must re-learn

how to enjoy it without neatly fencing it in. My struggles in this area were apparent in my own test results, and thankfully my mentor took time to discuss the implications of these findings with me.

My natural based style of learning (Gregorc, 1988) suggests that I learn best from experimenting, using a trial-and-error approach, and most importantly, that I am able to take what I need from formal instruction, moving at my own autonomous pace toward competency. This is not particularly a style of thinker or learner which has historically been embraced by traditional education. However, I survived the experience because I am also a crowd-pleaser and an award winning actress. As early as kindergarten I learned the skills of "working the crowd", and today often reflect upon the feelings of dread I experienced each morning as I got ready for school. I didn't hate learning; I hated the place, the imposition of it all, the demands which I perceived to be unreasonable for human beings, and the restrictions and rules which stifled my sense of worth and creativity. But again, I knew the game of school, and some of the time I was able to play it.

It wasn't until my adult life that I began to develop a fondness for the place, school. But by that time, the place itself wasn't the same. The schools I chose to attend didn't seat the students in neat little rows; to my pleasure we didn't have to salivate to the ringing of a bell. Most of my instructors or mentors were genuinely interested in *listening* to me. It was a novelty to feel understood, to feel valued for my ideas, my creativity. As I began to foster a love of school, because this was the place where I had to be in order to accomplish my self-set goals, I became a dedicated advocate for those women who never were able to feel comfortable nor welcome in school. I wanted to make a difference. I wanted to scrutinize the reasons why they had to continually struggle, why they felt "less than."

My personal concerns for women with learning disabilities (LD/ADD), and for women who have suffered psychological traumatic exposure (PTE), inclusive of classroom trauma, grew from my empathy for those individuals who have suffered cognitively, neurobiologically, socio-emotionally and culturally as a result of these conditions and the

resulting manifestations. My empathy has been historically inclusive of women, men, adolescents and children. The focus of my research is women with LD not only because I am a woman, but also because I have facilitated the metacognitive development and awareness of women with LD for over six years in support groups as well as in one-to-one interactions. Women with LD are what I know best in terms of studying a specific group of individuals who have sustained significant psychological trauma.

For over thirteen years I have observed how the mere existence of LD can affect a woman's life both in and out of the academic arena. I was curious (and often driven) to know if my ideas about the impact of psychological trauma on learning and functioning could be connected to women with LD, and what exactly were the nature of these connections or relationships. Additionally, I wanted to analyze evidence that classroom trauma was a very real psycholgical trauma, and one which deserves attention and recognition in the fields of education and psychology. I felt that the implications of classroom trauma do indeed cross and overlap boundaries in many disciplines; I needed to find a way to provide convincing evidence of this. I desperately wanted to study the *impact of psychological trauma on learning and functioning in women with LD* . No matter how many questions and hypotheses I have composed, defined and re-defined, I return to the title of my project time and time again. This is my perceptual check. This is what matters. This is the truth the women tell. This is how I came to be in this place.

As a Feminist

As a woman still in the process (because it is an ongoing, never-ending process) of discovering my identity as a teacher, learner, thinker, philosopher, artist and human being, it became necessary for me to acknowledge the feminist perspective within my self and my work. At first I thought that my feminist self was yet another facet to my being, but soon into my research I learned that my feminist self was who I am in a very holistic sense, not just a part of who I am. Before I really experienced this "a-ha" moment in my thinking,

and before I reflected on my presumptuous self as a caregiver, I decided that the women with whom I would be working in my study needed to be "enlightened"; this would be part of what I could do *for* them. Again, I learned quickly that this is a process which evolves as self discovery, and not a component to be experienced, discovered or learned in isolation. It comes. It arrives. At different times for different women. For different reasons.

As a result of this kind of self-reflection I searched for feminist theorists with whom I felt a spiritual and philosophical kinship. I attended conferences filled with speakers and workshops which provided the women in attendance with perspectives on feminism. I stood to cheer the gurus of women's developmental theory; I questioned myself repeatedly. I listened carefully, but was never quite able to identify my thoughts and feelings with their speeches or their writings. Eventually I learned that I must carefully monitor the choice of language I used; to be politically incorrect is to be considered anti-feminist in many circles. Occasionally, I would grasp at a shred of some theory which vaguely defined a split atom of what I perceived to be my belief system. Often I was disappointed to find that theories were over-defined in terms of their ultimate categorizations, an antithesis of what I felt my feminist perspective and approach was.

Worell and Remer (1992) in *Feminist Perspectives in Therapy* gave me my clearest insights into who I felt I was, and more importantly, who I felt I wasn't. I was amazed to find charts and diagrams with neat categories and columns, indicating where a woman might fall on a continuum of feminist beliefs. Frantically I searched for my self, only to find that categories from different paradigms described my innermost feelings, but that I didn't have a slot in which to comfortably place my self and my attributes. I chastised myself for not knowing better. Feminist feelings cannot be pigeonholed, just as preferred learning styles cannot be diagnosed in terms of isolated categories. I subscribed to *Women & Therapy* and *Psychology of Women Quarterly*, two journals which are highly respected by many clinicians and practitioners. Although I found a great deal of talk about feminist

theory and perspective, I felt a sense of hierarchical relationships in a great deal of the research presented. Rarely were the subjects' stories or accounts recognized as the truth without supportive quantitative data. I questioned whether this was a feminist approach or whether this was yet another perspective or extension of traditional research methodology conducted by women.

Suddenly I realized that it was not necessary for me to frantically search for my identity as a woman through the espoused theories of other women. I did not need to define my feminist self through other women, although my preferred style is to validate my intuition and beliefs through theorists who are recognized as "pioneers." What I needed to accept was the fact that I was often politically incorrect in my attempts to describe what it was that I felt and believed, and that being politically incorrect was not a horrific blunder if my goal remained altruistic. It didn't make me wrong or a bad person. For a while I experienced solace from Steinam's (1992, p.6) discussion of the core of self-esteem, and her words: "we teach what we need to learn and write what we need to know." I wanted to enlighten the subjects in my study about their rights as women when I still wasn't sure exactly what the "rules" were myself. I am still learning. But I am driven to *know*, and will find a way to express this through my writing, and through listening deeply to other women who do know, even if their knowing is quite unconscious.

I didn't need to be attached to a recognizable label in order to be accepted into a special chapter of sisterhood; I just needed to be me. Paradoxically, a label can be comforting, and can provide a sense of belonging. I wanted the women with whom I worked to feel secure with who they were: with their labels which were designated to them by society and which were often self-imposed; with their language-based "disabilites"; with their processing "differences"; most importantly with their shame and humiliation which grew as a result of their perceived inadequacies as a result of the abuse they sustained in educational systems.

If I wanted to conduct my research by walking with them as much as I could, and by listening as deeply as I could, then I had to do just that - be *with* them, and listen with my whole being. That is the feminist perspective I bring to my work; simply my need for a connection to another human spirit in order to uncover and appreciate truths. I discovered that when I did just that, everything fell into its natural place. My feminist perspective became my methodology. Even though I at times faltered because I was unsure of myself and I used methods and instruments which made me repeatedly question my beliefs and values, I allowed the women to demonstrate the truth through their stories, through their feelings, thoughts, tears and humor. Their words are the truth. No measure can dispute this kind of truth telling. No measure, no number is that powerful.

STATEMENT OF THE PROBLEM

This study speaks of my feminist self as a researcher, the culture of women with learning disabilities, and the various aspects of psychological trauma, specifically classroom trauma. Through qualitiative methods, I will address 1.) the impact of psychological trauma on learning and functioning, and 2.) classroom trauma as a psychological trauma. Much of my learning, my knowing, comes from sixteen years of working with individuals with learning differences, twelve years of fostering metacognitive development in college students with learning disabilities (LD/ADD), six years of facilitating support groups for women with LD/ADD, and ultimately as a result of my relationships with the women whom it was my privilege to interview for this doctoral study.

Women with Learning Disabilities as a Culture

In a supportive group setting for women who are LD, it is possible for the voices of the participants to be heard individually and collectively as a culture unto itself. I am speaking from personal experiences in working with support groups which address issues pertinent in the lives of women with learning disabilities. It is in settings where women listen to, interact with, and support one another, that their social microcosm emerges as more than just a group, but becomes a culture exhibiting unique collective behaviors and attributes which other cultures and subcultures possess.

When I am immersed in the group process, it becomes clear how the members' collective behaviors and attributes, cognitively, neurobiologically, socially and emotionally, all contribute to their own culture as women who are LD. Despite their unique differences in style, diagnosed learning disabilities, and individual family cultures, they bond into a very cohesive group who shares common traits and concerns which are recognized and respected by each woman. It is with that recognition of a common culture that they become the driving force in their own healing process.

Where expressive language is lacking, encouragement is present to cultivate communication. Where silence prevails, there exists a quiet voice of experience, willing to share feelings so that others may be encouraged to speak in their own manner, in their own language. No one's experience, worth or ability is minimized, only potentialized. There is a value to every feeling, to every disclosure. Secrets are safe to share in a setting where each woman has experienced and endured emotional pain as a result of learning disabilities. As a result of one-to-one interaction with an educational therapist and/or group interaction, some women gain a deeper insight into self and move on quickly. Some remain in a kind of holding-pattern, like a plane circling, waiting for a safe time to touch down, to land. They may need the one-to-one contact and/or the group interaction as a means of reality-checking their progress both in and out of the classroom environment, and as an additional healing source when the connection between their learning and functioning, their trauma histories and their LD become nebulous. The time lines vary according to each profile and according to the amount of psychological trauma endured by each woman with LD.

> In describing their lives, women commonly talked about voice and silence: "speaking up", "speaking out", "being silenced", "not being heard", "really listening", "really talking", "words as weapons", "feeling deaf and dumb", "having no words", "saying what you mean", "listening to be heard", and so on in an endless variety of connotations all having to do with sense of mind, self-worth, and feelings of isolation from or connection to others. We found that women repeatedly used the metaphor of voice to depict their intellectual and ethical development; and that the development of a sense of voice, mind, and self were intricately intertwined. We adopted the metaphor of voice and silence as our own.
> (Belenky, Clinchy, Goldberger & Tarule, 1986, p.18,19)

The silence which many women exhibit both in and out of a group setting may be attributed not only to cultural differences, but also to the existence of expressive language deficits and/or to the existence of social/perceptual disorders. It is imperative that a group leader (educational therapist) have experience in working with learning disabled adults, and have a fundamental knowledge of diagnostic testing which determines the presence of specific learning disabilities and other co-existing disorders. The existence of learning disabilities may affect the way in which some women perceive themselves individually, and collectively as well. Often learning disabled women are so steeped in keeping their secrets and hiding the shame of their self-perceived imperfections, that they do not develop an awareness of their fundamental rights as women. Additionally, they do not feel capable of opposing authorities or systems who violate and negate them as valuable members of society. Many of these women, because of their past experiences of feeling "dumb" both in and out of the classroom, are afraid to step forward, take a stance, and defend themselves or others against a society which often views them as being "less than." The group setting provides a forum and learning opportunity for changes to be made in their personal developments and perceptions of themselves as valuable members of society.

Each woman who is LD brings her personal culture and background to a group as well as her emotional and cognitive self. She may not bring a basic understanding of feminism, depending upon her life experience and her culture. Her lack of knowledge of feminism may contribute to behaviors which allow her to keep re-experiencing certain types of psychological stress or traumatic exposure. These experiences may be academically or classroom-based or they may include other types of psychological trauma such as physical and/or sexual abuse. Many different types of psychological trauma may have occurred; many types of adaptive skills may have been necessary to employ for both personal and academic survival. In addition, each learning disability takes a life and form of its own, wearing its own disguise or mask, presenting a unique facade to the outside world. The secret has usually been well preserved for many years. When a woman's secret becomes

difficult to hide, then she may become silent, making her secret difficult to uncover by others, or she may act out in a variety of ways in order to divert others' attention from the leaked information.

The culture of women who are LD knows no socio-economic, ethnic nor racial boundaries. Their experiences as women in society and within the classroom setting may differ greatly according to the personal cultures they bring to the group, yet the universality or commonality of their classroom traumas bonds them. Their academic insults and adaptive skills will differ according to their own abilities, family culture, and the school culture in which they were educated. Their culture as women with LD, both personally and as a group, determines the existence and nature of their silence. They are members of three larger cultures: 1.) gender-culture, 2.) adult learners, and 3.) LD culture.

"Culture obviously influences one's beliefs and social practices and there is evidence that people actively use cultural ideas about gender to perceive and understand the social categories of male and female" (Beall & Sternberg, 1993, p.132). As a gender-culture, women have had to fight numerous stereotypical labels. ". . . any particular woman's success depends on both her individual assets and the discriminatory level of her particular situation, as well as that of society at large" (Beall & Sternberg, 1993, p.37). Women tend to express themselves within their interpersonal relationships in a much different manner than men. Their speech and communication style in general is one of support of the speaker, contributional in nature as opposed to competitive. Because of this they are often viewed as being less participatory. Some would view them as silent, as indeed, many are.

> . . . . restraint is *not* the same in a man as in a woman, nor justice
> or courage, either, as Socrates thought; the one is the courage
> of a ruler, the other the courage of a servant, and likewise with the
> other virtues .
> - Aristotle (circa 335 B.C./1992, p.95; from Beall & Sternberg, 1993)

The behaviors which are commonly shared by women who are LD help to constitute and define their culture. According to Wardhaugh, (1992, p.217), "culture is the know-how that a person must possess to get through the task of daily living" (within a specific group). Women who are LD learn particular behaviors, often identified as compensatory skills or strategies, which enable them to function within society and outside their cultural group; their genetic (or neurobiological) makeups may be a common characteristic which identifies them to others, but the attitudes and learned behaviors as attributes, enable them to be a culturally cohesive group.

Diane Goss, an Associate Professor and learning specialist at Curry College, has spent a great deal of her time working with college students in identifying and acknowledging cultural differences. She defines her work with students who are learning disabled as challenging cultural norms within the realm of special education. She defines culture in part as the learned behaviors, values, norms, beliefs, attitudes and other attributes that facilitate interactions within a group of people linked by shared characteristics, and who define themselves as members of this particular group. She said during our interview in March, 1994:

By this working definition, women with learning disabilities can be identified as a culture. You have to identify yourself as being part of a group, and by that fact you are saying you are not part of another group. Our college students who are LD see themselves as being members of the group that was unable to succeed in a culturally-approved-of group of people who were able to achieve. They couldn't meet the standards and the norms, and they couldn't perform the behaviors that were expected of the culturally-approved-of students who received approval. In that way they saw themselves as being "other", and also saw themselves as being like an identifiable group of people. Somehow they categorize themselves by identifying with those who are like themselves. Then they start to develop some common characteristics among themselves because they identify with

this group, and other people start to see them as being different, begin treating them in different ways, and therefore again, they have similar responses (usually negative), and develop more characteristics common to the group. As other people treat them as less able, then as a group they develop certain shared behaviors and attitudes. They develop by their own definition and identification with others who they see as being defined similarly (LD), and by the labels and definitions of others. Those two factors contribute to their own common characteristics, common to the LD culture.

As in any culture, there also exist sub-cultures; women who are LD, deaf women, physically challenged women, Mic-mac women, Korean women, Acadienne women, Jewish women, African-American women, Lesbian women, women visual artists, women musicians. And within each of these sub-cultures exist more sub-cultures. Estes describes culture as being "the family of the family. There is a saying 'cultura cura', culture cures. If the culture is a healer, the families learn how to heal; they will struggle less, be more reparative, far less wounding, far more graceful and loving "(Estes, 1992, p.68). It was with this description in mind, that I felt sure in identifying women who are LD as a culture unto themselves. In my experience facilitating a support group for women who are LD, I have found that because of their common attributes and characteristics ranging from diagnostic test results to shared feelings of secrecy, shame and low self-esteem, these women are the gentle listeners and healing sources for one another. The depth of empathy they are able to provide for one another cannot be replicated through another type of group support nor from another kind of therapy. They know and understand each other's challenges in expressive language whether spoken or written, and sit in quiet acceptance of the degrees of silence, and struggle for expression demonstrated by each group member.

> We might readily agree that within what we loosely call society or culture there are sub-cultures. In fact, there are innumerable sub-groupings. We've noticed that each can be distinguished by characteristic ways of behaving,

> dressing, eating, moving, talking, etc. Differences can run very deep: values, attitudes, beliefs, attachments and animosities. Included is the nature of our participation in language and literacy (Stokes, 3-29-93).

In my experiences facilitating a support group for women who are LD, their use and understanding of language, and especially their acceptance of one another's difficulties with expression, shaped and determined their culture (as a group). Even their choice of descriptors (e.g., feeling "dumb," "not as good as," or "not as smart as') contribute to defining them as their own culture.

The system and its expectations have been determined by a group who have targeted "standard" English as the norm for all cultures. "Standard English" or "acceptable English" is not used by many women who are LD because of the personal experiences and contextual cultures they bring to the culture of women who are LD. Their difficulties in expressing their thoughts, articulating their understanding, and in word-retrieval give language a different "sound", a different feeling which is not honored or respected by school systems as being within the norm. As a small example, deaf women (who may be LD as well) who are not able to acquire speech which is acceptable within the "normal" classroom, are not only labeled as different or abnormal, but are considered "outside" the normal school/classroom culture. Often these women are left to create their achievements and socialization within the deaf community, their gifts and modes of communication being ignored, disrespected and considered inappropriate for the mainstream.

School systems, and standardized testing determine group and individual norms for the level of language. Consideration is not paid to individual levels of development within a sub-group. If a child's level of proficiency is determined by a standardized test, the system behaves accordingly, judging that student's potential and placement within the society and culture of that school. Labels are issued, students are shuffled and herded into categories of learners like cattle. Expectations are defined. Outcomes are pre-determined.

Either too much is expected as a result of scores which measure what a person intrinsically knows and understands about language, or too little is expected because some students, despite their language proficiency or cultural difference, perform inadequately on objective tests. Women who are LD are often misunderstood and underestimated intellectually as a result of difficulty in articulation.

The contributing factor of auditory discrimination is another cultural characteristic of women who are LD. If they can't understand it, then they can't tell you about it. They can't tell you what they don't understand, because the language didn't make any sense, syntactically or auditorally; nothing was able to fit into what they already knew. For neurological reasons and/or cultural reasons the information or language just didn't find a place in the schemata to fit. The information may have sounded garbled, or it may not have found a connection with existing language or knowledge.

Classroom Trauma:
The Underlying Problem

The many faces, masks and dramatic outcomes of academic difficulties and abuses sustained by women with LD both in and out of the classroom environment are the focal point of the problem. To be able to put a name, a label, on these realities is comforting - just as the label of LD can be for some individuals. I will call it *classroom trauma*, and will refer to it throughout this dissertation, just as I have alluded and referred to it in my introduction. Later, in my description of *The Composite* I will describe the label in greater detail and depth. But for now, let me say that the greatest problem is that women with learning disabilities, or learning differences, fight academic and socio-emotional survival on a daily basis in educational settings. Because of their unique processing and language difficulties, the educational system as an organization often does not respect individual differences and needs, and do regard such differences as being negative, not right, abnormal, or less than. Attitudes of this nature often precipitate unfair treatment by peers, and sometimes by teachers who just don't know how to facilitate the learning of a student

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who may process information and language outside of the textbook examples of teaching and learning theories.

These students who present themselves in the classroom as different, run the risk of being treated as just that. To continue the chain of cause and effect, the "different ones" may be singled out to be made an examples of, teased, and called names. Women who are now in their thirties and older were made to feel as children and adolescents as complaining, lazy, unmotivated and/or hyperactive students by educational and mental health professionals. They were misused, mislabeled and misguided throughout much of their lives by professionals who genuinely felt that their diagnoses were accurate, and their treatment plans "should" work, although they often didn't because they couldn't. The chain seems neverending.

A place to begin to look at what went wrong, and what can be done to heal the psychological traumas endured by so many women with LD, is right in the classroom. Classroom trauma. It's real, and although it may not occur in parts of North America the way it did twenty, thirty or fifty years ago, it still does occur. Daily. That's the problem.

Chapter II

REVIEW OF THE LITERATURE

THE COMPOSITE:
The Cognitive, Neurobiological, Social and Emotional Self

The variables which I have identified as commonly occurring in women who are learning disabled (LD) are: 1.) the cognitive domain, 2.) the neurobiological domain, 3.) the social domain, and 4.) the emotional domain. Each variable contributes to how a learning disabled woman may behave in a variety of life-situations. Each variable may become a primary force, a secondary force, or a tertiary factor, depending upon a woman's individual culture or her collective culture as a woman who is learning disabled. Additionally, each variable, each domain works together, becomes integrated, and contributes to the gestalt of the behavior and culture of women who are LD. For the

purposes of this paper I will define women who are learning disabled as individuals who have been diagnosed with specific, neurologically based learning difficulties (e.g., dyslexia, nonverbal LD, (Attention Deficit with Hyperactivity Disorder (ADHD); the degree of disability and the other disorders which may co-exist with LD vary; see appendix B for definitions). I will discuss the variables in the experience of LD women in terms of the four domains which influence their behavior and culture. Although these domains are discussed separately, they are very much integrated as they manifest themselves in the lives of LD women.

THE COGNITIVE DOMAIN

Cognition may be defined as the faculty of knowing or thinking (Merriam-Webster, 1960). The cognitive domain of women's behavior and culture varies according to each woman's intellectual capacity, her natural-based thinking style (as opposed to her role-based style or the style which is adapted for the survival of specific situations), and the degree of diagnosed learning disability present. This domain may be inclusive of thought processes, memory, the acquisition of academic skills, and language as they affect learning and functioning in each woman who is LD. The components within the description and contribution of the cognitive domain are often the same as those found and described in both the neurobiological and social domains. It is also important to consider learning disabilities as part of the cognitive domain, as the presence of a hidden disability of this nature directly influences thinking, memory and language processes. If learning disabilities are to be considered as part of the cognitive domain, then the implications for treatment, both academically and psychologically, are of vital importance as well.

The forums which most effectively demonstrate the common cognitive variable in the behavior and in the subculture of women who are LD are the classroom setting and supportive group settings which address LD issues for women. In the classroom which exists within a school culture, there are certain expectations which have been designed by a

group of professionals who have set goals, standards, and norms. Earlier in their educations these women experienced the classroom environment in a much different way than most of their peers or family members. Because of their learning disabilities, most of these women, as children, experienced failure in the classroom. Often, they did not learn to read "on time" with their peers. Their writing skills were usually not within the established norms, and their spelling impeded this process even further. Some women who are LD experienced severe deficits in short and/or long term memory skills; testing situations became nightmares. Language deficits manifested themselves in both expressive and receptive language. Some women who are LD were not able to articulate in spoken language the quality of their thoughts, feelings or ideas. Lectures were painful; too much auditory stimuli caused many women to "zone out", or dissociate. Coupled with short term memory and spatial organizational difficulties, listening to instructions became a monumental task to be dreaded.

As adults, many of these women still experience the same kinds of difficulties with cognitively-based tasks. Women in their 30's, 40's and 50's may not have been formally diagnosed with a specific learning disability during their earlier years in school. However, they may have been labeled as "slow", "lazy" or a "dreamer" by their teachers; their peers may have referred to them as "dumb." One learning disabled woman I interviewed referred to herself as having the "dumb girl syndrome" as a direct result of believing herself to be intellectually and academically "less than" her peers for most of her life. The mistaken beliefs that each woman carries with her in regard to her ability to think, problem solve and successfully achieve in cognitively-based tasks, remain, permeating women's perception of self. These beliefs are imprinted. They adhere to the mind and the soul in a most invasive and permanent way. They can suck the life and energy from a woman's desire for success and respect as an intelligent and worthwhile contributor to society.

The most common variable within the cognitive domain is that of language. Within the cognitive aspect of development lies language and the power which it endows to

humans to interact, to communicate knowledge, needs, feelings. Our language systems (oral, written and nonverbal) consist of more than syntactic organization, and more than linguistic study. Whether by spoken word, written expression or folded arms across the chest, language regulates the homeostatic existence of human interactions, determining our mutual understanding and caring for one another, or our revenge and intolerance of diverse individuals and groups.

The cognitive aspect of the common variables in learning disabled women's behavior and culture manifests itself not only in the pursuit of academic endeavors, but also in daily existence. It permeates every facet of life. Thinking, cognitive styles, problem-solving, and expressive and receptive language ability are areas which determine the quality and effectiveness of interpersonal communications and relationships. The added complication of a learning disability often slows down the thinking process, temporarily re-routes problem-solving, and convolutes or silences expressive language.

A Metaphor for The Developmental Perspective

> Their underdeveloped vocal organs made precise articulation impossible for people of the Clan. The few sounds they used as emphasis had evolved from cries of warning or a need to gain attention, and the importance attached to verbalizations was a part of their traditions. Their primary means of communication -- hand signals, gestures, positions; and an intuition born of intimate contact, established customs, and perceptive discernment of expressions and postures -- were expressive, but limited. Specific objects seen by one were difficult to describe to others, and abstract concepts even more so.
> (Auel, 1980, p.38)

Early human development bore signs of communication through language, however indistinct the verbal articulation was. As a result of survival, individually and in groups (as

in a race, culture or gender), humans communicated their needs through sounds, gestures and *intuition born of intimate contact.* Looking at the work of author Jean Auel in *The Clan of The Cave Bear*, a novel which offers an appropriate allegorical metaphor for this study, it becomes easier to imagine the evolution or development of language in human beings. By tracing the comparisons in her story of cultural/gender roles which were established long before abstract thought could be communicated clearly through spoken or written language, it also becomes easier to recognize the gender differences in language development., and their impact upon women's social and intellectual development in society. "The difference in the brains of men and women was imposed by nature, and only cemented by culture. Any child with knowledge rightfully belonging to the opposite gender at birth lost it through lack of stimulation by the time adult status was reached" (Auel, 1980, p.37). Lack of acknowledgement or indifference is effective in retarding or molding the development of individuals or groups, cognitively, socially and emotionally. Gender roles are determined early, the power of language playing a vital role in the outcome, determining the existence or nonexistence of silence.

In Auel's story, Ayla, a female child from another early culture who demonstrated threateningly superior intellectual skills in comparison to the Clan with whom she was living, gave a vivid example of women's language development and cognition. Her brain was in a different stage of development than her caregivers; her language system was more sophisticated, her thinking had become more conceptual, less primitive. Very simply, her tribe, her culture, had developed larger frontal lobes in their brains. Despite her superior skills in language and thinking, she learned to survive in her new surroundings by observing how each gender behaved and communicated, how women remained more silent within the Clan. Her primary caregiver, a childless woman of the Clan, was aware of her own phenomenon of memory, but only as it was associated with other experiences which Piaget might have described as the processes of assimilation and accommodation. She could remember when she learned, but was not aware of how she

made the association, or how she learned it. Metacognitive awareness involves frontal lobe thinking in order to engage in the process of thinking about thinking. The Clan was not neurologically equipped to engage in that kind of activity at that time. The silence of a woman may have occurred as a result of the Clan's cultural, or socio-political dynamics, as well as from the bioneurological factors during that period in human brain development.

> All those primitive people, with almost no frontal lobes, and speech limited by undeveloped vocal organs, but with huge brains - larger than any race of man then living or future generations yet unborn - were unique. They were the culmination of a branch of mankind whose brain was developed in the back of their heads, in the occipital and the parietal regions that control vision and bodily sensation and store memory.
> (Auel, 1980, p.33)

Is some language development innate? How great are the roles of nurturance and cultural expectations in language? One theory in the relationship between language and culture is that the culture, or the values and behaviors of a group, determine how the language is used. The linguist, Edward Sapir, stated that culture and language could not be understood in isolation; they had to be viewed together as one was dependent upon the other (Wardhaugh, 1992). This is because one's use of language (whether or not this is acceptable to others within or outside your culture) determines how one perceives one's own social world. In other words, the speaker is not merely reporting on an event or an idea, but is using her own language to impose a meaning or feeling on the event or idea. It becomes a personalizing process, unique to the individual. In my experiences facilitating a LD women's support group, their use and understanding of language, and especially their acceptance of one another's difficulty with expression, shaped and determined their culture (as a group). Even their choice of descriptors (e.g. feeling "dumb," "not as good as," or "not as smart as") contribute to defining them as their own culture.

Auel wrote that the Clan had extraordinary memories that enabled them to draw upon instinctual learned behaviors from generations ago. "They could recall their racial memory, their own evolution" (Auel, 1980, p.30). If this is true, then is it possible that an actual system for language may exist in the brain, just waiting for the right set of circumstances in order to begin working? Or is it not a system, but a series of neurological possibilities which exist in order for proper integration to occur?

Ayla learned that specific tasks belonged to the domain of women, and others to men. Women did not make major decisions, did not speak out, even if they were *the ones in the know*. The appropriate neurological network was in place, but female survival, seemingly determined by man at some point in time, depended upon women's timing, knowing her place, not displaying herself as knowing more or better. In the metaphorical sense, she may have lost her voice, although in reality it was still there, waiting to be unleashed, discovered, heard. Unless some neurological system had misfired, or nature had been remiss, male and female language development occurred, possibly through a wide variety of cognitive styles, but nevertheless it occurred.

THE NEUROBIOLOGICAL DOMAIN

The neurobiological domain of women's behavior and culture is a continuation, extension and sometimes replication of the cognitive aspect. Additionally, this domain is inclusive of, and influential to the emotional aspect of learning and functioning. The nature and quality of LD women's thinking, problem-solving, and language are contingent upon conditioning, environmental stimuli, heredity, and on the functioning of the human brain. The complexities of this functioning are due to the individual neurobiological frameworks which mother nature has put in place, and due also to external stimuli which affect specific areas of the brain responsible for emotions, behavior and learning. Psychological traumatic exposure triggers neurobiological functioning which in turn creates a plethora of symptomatology. The stages of psychological trauma include: 1.) traumatic exposure,

2.) the trauma imprint, and 3.) post-traumatic adaptation. More specifically, what must be investigated in order to more fully understand the neurobiological aspect of the behavior and culture of women who are LD are: 1.) brain function, 2.) memory, 3.) survivor guilt, 4.) the death imprint, and 5.) the process and phenomena of post traumatic stress disorder (PTSD).

By definition, psychological trauma is an external event(s) of such intensity and overwhelming quality that the recipient, participant or victim is unable to defend oneself or another being in a manner in which they feel is effective. In the midst of traumatic exposure people feel too frightened and helpless to change the situation or to intervene in a meaningful way. Judith Herman defines psychological trauma as:

> . . . an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning (Herman, 1992, p.33)

It is useful to develop a continuum of traumatic events in order to better understand what psychological trauma is. Each person perceives life's events in different ways according to life experience, culture, temperament and cognitive style. One person's stressful situation may be someone else's traumatic event. One learning disabled woman may have successfully survived a most humiliating and abusive classroom situation, while the same series of events may have regressed another learning disabled woman into a prior stage of development. According to Flannery (1993), no matter how hard an individual may try it is impossible to respond to certain traumatic events in an effective way.

When viewed in this perspective it becomes clear that psychological trauma knows no boundaries of discrimination; a traumatized person is rendered helpless whether he or she actually experiences the event, or has witnessed it as an "on-looker."

In order to better understand the meaning of psychological trauma and the imprint that traumatic exposure encodes in the adult survivor, it is important to look first at the experience of the child who became that adult. Robert Lifton (1983) stated that in order to understand adult behavior as a result of psychological trauma, we must first investigate early childhood experiences. "Childhood trauma sets horrible images, once and for all, into the mind's circuitry. These horrid images will "run" by day, unconsciously impelling silent musings, fantasies, physical discomforts, actions, and play " (Terr, 1990, p.216). Lifton felt that the same was true in reverse; we may gain deeper insight into children's behaviors and experiences if we look at the adult model. According to Bessel van der Kolk:

> The essence of psychological trauma is the loss of faith that there is order and continuity in life. Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions or experiences. This results in a state of helplessness, a feeling that one's actions have no bearing on the outcome of one's life (van der Kolk, 1987, p.31).

Rice-Smith (1993) has developed a Trauma Assessment Tool for purposes of evaluation and clinical recommendations for child and adolescent survivors of incest. She uses the concepts of temporal recency and repetition as well as a simple and complex exposure and imprint, and categorizes the characteristics of traumatic exposure as Simple-Acute Imprint, Complex-Acute Imprint, Simple-Chronic Imprint and Complex-Chronic Imprint. Exposure to psychological trauma has an impact on every area of an individual's life, psychologically, physiologically, socially, and culturally (Rice-Smith, 1993).

> In situations of acute simple or recent traumatic exposure, a person's mental exposure and mental integration are taxed. We see post-traumatic fragmentation in disorders of attention; scanning; information collection; access to relevant memories that associate significant meaning to perception, judgment, and planning; the capacity to implement plans; and the capacity to implement feedback (Caplan, 1981). Recent (acute) or on-going (chronic) traumatic exposures of complex type contribute to complex sequelae disorders in self and development (Rice-Smith, 1993, p.9).

The concept of trauma imprint is important to the neurobiological domain of the behavior and culture of women who are LD. Ethnologists have renewed interest in the study of animal behavior in natural environments, referring to this research as ***species-specific behavior*** rather than instinctual behavior (Hilgard, Atkinson & Atkinson, 1979). Imprinting, a component of species-specific research, ethologically refers to early attachments which are formed and learned between children and their parents or caregivers, the people to whom the child trusts and hopes will answer his or her needs. According to van der Kolk (1987), the imprinted object (e.g., the parent) can also become the threatening factor in the life of a child, even while the child's attachment may remain strong and become even more fixed. For some women who are learning disabled, the imprinted object may be a teacher, a classroom, or a trusted authority figure as well as that of a parent.

> After the development of object constancy, overwhelming traumatic experiences cause a loss of trust that the separation call will be answered. In both children and adults, this may lead to temporary or lasting disruptions in the capacity to modulate emotions and engage in social affiliation. The clinical symptoms of this lost trust can be as severe as the symptoms of those in whom basic trust never developed (van der Kolk, 1987, p.35).

More specific to the focus of this paper is the work of Robert Lifton (1983) which addresses and describes the death imprint, one of the characteristics he identifies in survivors. This type of imprint is recognized as an intrusion of a feeling or threat which may occur once, suddenly from a single incident, or over a longer period of time.

> To be experienced, the death imprint must call forth prior imagery either of actual death or of death equivalents. In that sense every death encounter is itself a reactivation of earlier "survivals." The degree of anxiety associated with the death imprint has to do with the impossibility of assimilating the death imprint - because of its suddenness, its extreme or protracted nature, or its association with the terror of premature, unacceptable dying.
> (Lifton, 1983, p.169)

Object constancy resembles the imprinting object which in turn resembles the death imprint; the survivor tends to return to the death imprint, clinging much as the child clings to the abusive parent, or other authority figure, returning to it again and again. "So bound to the image can the survivor be that one can speak of a thralldom to death or a *death spell*" (Lifton, 1983, p.170). The death imprint can impose the same kind of paradoxical feelings upon a survivor as those presented by an abusing parent or other significant figure; fear and anxiety are present in relation to the image, or the abusing parent, but the instinctual drive to return to it, to be fixed or captured by it, is overwhelming, almost part of an individual's existing schema. There appears to be a psychic "seduction" in the phenomena, the imprinting object being the "seductor", the survivor the "seductee", unable to resist the return to pain.

Post-traumatic stress adaptation is a principle of psychoformative theory. It is termed by Lifton (1988) to be the normative principle and the "adaptive process of reaction to an abnormal situation". By definition, adaptation means to adjust, accommodate,

reconcile. Human beings attempt to adjust to the aftermath of trauma, whether by effectively and pro-actively coping or by sinking into a dissociative abyss. When the organism is assaulted by psychological trauma, the neurological system scurries to accommodate this new invasion of stimuli. Reconciliation of the event(s) deals with the self's need to seek intrinsic harmony , and for the organism's need for an equilibriated status. Familiar responses to stress or psychologically traumatic events are considered adaptive behavior. We scan our schema in search of methods of coping which were effective in the past - we seek what we know. With each developmental crisis, survivors accrue coping strategies or compensatory skills which may be later called upon to deal with subsequent crises in life. "Thus it may be anticipated that successful resolution of developmental crises leads to a sense of efficacy and ego integrity in late life" (Moos & Billings, 1982; Wilson, 1980, from Wilson, Harel, Kahana, 1988, p.72). A learning disabled woman has accrued a repertoire of compensatory strategies which she has used in past classroom situations which were perceived as threatening; her strategies are fully utilized in daily life as well as in order to step between the "mines" so that she may avoid the danger of explosion or exposure.

Stressful situations are not synonymous with traumatic exposure, although everyone' s tolerance and perception of what it is that is experienced as traumatic is different. Stress may be defined in terms of stimulus-based reactions or neurological responses. "Monat and Lazarus (1977) suggest that stress is a demand that disrupts homeostasis, and thus taxes the individual's adaptive resources" (Wilson, Harel & Kahana, 1988, p.56). Each individual is affected differently by stressful situations; no one's experience can be minimized, invalidated. If viewed on a continuum, the stress phenomenon may acknowledge an external event which interferes with learning/functioning; on the opposite end of the continuum is an external event which leaves the victim rendered helpless. We all possess different skills for coping and

surviving those experiences which render us helpless and overwhelmed. Some of us survive commendably well, some not at all.

In order to gain a deeper insight into the neurobiological domain of the behavior and culture of women who are LD, it becomes necessary to look at brain function and trauma, as they interrelate. First, I will define neurobiology and psychological trauma within the context of this paper. The "neuro" aspect of neurobiology pertains to brain function, and within the context of my study is specifically the limbic system. The three neuroanatonic brain axes are :

> 1.) the anterior/posterior axis, involving executive and control (output) processes, as opposed to the input, or reception/processing, of information;
> 2.) the lateral axis, involving the two hemispheric systems and their contrasting information-processing styles; and
> 3.) the cortical/subcortical axis, involving complex feedback relationships between higher-order planning systems and the extensive subcortical systems mediating life-support, arousal, drive responses, and the regulation and execution of behavior in general.
> (Rudel, Holmes, Pardes, 1988, p.113)

Although the three neuroanatonic brain axes are involved in learning the functioning, the cortical/subcortical axis comes to the forefront of this study as it deals with the mind-body connection, or the impact of emotions on learning and functioning. The limbic system is specifically where the "neuro" aspect of neurobiology is located within the context of this study. According to Robert Ornstein (1984) the way to remember "limbic functions are the 'four f's' of survival: feeding, fighting, fleeing, and sexual reproduction" (p.28). Within the limbic system is found the amygdala and the hippocampus, two relatively small areas of the brain where the cockpit or control panel for our fight or flight from danger is located. They determine how our bodies will react to specific situations when our memories have

connected one experience to a more primitive and threatening event which may be referred to as the original traumatic event. This brings me to the "biological" aspect of neurobiological.

Biology is the branch of knowledge which concerns itself with the treatment of living organisms. The living organisms in this case are women with learning disabilities. The neurobiological domain in this research therefore deals with the emotional and biological responses to external stimuli. In most case studies this may mean the way that individual women with learning disabilities react or respond to classroom trauma or to other types of psychological trauma which impacts learning and functioning. Biologically our bodies react to how we *feel*, to how our emotions ebb and flow with each small stress or larger psychological traumatic exposure. Each of us responds in a variety of ways to these insults which intrude upon our lives on a daily basis, some unfortunately in a much more intense and threatening way than others. The mind-body connection manifests itself in unique ways according to the frequency and intensity of the stress or trauma which has been experienced, and also according to the mysterious internal stamina present within each of us. This strange and unidentifiable ability to move through life's challenges differs in each individual, and goes beyond what has been termed as coping and adaptation.

For the purpose of this study, psychological trauma is defined as an intrusive, external event which is sufficiently powerful, terrorizing and evil to disconnect or short-circuit the mind-body connection, leaving the victim feeling helpless. It is noteworthy that the need to keep the secrets of many types of psychological traumatic exposures and the paradoxical desire to shout these atrocities from the rooftops is traumatic in itself. Both actions require great energy and will on a daily basis. There is no rest. Secrets are the keepers of the silence and the contributors to evil. Women who are learning disabled, and have spent many hours being repeatedly humiliated and violated both in and out of the classroom environment, know on an intimate level how their invisible disabilities keep them traumatized.

When considering the impact of psychological trauma on the behavior of women who are learning disabled, the theories of Jean Piaget offer a perspective which deals with how an individual obtains information, organizes it, and fits it into an already-existing fund of knowledge. The coordination of assimilation and accommodation (equilibration), make learning possible, and influence behavior in a direct way. When trauma intrudes upon this process, then equilibration becomes more difficult to achieve, as the new stimuli cannot always be accommodated in the appropriate developmental stage, but must seek a level which is familiar and has demonstrated past success for survival. Again, when a learning disabled woman experiences a classroom trauma, or a psychological trauma which is even vaguely reminiscent of the original trauma, then she may automatically shift into a prior stage of development in order to accommodate the intrusive and painful stimuli which impedes her functioning. She will seek to achieve her comfort level; she will seek her personal and individual state of equilibrium.

> In Piaget's theory, equilibrium is dynamic; it is a system of compensating actions that maintain a steady state. That steady state is a condition of the system in which the internal activities of the organism completely compensate for intrusions from without. (Phillips, 1981, p.30)

What appear to be developmental delays or arrestations in learning or behavior often go undiagnosed and untreated unless a formal assessment is requested. An evaluation may be required under the guise of concern by a teacher or a parent. Often the desire for formal evaluation comes from an intuitive level (by a parent and/or professional). Confirmation of a suspicion or a sense of cognitive difficulty needs to be validated through what is perceived as scientific method. In some children, levels of maturation do not seem to be where the involved parents and professionals feel that they should be. At the root of the diagnosed learning or behavior problem may lie a significant trauma(s) in the child's life,

causing lags in development observed both in and out of the classroom environment. Often this has been the case for women with LD. Their behaviors, both in and out of the classroom environment, have been directly affected by traumas on some level, and often by psychological traumatic exposures on a multitude of levels.

> When a child's systems are overloaded because of fear and pain, the child loses the ability to shift easily through sets and to previously assimilated signs and symbols. He has lost the function of accommodation, the ability to self-correct, to anticipate, to admit ranges of possibilities. Earlier coping mechanisms are activated and repeated to ensure the safety of sameness.
> (Rice-Smith, 1993, from Krystal, 1978)

Rice-Smith (1993) reported that psychotic children were not able to assess or read people's intentions, an example of the impact of psychological traumatic exposure on learning and functioning. If this information was gleaned from diagnostic testing such as the WISC-R, then it might be interpreted to be a difficulty in visual sequential thinking, indicated also from the Picture Arrangement subtest, also a measure of social intelligence or the ability to read people and situations. WISC-R subtest results may also indicate what was referred to by Rice-Smith (from Schmid-Kitsikis, 1976) "as the incapacity to move beyond the search stage of problem solving, or not able to use anticipation or develop coping strategies for problem solving " (p.130). Schmid-Kitsikis also spoke of the child's difficulties with spatial and motor disturbances. Again, it would be interesting to know if these findings were connected to WISC-R testing as well as to observational data, as it would begin to build a learning profile, an indication of what may be happening in the classroom as well as at home or in the office of a mental health professional. This poses an important question to be further investigated: Do specific learning deficits have any bearing on how traumatic stimuli are perceived and organized?

Caplan and Walker (1979) noted that psychotic children experienced difficulties in Gardner's (1985) visual domain. Would that correlate with subtest results on the Performance mode of the WISC-R (e.g. Picture Arrangement, Picture Completion, Digit Symbol)? Verbal developmental delays were also found in psychotic children. How many individuals experienced these delays or deficits due to familial transmission as well as from the residual effects of psychological trauma? Are any of these individuals rendered silent by their psychological traumas? If so, can this be influenced by the presence of a diagnosed learning disability? These are areas which I will further investigate in my dissertation.

The process of the transmission of familial learning disorders is not fully clear as yet (Rudel, Holmes & Pardes, 1984), although researchers are currently offering many theories on the subject. According to Geschwind and Galaburda (1985), certain aspects of autoimmune functioning have been connected to dyslexia. The limbic system which includes the functioning of our immune system, is also affected by psychological trauma. The process of kindling in the brain follows intermittent episodes of trauma; "repeated electrical stimulation of the amygdala causes long-term alterations in neuronal excitability" (van der Kolk, 1987, p.68). The norepinephrine produced by the brain may produce a response as intense as the original traumatizing episode, often resulting in a vigilant alertness. The changes which have occurred in the limbic system as a result, in turn, cause even minor anxiety-provoking events to be responded to with the intensity of the original traumatic event. The victim, in this case a woman who is LD, may reside in an almost constant state of hyperarousal, hypervigilance. Her human radar seems to be constantly at work. Symbolic reminders of original traumas, both positive and negative, will trigger kindling. The cycle of kindling continues when the triggering events, or traumatic events, have diminished or passed. A withdrawal in endorphins and norepiniphrine is experienced, creating flu-like symptoms which cause frightening feelings (e.g., "what is happening to me?"). When fear registers, then norepiniphrine increased once again,

reactiviating the process (Flannery, 1993). The process of kindling in the brain may directly affect testing results as well as the behavioral observations made by the examiner. Additionally, kindling may be an observable phenomena within the group setting, as one woman's reported experience may trigger a series of responses in another. "A history of significant emotional insult can call into question the appropriate development of all behavior (associated with any axis)" (Rudel, Holmes, Pardes, 1984, p.149).

The Amygdala

Emotion and memory. Body and mind. These are inseparable entities which comprise the cognitive and neurobiological aspects of LD women's behavior. The amygdala lies in the medial wall of the temporal lobes, and is part of the brain's limbic system. "The involvement of the amygdala in emotion, learning, and memory has been suspected for many years, but the last decade has seen a tremendous acceleration in research uncovering the fine details of its functions" (Aggleton, 1992, p.xi).

Most case studies of amygdala stimulation are too crude and nebulous for absolute proof that this tiny, almond shaped part of the brain is solely responsible for specific emotional and bodily responses as a result of psychological trauma. It is believed that the amygdala is responsible for a wide range of behaviors (Aggleton, 1992). "Amygdala stimulation evokes various mental and somatic aspects of emotion. Any role of the amygdala in evoking these phenomena will be limited to the information that the amygdala receives" (Halgren, from Aggleton, 1992, p.201). The process of kindling takes place in the amygdala. Originally, kindling was viewed as epileptic seizure activity caused by electrical stimulation or specific drugs. Nonconvulsive behaviors, as a result of amygdala kindling, include learning and memory (Aggleton, 1992).

The amygdala operates within the cognitive processing system as well as the driver of emotional response . "While presumably the amygdala performs emotional evaluation, it does so within the cognitive system. This could explain why it has been so difficult to

dissociate emotional from cognitive processing in humans "(Halgren, from Aggleton, 1992, p.212). Each mode, the emotional and cognitive, are systems which work within a structure. When humans respond emotionally to stimuli much of this occurs because there are conditioned responses to certain situations which have occurred over a period of time, sometimes a lifetime. The situation does not have to be replicated exactly, but has to be only reminiscent of, or similar to the original episode/stimuli. This has been learned. Therefore there is a cognitive structure supporting what appears to be pure emotional response.

Emotional memories are stored in the amygdala, some becoming permanent. This explains the response or output which occurs when similar stimuli is accepted and processed. What may have been a childhood reaction or behavior to a specific trauma may repeat itself externally as an emotional and physiological response or behavior because of its reminiscent characteristics. "Conditioning does not create new emotional responses but instead simply allow new stimuli to serve as triggers capable of activating existing, often hard-wired, species-specific emotional reactions "(LeDoux, cited by Aggleton, 1992, p.343). Is it safe to say that the amygdala is the receptacle for traumatic memories, holding them prisoners to never be set completely free?

Memory

We want to forget painful events. *We want to remember* how to divide and multiply in order to broaden our conceptual knowledge. There are intrusive memories. There are memories that mark the beautiful times in our lives. We depend on our memories to learn, to function, to carry us from one place to the next, both mentally and physically. Our memories are our personal time machines, hopefully reliant when we need them, maddeningly troublesome when we least expect it. Memory is an intricate and sophisticated neurologically-based system which we are still exploring.

Pierre Janet viewed the memory system as the "central organizing apparatus of the mind, which categorizes and integrates all aspects of experience and automatically integrates them into ever enlarging and flexible meaning schemes "(Janet 1939; Perry & Laurence 1984, from van der Kolk, 1991p.426). This sounds like Piaget's assimilation and accommodation; stimuli is accepted into the organism, scanned, organized, shuffled and made to *fit*. When the actual *fit* is made, the information is *stored*. Janet went on to explain that when trauma is experienced the new stimuli may not easily fit into already existing schemes. The event may have to be integrated and accommodated in a different way. Fragments of the event, strands of memory, may surface, presenting itself as strange and unidentifiable feelings and behaviors, sensations or thoughts.

According to Janet, there existed two types of memory: traumatic memory and narrative memory. When situations reminiscent of the original trauma occurred, then the memory emerged as well, where it may previously have been suppressed. Traumatic memory is isolated in that it is not related to the social act of *telling* the story in a natural manner. When a traumatic event is related it may be coupled with fragments of other memories and/or physiological symptoms (van der Kolk, 1987). It does not necessarily make sense within the context of a conversation or thoughts which lead in a structured kind of way to the actual event. An ordinary or narrative memory may allow for learning to take place as the cognitive structure provides fertile ground for connections, association, assimilation and accommodation. However, when traumatic memories arise, the cognitive system is derailed, the human gyroscope is tipped, and it becomes a struggle for appropriate matching, categorizing and accommodating to take place.

> The mind thus engages in two paradoxical activities:
> on the one hand, it creates schemes, and tries to fit all new
> experiences to fit its preconceptions. At the same time, it also
> is constantly looking for new ways of putting things together,
> for new categories to create (Calvin, 1990, from van der Kolk,
> 1991, p.439).

For example, when a child is learning a new concept in the classroom, and is able to connect this new information to an already existing scheme, then the concept may be learned. "Preexisting schemes determine to what extent new information is absorbed and integrated "(van der Kolk, 1991, p.439). When a child has experienced humiliation in the classroom environment, she may find herself in a scene which is reminiscent of an earlier trauma, where fragments of that memory may surface, tipping her gyroscope and again immobilizing her. The only learning that will take place under those circumstances is the frantic scanning for a safe place in her mind to hide, to survive, to cope with the present situation. She has learned to behave this way. She is conditioned to respond and behave according to her familiarity with this experience.

Understanding how the brain stores memories is still a great challenge in neuroscience. The hippocampus (which comes from the Latin word for "sea horse") is part of the limbic system. The hippocampus is not responsible for the storage of memories, but for accepting new ones as they enter the system. Damage to the hippocampus may result in the inability to remember what was *seen*, the visual image. "Mishkin thinks that there is a circuit from primary visual cortex to visual area TE to hippocampus, and other regions of the limbic system play a critical role in placing the memory of the visual object into storage (Ornstein & Thompson, 1984, p.138).'

State-dependent learning is when memories are accessed as a result of reliving visual and motoric traumatic experiences. The experience does not need to be replicated, but only be reminiscent of the original event in order to produce an emotional response. Often the reenactments are preceded by physiological arousal (van der Kolk, 1987). "The more the contextual stimuli resemble conditions prevailing at the time of the original storage, the more memory retrieval is likely. Conversely, the more often people find themselves in emotional states resembling the traumatic one, the more they will 'remember' the trauma "(van der Kolk, 1993, p.228).

People with trauma histories may react to a variety of anxiety provoking events with the same degree of distress as they did to an original trauma. A trigger mechanism has been created for them. Without stabilization, these people will often find themselves in a state of disorganization, struggling for a sense of equilibrium. Their gyroscopes may feel tipped more often than the norm. Storing new information in memory and making connections will become difficult. Learning will again be like trying to walk into a hurricane. LD women bring the neurobiological aspects of psychological trauma to their collective culture as a portion of their attributes and behaviors.

The Death Imprint: Survivor Guilt

> Any claim to psychological insight must be tested against disorder. I believe that principles around death and continuity can contribute to understanding the major psychiatric syndromes. Yet at the clinical and conceptual heart of psychiatry, death-related issues have been most neglected, . . . (Lifton, p.163, 1983).

Much attention (although not enough) has been paid to the posttraumatic syndrome which may follow the witnessing of death or another type of psychological traumatic exposure. In most of these studies survivors of large-scale atrocities have been involved; Hiroshima, the Holocaust and veterans from World War I and Viet Nam. Less attention and little acknowledgment is given to the individual, whether child, adolescent or elder adult who witnesses the death of a significant person in their life. Indeed, the feelings of helplessness are no less, the frozen state is no less intense, and the clinging essence of guilt may be as pervasive. How can the depth of despair, and sometimes horror, be less for a mother watching her child fight for breath, than for a man holding his army buddy's hand as he struggles for life on a battle field? Is it less important that an eighty year old man watch his wife die in his arms, suddenly, without warning? Is there a way to measure this? The human response to the trauma may occur in relatively the same manner in each case.

The brain may react in the same way, causing the body and mind connection to behave in ways which are characteristic of the human trauma response. What is different is often the perceptions of others as to the significance of the event, and the people involved.

Children demonstrate changes in behavior both in and out of the classroom environment when a death has occurred in the family. Regardless of whether the significant person, usually a parent, died suddenly, violently, or from a chronic disease of significant duration, the child reacts with a variety of behaviors. Learning usually is interrupted, and often comes to a halt.

> Many children . . . whose previous development had been sound, demonstrate moderate declines in learning as a result of the death of a parent. Other children who have pre-existing neurocognitive deficits or emotional conflicts or deficits tend to show significant and prolonged regression. Where the death of a parent is due to a violent event or chronic illness, children also have a more difficult time adapting. The most difficult and prolonged adaptation and the poorest prognosis occurs when several of these factors coexist.
> (Webber & Knight-Birnbaum, cited by Field et al, 1993, p.147)

When a learning disability is present then the adaptation to the original trauma, and ultimately to the loss of the parent, may become overwhelming in its manifestations in general behavior and learning both in and out of the classroom setting. The child may regress in development depending upon her developmental stage at the time of the trauma. By the time she has reached adulthood, she may have been diagnosed with a learning disability which was present from birth, or as a direct result from regression in development due to an original trauma. Additionally, she may commonly suffer from the co-existence of more than one deficit; the trauma may have caused emotional difficulties which further impede learning and affect behaviors, thereby continuing and expanding upon the difficulties of an already existing learning disability. The cycle continues. Until

the appropriate remediation and intervention takes place, the adult woman does not always understand why her "trigger responses" (possible PTSD) occur when they do, why they occur at all, or how to cope with and understand this strange phenomena (Webber & Knight-Birnbaum, from Field et al, 1993).

Before survivor guilt can be discussed and the impact which death may have upon a child's learning and behavior may be properly acknowledged, it is important to understand the death imprint. "The death imprint consists of the radical intrusion of an image feeling of threat or end to life. Of great importance is the degree of unacceptability of death contained in the image - of prematurity, grotesqueness, and absurdity "(Lifton, as cited in Wilson, Harel & Kahana, p.18, 1988). A trauma of this nature presents the survivor with a unique challenge in fitting this new (or repeated) experience into already-existing schema. The scene may be revisited again and again, through imaging, flashbacks, nightmares, or from the conscious involvement in a reenactment which may be reminiscent of the original death trauma.

The death imprint leaves the survivor with a paradoxical inclusion of both the fear of dying and the death of self, for in the midst of witnessing death, the survivor may become the observer, stepping back and away to a safer place in the mind where nothing is felt. The mind must become desensitized to the scene; it must die, become numb.

Should guilt be renamed in order to accurately describe survivors? Is it really like the guilt that may be experienced by the victimizer, the perpetrator? Is survivor guilt like shame? The survivor who suffers from guilt as a result of unresolved feelings of inadequacy and shame due to their witnessing of death and/or incomplete or unsuccessful rescue, tends to keep replaying the incident repeatedly in life, in dreams, and often through the expressive arts. Some survivors hope that they may be able to rewrite the script - "whether by preventing others from dying, taking bolder actions of any kind, experiencing strong compassion and pity, or perhaps suffering or dying in place of the other or others. In that way the hope is to be relieved of the burden of self-blame "(Lifton, p.171, 1983).

> Guilt threatens either when it predominates in its disintegrating potential or when its absence permits inwardly unchallenged destructiveness. In its relationship to vitality no less than to death imagery, the experience of guilt is central to our paradigm and to the balancing functions of the human mind (Lifton, p.146, 1983).

A child will be directly affected by the death of a significant person in her life; her behavior both in and out of the classroom environment will change. The intensity of the responses or behaviors will depend upon whether or not the child has witnessed the death, and/or is desperately attempting to fit the new loss, or trauma, into existing schema. Survivor guilt is a phenomenon which will follow each woman throughout her adult life and will trigger responses and behaviors identifiable as post traumatic stress disorder in many instances. This phenomenon and the behaviors which are the results of it, also become attributes of the neurobiological aspect which contributes to LD women's culture.

Post Traumatic Stress Disorder

The aftermath of a survivor's experience with a traumatic event is referred to as Post Traumatic Stress Disorder (PTSD). PTSD may result from a single incident of trauma or from repeated frightening incidents (Flannery, 1992). When these events are not dealt with appropriately, and within a relatively short period of time, then PTSD will intrude in the life of the survivor, affecting daily routine, learning and functioning. Acute symptoms of stress will occur and reoccur at different rates and with varying intensity according to each individual. The symptomatology appears universal, the experience itself is highly individual.

Flannery (1992) breaks the symptoms of PTSD into three major categories: physical symptoms, intrusive symptoms, and avoidant symptoms.

Physical Symptoms	Hypervigilance Exaggerated startle response Difficulty sleeping Difficulty with concentration or memory Mood irritability - especially anger and depression
Intrusive Symptoms	Recurring, distressing recollections (thoughts, memories, dreams, nightmares, flashbacks) Physical or psychological distress at an event that symbolizes trauma Grief or Survivor Guilt
Avoidant Symptoms	Avoiding specific thoughts, feelings, activities or situations Diminished interest in significant activities Restricted range of emotions (numbness)

Survivors who have been diagnosed with PTSD do not have a normal baseline of arousal, or attention (Herman, 1992). Their minds are in a constant state of vigilance; they are like watchdogs, protecting the organism, the self, from intruders or threatening stimuli which will upset the sense of equilibrium, tipping the gyroscope. The nervous system is on alert; every sense is heightened.

When the human response to trauma is not dealt with in a timely way, then the survivor may enter the acute/protest phase of PTSD, characterized chiefly by anxiety and fearfulness. If there is an abatement in symptoms which may reoccur months later, then

the survivor is in the chronic/numbing phase of PTSD, characterized by feelings of numbness and depression (Flannery, 1992).

The phenomena of PTSD intrudes in the lives of children who have experienced varying degrees of psychological trauma. When symptoms are left unattended, then the individual will often shift in and out of the stages described by Flannery. It takes only a vaguely reminiscent incident to trigger symptoms. When carried over to adulthood, a woman may experience symptoms in her daily life, accepting both the triggers and the symptomatology as part of her schema, part of her personal landscape. It may take an insightful and skilled educational therapist or psychotherapist who is knowledgeable about learning disabilities and PTSD to recognize the long ignored symptoms. The existence of this disorder further complicates the already existing struggles from a learning disability. Behavior is affected on many levels. The characteristics add to each woman's list of cultural characteristics unique to the culture of women who are LD.

THE SOCIAL DOMAIN

The cognitive and neurobiological domains of the behavior and culture of women who are LD are embedded within the social domain. These three variables are ever present, one not in exisitence without the other, throughout human development. The social domain is visible both in and out of classroom settings; it determines the success or failure of nearly every interpersonal relationship and every human communication. Interpersonal communciation depends upon the individual ability to convey thoughts and feelings to one another, and to be able to adequately "read" the other person's needs and feelings. There is a reciprocity about the cycle of expressive and receptive language. When I describe the meaningfulness of the social domain of the behavior and culture of women who are LD, I will do so within the context of the classroom setting and/or a supportive group setting, although difficulty with communication and relationships for women who are LD (and all adults) occur within the broader context of daily personal interactions.

> . . . it is a commonly held notion that persons who experience significant difficulties in learning are most definitely susceptible to disorders in other areas of human functioning, such as the "emotional" and "social" dimensions of life. It is in this sense that characterize learning disabilities (LD) as "life" or "lifetime" disabilities (Rourke & Fuerst, 1991, p.1).

The child who is learning disabled and who speaks out of turn, interrupts, is "truthful" with others to the point of being offensive, who has difficulty "sensing" others' feelings, "reading" others' facial expressions, is at high risk for being alienated from her peers, and often from the adults in her life as well. When a social deficit of this nature follows a woman into adulthood, there is a strong possibility that she will have experienced few healthy and successful relationships. Often these adults can "clear a room" in little time, and conversely they will often hide away from others, hoping not to be spoken to, or questioned, for fear that they will respond inappropriately. They have learned that they do not respond in a manner in which others find welcoming. But they have not learned how to remediate their deficit. However, there are other LD women who experience this deficit, and continue through life unaware of the social disasters they have left in their wake. They plod through life believing that they are victimized again and again by others, not because they have spoken out of turn or tactlessly to another person, but because people just don't like them. The former example can be remediated much more easily than the latter.

One perspective to consider within the social aspect of the behavior and culture of women who are LD is sensory integration. "The vestibular system is the sensory system that responds to the position of the head in relation to gravity and accelerated or decelerated movement. Underactive vestibular responses are characterized by poor integration of the two sides of the body and brain, and difficulty in learning to read or compute" (Ayres, 1979, p.185). This is not information that is often found in most learning profiles, and it may not be included in the reports of many neuropsychologists as well. But the

implications are important. When the vestibular system is not functioning adequately then reading may not be the only area affected. Vestibular information lets us know where we are in space. "A kindergarten child with a vestibular problem may have trouble pasting one piece of paper on another, because his brain cannot line up the two pieces in space" (Ayres, 1979, p.75). Additionally, a child or adult with this dysfunction may experience difficulty in printing or writing, and in judging physical distance and space between herself and an object or destination. The vestibular system plays a vital role in social relationships as the person affected is not always sure of how close to stand to another person, and may be perceived by others as someone who "does not know her own space." Finding her way around, giving and receiving directions, and bumping into people and objects are some of the characteristics of this dysfunction. Space cannot be seen nor felt; cognitive processing cannot identify it, nor place the person in a safe place within that space. Feeling "lost in space" is a frightening feeling, and one which may affect a child or woman's ability to function in relationships or in groups. "If the child's relationship to the earth is not secure, then all other relationships fail to develop optimally" (Ayres, 1979, p.77).

Language disorders in learning disabilities (LLD) also include problems in nonverbal communication. Like sensory integration, the process that suffers most widely is visual-spatial understanding and functioning. A child or adult who experiences difficulty in nonverbal communication, especially if body movement is involved in the reception or expression, will find it difficult to convey her message and understand the cues given by others in "higher-level, complex emotions, intentions, and reactions such as avoidance, empathy, frustration, or indecisiveness" (Wiig, from Capute, Accardo & Shapiro, 1994, p.145). Some investigators have claimed that "children with nonverbal learning disabilities (i.e., V>P) are at elevated risk for social difficulties" (Rourke 1989; Rourke & Feurst 1992; Semrud-Clikeman & Hynd 1990; from Capute, Accardo & Shapiro, 1994, p.166).

Social ability is a cognitive function found within the domain of personal interactions. According to Michelson, Sugai, Wood, and Kazdin (1983) the following seven components are included in social skills:

> 1. Social skills are primarily acquired through learning (e.g., observation, modeling, rehearsal, and feedback).
> 2. Social skills comprise specific and discrete verbal and nonverbal behaviors.
> 3. Social skills entail both effective and appropriate initiations and responses.
> 4. Social skills maximize social reinforcement (e.g., positive responses from one's social environment).
> 5. Social skills are interactive by nature and entail both effective and appropriate responsiveness (e.g., reciprocity and timing of specific behaviors).
> 6. Social skill performance is influenced by the characteristics of the environment (i.e., situational specificity). That is, such factors as age, sex, and status of the recipient affect one's performance.
> 7. Deficits and excesses in social performance can be specified and targeted for intervention.
>
> (p.294)

Social skills are learned, but the concept of social competence is a much subtler kind of behavior, and weighs heavily upon individual value and judgment systems. According to Hazel, Sherman, Schumaker, and Sheldon (1985) social competence requires that an individual must:

> 1. Discriminate situations in which social behavior is appropriate;
> 2. Choose appropriate skills to be used in a given situation;
> 3. Perform these skills fluently in appropriate combinations according to current social mores;
> 4. Accurately perceive the other person's verbal and nonverbal cues; and
> 5. Flexibly adjust to those cues.
>
> (Hazel & Schumaker, from Kavanaugh & Truss, 1988, p. 294)

Social skills are based on cause and effect relationships, and can be taught over a period of time, depending upon the nature and degree of a child or woman's learning disability. Social competence demands that an individual be able to "read" expressions, find meaning through subtle cues, and be able to react to these subtleties appropriately. If a woman suffers from a vestibular dysfunction (Ayres, 1979) then her system is not able to read nor respond appropriately to what she may see as being appropriate behavior. However, there are profiles which indicate that an individual may not spontaneously respond adequately to a variety of social interactions and expectations, but the potential may be present in order to learn positive responses which may lead to successful interactions and relationships for the future.

Rice-Smith stated that according to Torro (1982) and others, the effects of trauma on cognition indicate delays to children's development of self and the ability to appropriately interact with others. The results of a study developed by Fish-Murray at the Trauma Clinic at Massachusetts General Hospital, indicated that the study group (abused and neglected children) did indeed exhibit deficits in self-knowledge and a sense of others. This area of *knowing* seemed to be where subjects experienced the deepest degree of damage. Again, it would be interesting to investigate the Performance subtests (from the WISC-III) on these individuals who demonstrate difficulty in *a sense of others*. Also, it is noteworthy that those women whose WAIS-R scores in the Performance mode are much lower than the Verbal mode appear to have a great deal of trouble within the group setting, trying to read the responses of others in order to better understand how they themselves are perceived by their peers.

Some women who are LD feel "less than" in social situations for a variety of reasons. Many of these women have not felt intellectually confident in their adult relationships. As result, they are easily subjugated in their marriages or relationships with significant others. Their skills with budgeting money, verbal banter and sequencing information may be as qualitatively sufficient, but slower in process than their partners.

Compounded by historical abuse of women's roles in society, women with LD can find themselves in most precarious and suffocating relationships, where personal growth, satisfaction and sense of worth seem nearly impossible to attain. "The socialized and patriarchal role for women to be compliant, obedient, and submissive causes women to feel shame or conflict about fighting back or getting out of psychologically violent relationships" (Cook, 1993, p.69).

Women of color and women with disabilities are easier targets for misuse in contemporary American society (Mirkin, 1994). Therefore, women who are LD and who experience social deficits and struggles in their relationships, may do so not only because of their specific social-cognitive disability, but also as a result of the restrictions that society has presented to them. Additionally, feminist psychology which sometimes addresses women's struggles with social deficits, often focuses on the experiences of white middle class women, ignoring women with hidden disabilities and differences, an antithesis of "feminist diversity" (Espin & Gawelek, 1992).

Dan Brown (1993) stated that affective states have been noticed in infants shortly after birth, and that some theorists propose models which are observable in stages of development. This may be viewed on a continuum, sometimes becoming "stuck" in a stage, or skipping a stage, according to the nature and severity of an individual's experienced trauma. The residual effects of trauma may render an individual unable to judge or respond appropriately to affective experiences. Within the group setting, either in or out of the classroom environment, a deficit in affective development may be responsible for difficulty in developing and maintaining relationships. At this time I am not aware of any studies which correlate these findings with other psychological assessments or evaluative tools such as WISC III or WAIS-R.

There are patterns which identify subgroups of children with LD who stand at a greater risk for a social deficit. According to Landau, Milich, and McFarland (1987) there are three subgroups which demonstrate this hypothesis; they are based on discrepancies

between the Verbal and Performance modes of intelligence on the WISC-R: V>P; V=P; V<P. Within these two modes of intelligence there may exist patterns among the subtests. This researcher looks for similar profiles and patterns on the WAIS-R when interviewing women with LD.

Social deficits are not recognized as being specifically linked to the LD population. However, it is interesting to note that a significant percentage of individuals who are LD suffer from social deficits. Within that subgroup there is another subgroup who have attention deficit disorder with hyperactivity (ADHD) as well as LD (Wiig, from Capute, Accardo & Shapiro, 1994). They also display struggles with poor peer relationships. The hyperactivity factor negatively influences the development and maintenance of relationships both in and out of the classroom environment. It has been my experience, especially in group work, that clients/students who are ADHD as well as LD often are the most steadfast monopolizers and have the greatest difficulty monitoring their own behavior in terms of interruptions and outbursts. There is a quality about some of the behaviors (in some clients) which is reminiscent of Tourette's syndrome - - the inability to hold back, to remain in command of one's self. Anger is verbally unleashed in what appears to be a spontaneous and uncontrolled manner by some children and adults who are LD/ADHD, especially if the individual is not being monitored by a physician for medication. It becomes difficult to maintain an equilibrium within the group; relationships with peers and teachers also become a struggle. The culture of the classroom or group setting becomes malleable to such behaviors as individual and collective boundaries get stretched and pushed, sometimes out of control.

The diversity of socialization skills within a group setting creates fertile ground for the women to assess how they interact with others. It provides opportunities for those who are less socially astute to experience some successful social interactions as a result of modeling, role playing, and accepting the feedback of other group members. During a one-to-one relationship with the group leader, or educational therapist, each woman can process

their interactive experiences, and become better self-monitors of their own behaviors. Those who have developed adequate, and sometimes outstanding skills in socialization become models. Those who have suffered from years of unsuccessful and painful relationships as a result of their learning disabilities use their peers who are stronger in these areas as models. The following are some of the many reasons why learning disabled women possess socialization problems:

1. A learning disability may cause a person to be unable to read gestures and facial expressions.
2. A learning disability may cause a person to be unable to hear voice tones, making it difficult for them to react.
3. A learning disability may directly affect a person's ability to communicate. ("I can't find words when I want them." "Speaking is hard for me." "I couldn't write, so I couldn't write notes to my friends or even take messages.")
4. A learning disability may cause egocentricity ("me, me, me"), which makes it difficult for a person to evaluate the impact of his behavior on others.
5. A learning disability may cause a person to become so concrete and literal that others find his or her comments inappropriate. ("But you said I was stifling your fun, and I haven't put my hands near you!")
6. A learning disability accompanied by hyperactivity, distractibility, and impulsivity affects social relations. ("I gave away the family secrets. Whatever the family did not want the world to know, I blurted out. I told my friends' secrets also.")
7. A learning disability may cause disorganization to the extent that peers cannot tolerate it. ("I was always late, got lost, forgot what I was supposed to bring.")
8. A learning disability may make a person unable to participate in ordinary activities that develop social skills. ("I was such a klutz, I couldn't go out for sports." "I got all mixed up when I played Monopoly or even a simple game

> like Uno and ruined it for everybody.")
> 9. A learning disability may cause a person to be ostracized. ("I was called *space cadet.*" "I was teased all through school for the awkward way I walked." "I went to the basement of our public school for classes with the 'Cootie' group. I'm relieved to be an adult now because it has finally stopped!")
> 10. A learning disability may cause a person to feel stupid and rotten and to withdraw from social interaction. ("Books became my best friends. I buried myself in them, once I could read.")
> 11. Misguided teachers and parents may subject the person with learning disabilities to intensive remedial studies that steal all time away from social interactions. ("The worst part of my youth was that I spent so much time with grown-ups. I had no friends.")
> (Smith, 1991, p.168-169)

In conclusion, all children and adult women who are LD do not suffer from social skills deficits, although the quality of their relationships may be affected by their learning disabilities for four major reasons. First, each individual possesses their own cognitive style and rate of processing information and language. The behavior and the nature of women who are LD, and their culture as a subgroup, are affected by the myriad of cognitive styles and abilities within the social microcosm of the group. Secondly, the severity of the learning disability will help to determine the quality of interpersonal relationships experienced by women who are LD, both one-to-one and in the group setting. The third factor is the consideration of sex: "female children who are LD are more likely to suffer social adjustment problems than males" (Bruck, 1985, from Kavanagh & Truss, 1988, p. 299). This occurs because "in all cultures, the experience and developmental contexts of women are different from those of their male peers. As such, all women, despite their racial/ethnic or social class background have their phenomenological experience dramatically molded by the variable of gender" (Espin & Gawelek, 1992). And

lastly, hyperactivity plays an important role in determining the quality of relationships experienced both in and out of the classroom and group environment.

The social domain of the behavior and culture of women who are LD is composed of not only social skills and social competence, but also the cognitive and neurobiological factors that are part of each individual's profile. The uniqueness of each LD woman's skills and competencies comprise the attributes which are common to their collective and unique culture.

THE EMOTIONAL DOMAIN

Emotions affect nearly every human task. They affect relationships, the effectiveness with which they are perceived, and how they are maintained. Emotions drive the ability to learn and function. The nature of emotions experienced by learning disabled women ranges from fearful, to intense anger, depression and shame. As a result, self-esteem is damaged, and learned helplessness may nest itself in the lives of these women in a most insidious way. The intent of discussing the emotional aspect of this paper is to outline the importance of the feeling of shame, and the state of being, depression, caused by a plethora of negative feelings and events in the lives of women who are LD. Shame and depression precipitate behaviors, or attributes, which are common themes in the culture of women who are LD.

> When a condition has been kept a secret,
> then shame is attached to the condition,
> and one can be overpowered by shame,
> which engenders guilt,
> which produces even more dissatisfaction
> which produces even more dissatisfaction
> with oneself. (Smith, 1991, p.20)

For most of their lives these women have put great energy into hiding the secret of their disabilities. They have felt ashamed that they have not been able to articulate,

problem-solve, and progress academically at the same rate as many of their peers or family members. Michael Lewis defines shame as "the feeling we have when we evaluate our actions, feelings, or behavior, and conclude that we have done wrong. It encompasses the *whole of ourselves;* it generates a wish to hide, to disappear, or even to die" (1992, p.2). To be able to discuss this issue in a group of women who share the same academic experiences, difficulties and feelings of shame, is an emotional release, but one which necessitates a great deal of support and reassurance in the healing process.

"The child with learning disabilities feels isolated from the parents' culture and learns to hide her 'shameful secret.' And, of course, as the child carries this secret into adulthood and begins to face adult responsibilities, the burden of it grows and grows" (Smith, 1991, p.20). Secrets precipitate shame, guilt, anger, and depression. Although these are emotions which naturally present themselves in varying forms during a lifetime, they impede learning and functioning when they persist in a disproportionate way. The emotional aspect of LD women's behavior and culture manifests itself in daily life, affecting academic performance, interpersonal relationships, and self-esteem.

Dorothy Ungerleider, a leader in the Association of Educational Therapy, talks often about the "third ear" of an educational therapist. It's necessary to always be listening to what is being said, and to listen even more carefully to what is not being said in order to uncover deeper truths which lurk behind the behaviors of learning disabled clients. Often women who are LD will wear a mask which conveys to her outward world that she is doing "just fine." Within her inward world she may be continuously re-experiencing feelings of fear of failure and shame because her personal and/or academic life are being threatened by either something very real, or something imagined (Field, Kaufman & Saltzman, 1993). Depression may be the enemy lurking around every corner, trying to evade the "third ear" of the educational therapist or any significant person in the LD woman's life. Depression is a common theme within the culture of women who are LD and one which is not always easy to identify.

> Although an association between learning disabilities and depression has been demonstrated, the nature of the relationship has not been established. A bi-directionality can be assumed, though, with the evidence that a depression may induce or exacerbate learning difficulties, while a learning disability is likely to put a child at risk for depression. (Osman, 1993, p. 92, cited by Field et al, 1993)

According to Aaron Beck (1976) there is a cognitive triad which constitutes depression: 1.) negative conception of self, 2.) negative conception or interpretation of events, and 3.) despair and general hopelessness about the future. LD women often feel negative about self, events in which they are involved and feel responsible for (e.g., daily activities on both personal and intellectual levels), and about how they see themselves in terms of their success in the future.

Lying awake, calculating the future,
Trying to unweave, unwind, unravel
And piece together the past and the future,
Between midnight and dawn, when the past is
all deception,
The future futureless . . . . - T.S. Eliot

Beck states that the theme of loss is dominant in depression. A number of years ago when I first began to read Beck I was not sure what that meant in terms of the learning disabled population. However, now I understand that in the particular case of LD women, the cognitive aspect of depression which involves negative thinking about self is a primary issue. These women have been assaulted with a series of events which pummel their self concepts. They see themselves as having experienced a loss of a self which others may possess and be entitled to through birth and/or opportunity. They have lost not only a piece

of their integrity as a result of numerous personal and academic humiliations, but have lost a part of their intellectual selves of which peers or family members may be fortunate enough to possess. The universe feels unjust. The incremental accumulation of shameful events takes a toll, often manifesting itself in depression which may be very externalized and thereby recognized by caregivers, or it may lay quietly, existing in secret, a natural state for its host and a challenging foe for any educational therapist.

It has been only recently that a connection is being made between learning disabilities and depression. When a state of depression exists in childhood as a result of learning disabilities, think how magnified this becomes when layers upon layers grow from one developmental period to another, into adulthood, into the time when educators and other professionals hope that an adult has learned to accept, cope, adapt, and compensate for her difficulties in learning and functioning. The emotional impact is great. The incidents of psychological trauma have been added to and revisited numerous times so that what exists in adulthood is full-blown depression, self-sabotaging behavior, and a battered self-esteem. Not all adults survive the LD history well. Those who do are usually ready to hold out a life-line for those who find it a struggle to achieve an inner peace with themselves as a direct result of their learning and functioning challenges. These behaviors are also part of the unique structure of LD women's culture.

According to Osman (Field et al, 1993, p.92-93) the following LD characteristics may be connected to depression in children (which ultimately lead to characteristics found in adults):

> 1. Low self-esteem and feelings of worthlessness, well documented in the LD population, have been found to contribute significantly to depression, as well as being a concomitant symptom of the disorder (Kovacs and Beck, 1977; Stevenson, 1984). Others in the field (Cohen, 1986) have hypothesized that it is the loss of self, the disparity between what one is and the sense of what one ought to be, that results in low grade, chronic depression. Failure to perform in school, as

expected, represents such a loss.

2. The anger and rage many youngsters feel in response to their learning problems may also result in depression if the anger is turned inward.
3. Poor peer relationships and the social isolation experienced by many young people with learning disabilities have also been associated with depressive disorders. When children have difficulty learning in the classroom and the playground, it is hard to feel happy.
4. Seligman (1975) claimed that reactive depression is the consequence of exposure to events outside of one's control. Many learning disabled children suffer from "learned helplessness," resulting from repeated academic failure and the perception that they have no control over what occurs in their lives. Some do assume responsibility - but only for their failures, while attributing their successes to luck.
5. Rourke (1989), Brumbeck (1982), and others have speculated that hemispheric differences (i.e., subtypes of learning disabilities) may also predispose some children and adolescents to depression. Rourke, Young, and Leenars (1989) found youngsters with nonverbal learning disabilities to be more at risk than others for depression and even suicide.

In agreement with Osman, I have found that women who are LD who have a significant discrepancy (sometimes abnormal; greater than 30 pt. discrepancy) on the WAIS-R between the verbal and performance modes of intelligence, the verbal being the higher of the two modes, more often than not experience social deficits and seem to be prone to more periods of depression, if not a steady kind of low-grade depression. Within the performance mode there are subtests which help to further indicate difficulties in social skills and depression which I investigate in my research project.

The emotional domain of the behavior and culture of women who are LD is the intangible variable present within this study. Even though issues of shame and depression cannot be seen or touched in any concrete way, the emotional factors which influence the learning and functioning of women who are LD are the driving forces behind each tiny achievement or any monumental leaps of intellectual growth. Without an adequate sense of

self in the present or projected into the future, not much learning or positive functioning will take place. Now that education and psychiatry have come this far, it's time to develop a model which addresses the connection between emotions and learning, emotions and learning disabilities, and all the variables which relate to each personal profile of an LD woman, and to her collective culture.

The Silent Journey:
the role of unconscious emotions and states

Throughout my study I have been amazed at how much attention is paid in research literature to the subject of anger. Although the women in the sample of my study are certainly angry, and justly so, I have found myself devoting a great deal of time to looking at not only why they're angry, but trying to identify the unconscious emotions which eventually led to, and co-exist with their anger. Additionally, I have come across an enormous amount of information on depression in women, and again, the population of women with whom I have worked have gone to battle time and time again with depression, a life-altering state of being.

Listening to the women's stories, I have repeatedly heard phrases and exclamations about being "*so embarassed I wanted to die!*", and feeling "*so ashamed because I couldn't read the directions*". It was from that point in their lives that the anger began to fester like a growing cancer, and that the repeated humiliations, sometimes on a daily basis in the classroom, precipitated depression. Eventually many of these women experienced so much anger and frequent bouts of depression that they withdrew from the life of the classroom, and often from life itself. Silence prevailed.

The realization of their common cycles with anger and depression led me to search deeper for information on shame and humiliation, as these unconscious emotions stood out as the foundations, or the impetus for other states of being. The hunt for understandable information on unconscious emotions was much more challenging than a search for

literature on anger and depression. As one colleague said to me, " depression is just anger turned inward!" Unfortunately, I heard that phrase several times throughout my research and began to feel my own anger swell at the simplicity with which such complex feelings and states of being have been identified.

The silence which seemed to permeate the lives of the women in this study manifested itself in a variety of ways, each way uniquely influenced by the presence of shame and humiliation. More often than not, the silence took the form of secret-keeping. So rather than begin with the scarlet heat of rage, and the grey thickness of depression, I chose to concentrate on discussing the unconscious emotions which are so aptly described by the women. These are the emotions which seem to determine whether or not an individual will eventually become depressed, will experience out-of-control anger, will just "give up" or will retreat into the safety of silence. These are the emotions which accompany the silent journey.

Humiliation:
"I'm so embarassed I could die . . ."

True to my referential style I immediately sought an favorite edition of Merriam-Wesbster (1960) for a definition of the verb, humiliate. It was described as "to reduce to a lower position in one's own eyes, or in the eyes of others; humble, mortify; abase." It fit. I had observed it in others, I had heard it inferred in the voices of others, I had heard the word used as describing a feeling, and I had felt it myself, just as most human beings have.

Some theorists have included humiliation under the umbrella of shame; others have sought to theoretically restructure the unconscious emotions so that humiliation and shame could be investigated and identified separately (Lewis, 1971, from Lindsay-Hartz, Rivera, & Mascolo, 1995). For many, shame and humiliation are but one. However, my research demonstrated that humiliation often preceded shame, sometimes with only split seconds between the two emotions, other times experiencing humiliation repeatedly before actual shame became an identifiable emotion or condition of the soul.

". . . . parents who use humiliation as a socializing technique are likely to induce shame in their children either directly, through certain classes of behavior, or indirectly, by provoking certain attributions in their children" (Lewis, 1992, p.139). Another individual needs to be present in order to complete the act of humiliation; a perpetrator inflicts the pain. When looking at classroom trauma, the perpetrator may be identified as the school system itself, the teacher or professor, or often the perpetrators are peers who may inflict abuse alone or with a group. Claire, an adovocate for other adults with learning disabilities, said that "*it's just embarassing to be different as a kid in school!*" When she reflected on one of her experiences as an adult in the workplace, she said, "*I can remember one time I was so embarassed. I collected all of the papers I had been working on in the office and stuck them in my bag because I didn't want anyone to see how many mistakes I had made.*" Ellen who was educated in Europe, spoke of her present struggle with returning to school. "*I say to people, oh, I'm just taking a class. I hate to answer any questions about the class because in the end I don't want them to say, well, what happened. And then I feel embarassed when I have to tell them that I failed.*"

The women I interviewed frequently reported incidents of ridicule which caused humiliation, leading to feelings of shame. Louise remembered her classroom trauma, and said, "*My trauma was sitting there and being ridiculed... publicly ridiculed by a teacher. I remember in high school he would go around the room and you would have to give answers from the homework. And I was totally . . . humiliated.*"

Darleen spoke of being laughed at when she was made to stand up and read in front of the class. "*I used to get laughed at because I didn't know half of the words. And then your spelling tests would get passed back; the first person in that row passed the tests back. And I would always get the D. They would always make fun of me.*" Humiliations of this nature, layered over extended periods of time eventually develop into shame. Then silence may become the chief compensator, the most effective coping and adapting technique both in and out of the classroom and workplace.

Shame:
the pain of feeling "less than . . ."

> Imagine what it is like to grow up in a world of constant criticism, reprimand, negative feedback, and punishment. What does that do to a person's sense of self-worth? Unable to please the people who matter most to them, people who grew up under these circumstances develop an all-pervasive feeling of not being OK, a feeling expressed by many adults with learning disabilities. This sense of inadequacy is nailed down by subsequent defeats and failures. As one adult with learning disabilities said in a seminar, "I'm just a screw-up. I have always been one" (Smith, 1991, p.146).

Each and every woman I interviewed epitomized a different facet of my research; the facets, the rays of light which resulted from each question seemed infinite. It felt like the process of understanding would never end. The answers were paradoxical in nature. The common threads were clear, yet each response was as unique as an individual fingerprint, leaving me with more questions, more doubts about whether I had searched far enough, deep enough, long enough.

I remember listening to Stacey and sitting in awe of her courage, her tenacity. I asked her what she remembered about her early years in school. She said, "*I hated school - forever! I always remember hating it. I always remember being different and not having a lot of friends. I always remember being teased. I remember all the fights with my parents at night about homework. Every single night. And my father putting my desk in a certain place in the house so he could watch me do my homework; like he could make my homework* happen."

"*I remember I never wanted to go outside for recess. One of the games was they had painted a map of the United States on the playground and it had all the names - no it*

didn't have the names of the states - you had to go to the right state. They would yell 'Utah!', and you would have to go stand on the right state. And I didn't know where anything was on the map so every day I would go to the nurse. I would tell her that I couldn't go to recess because I was sick. I never wanted to go to recess because I didn't understand that game."

Like many other children, adolescents and adults with learning disabilities, Stacey had learned to artfully hide what she perceived as her shortcoming, her inability, her secret. Many of the women reported that they felt "ashamed" of themselves in situations similar to the one Stacey illustrated. When I asked why they experienced shame, they said it was because they felt "stupid", a word which made me wince each time I heard it used as a self-descriptor, a word which still makes me angry when I think of how many individuals have been made to feel that way.

"The child with learning disabilities feels isolated from the parents' culture and learns to hide her 'shameful secret.' And, of course, as the child carries this secret into adulthood and begins to face adult responsibilities, the burden of it grows and grows" (Smith, 1991, p.20). Secrets precipitate shame, and although this is an emotion which naturally presents itself in varying forms during a lifetime, it impedes learning and functioning when it persists in a disproportionate way. The emotional aspect of LD women's behavior and culture manifests itself in daily life, affecting academic performance, interpersonal relationships and self-esteem.

The issue of shame has received little attention in terms of cognitive analysis. Guilt is a feeling that has been widely discussed and written about. When a person is guilty, they are guilty about *something*; the feeling is externalized and projected to someone or something outside the self. When an individual feels shame, they feel badly about the self; the feeling is internalized, focused inward, making the self responsible for what is perceived by the self to be an unforgiveable feeling, thought or deed. Michael Lewis (1992) , one of the first theorists to analyze and theorize the issues of shame, states that

two categories exist within shame: 1.) events related to an *act* committed by the self, and 2.) events related to *thoughts* about the self. Shame is a self-conscious kind of phenomenon or feeling. If a person who commits wrongful acts, and does not have self-conscious feelings about themselves in relation to the act, then the behavior resembles some form of sociopathic state, a lack of remorse, or an emotional removal or connection to and from the act or the thoughts in relation to the event.

At the foundation of understanding shame is the idea of a multi-faceted self (Lewis, 1992). Awareness of the objective and subjective states of self has neurobiological as well as emotional roots, specifically in the amygdala, a tiny part of the brain located in the limbic system (see the *Neurobiological Aspect).* According to LeDoux (from Lewis, 1992, p.40), "the amygdala may be a focal structure in the affective network . . . " Shame may also be viewed in two separate models: global and specific. If this is considered in terms of developmental theory, very often younger women will tend to blame themselves, or feel ashamed, in a very global way (e.g., "I am a bad person." "I am less than . ."). Older adolescents or women may tend to be more specific (e.g., "Next time I won't say that." "I won't act that way the next time."). Women with learning disabilities, when faced with yet another classroom humiliation, or an event which is reminiscent of an original trauma, may regress to a previous stage of development where there is an established familiarity with coping and adapting. This is a recognizeable parallel to Piaget's developmental theory which indicates that when new information cannot be fit into the schema, then the individual will scan *backwards to another stage* of development that can accommodate the stimuli and facilitate coping and adapting. Women with learning disabilities will often be heard saying "I'm so stupid!" or "I can't do anything right!" because they have experienced another situation which throws them back to a previous stage of development where their shame is of a global nature, blaming the self as a whole for whatever event or feeling took place in relation to the situation. The blaming of self was apparent in the women I interviewed when they repeatedly referred to themselves as "stupid" or of "feeling stupid."

Bryanna, educated in two countries as a young child, said "*I thought I was stupid. So, when I was younger, I mostly stayed by myself and separate because I just didn't feel like I was able to fit in. Sometimes if someone was talking and I couldn't understand what they were saying I was ashamed to have them repeat the question or whatever they would say out of fear that they would think that I was stupid.*" The shame experienced by the women in my doctoral study finds its roots in their feelings of difference and of their perceptions of being intellectually "less than." The women's accounts of "The Reading Circle" were the clearest examples of their feelings of shame and humiliation as a result of their interviewing and testing.

SILENCE:
Keeping the Secret

When a child with LD has been treated insensitively, has been ridiculed both in and out of the classroom environment, and has not been able to effectively communicate and compete with her peers, then she may be driven to silence. As an adult, the silence has become a protective wall, an insulator, against further attack. The silence becomes so thick that it is difficult to permeate it with mere coaxing and encouragement. It has been my experience that depression may keep an even pace with the degree of silence present. Often they appear to be one in the same; they have merged in some insidious way to mask the underlying feelings which are responsible for the chasm of silent despair they convey to the outside world.

A different and very optimistic perspective on depression is offered by Thomas Moore: "Melancholy gives the soul an opportunity to express a side of its nature that is as valid as any other, but is hidden out of our distaste for its darkness and bitterness" (Moore, 1992, p.138). This puts depression, as a state of being, into a more positive context; the

feelings which accompany depression are also its attributes, and are important parts of our contextual selves, driving our choices to move from one place in our lives to another. It sounds as if Moore is asking that we just try to accept depression as part of who we are, stopping to recognize how we are coaxed into reflection as a result of experiencing it. Moore may also be more accepting of the silence of women who are LD, viewing it as a positive way to reflect, observe, protect and plan. But is this acceptable for who women are and strive to be? Is this different for men? "We might also discover that depression has its own angel, a guiding spirit whose job it is to carry the soul away to its remote places where it finds unique insight and enjoys a special vision." (Moore, 1992, p.154)

Unfortunately, women with LD (and all learners) who have been diagnosed with specific cognitive/processing differences have been viewed as just that; "different." They have performed differently in many intellectual and daily tasks, are often perceived differently by their peers and family members, and most importantly, they feel different. They feel abnormal. Their silence has camouflaged the feelings of being "less than" or different. When the expression is smothered by silence then their vulnerabilities are better hidden, more protected.

> As noted by feminist scholars (Hare-Mustin & Maracek, 1988; Fine, 1989), because psychology is the discipline that studies individual differences in human nature, it does not know how to study human diversity except as "difference". And differences, even when created by societal power structures, are defined as inherently abnormal or innate (Espin & Gawelek, 1994, p.3).

For many, the revisitation to the place (the classroom) of severe stress and abuse triggers symptoms of post-traumatic stress disorder. This is where the integration of the emotional and neurobiological variables prevail. For many LD women the choice to remain silent throughout any post-traumatic stress incidents may be viewed as "smart", or it may have become a coping and adapting mechanism. The anger which manifests itself as a

> escape: If we deny it, we fossilize and learn to live without living. If we accept it, we become more fully human - and, in doing, learn to suffer, because we cannot love one another without suffering with one another the sins of the world that gladly would extinguish this need of ours, to be heard to speech. . . .There is in each of us a need to be heard to speech.
> This need is the root of all genuine healing and the source of all creative revolutionary movement. It is the wellspring of our redemption,
> and it is the hope of the world.
> -Carter Heyward, *A Shameless Sacred Passion*, 1992

Whether women who are LD are silent because they find it difficult to express themselves as a result of a language-processing deficit and/or because the psychological trauma which they have endured has suffocated their voices to a quiet death, there exists a void in their lives which silently screams to be heard and understood. They may speak within their culture of their experienced injustices and atrocities which occurred both in and out of the classroom environment, but their hushed secrets about shameful feelings of their fear of failure and intellectual inadequacy remain silent to the outsiders. There is no celebration. Only from within the culture (or those who profess to advocate it), when one of the members has achieved a success. No one else would understand. For whatever reason, silence permeates the lives of too many women, inhibiting their growth, their expression, their needs, their wisdom, their intelligence. "Fools!" said I, "You do not know, silence like a cancer grows." (Paul Simon) Unfortunately, silence, if left to permeate the lives of women, does grow and spread insidiously like a disease. It becomes more difficult as time passes to be heard or understood, or to gather the courage to attempt to cry out for acknowledgement. The secret becomes more burdensome, and more troublesome to heal.

The cognitve, neurobiological and social aspects of the silence of women who are learning disabled often work in an integrated manner. There are times when the cognitive and neurobiological variables of women with LD seem to be responsible for their lack of

voice, or silence. At another time, these variables fade into the background and make room for the social factors which are so directly connected to the ability to make oneself be heard and understood. And at yet a different time women's personal cultures, aside from their collective culture as women who are LD, command all the attention, the causality and sometimes the blame for their silence.

The Cognitive Aspect

A young woman interviewed in *Women's Ways of Knowing* (Belenky et al., 1986) could not complete a statement with language which indicated *an interior voice that could give herself mental directions and exhortations.* A tall order for a pregnant fifteen year old! Very possibly, her language skills, and possibly her abstract thinking skills, were developmentally not at a level where they could convey sophisticated concepts and insights of self. To look even further, her emotional and social experiences may have contributed to a temporary inability to respond in a way in which the interviewer perceived as being adequate. Additonally, her socio-cultural background was not acknowledged in this vignette. The cognitive component of this vignette, the girl's actual ability to "give herself mental directions and exhortations", was not addressed. This leads many readers to feel that some mysterious kind of phenomenon has taken place, and that an individual's ability to communicate or be heard is hampered by some unknown and supernatural kind of force. The loss of voice or silence is shrouded in mystery and not connected to any concrete anchor which would help the reader to understand what has happened to the fifteen year old girl.

Women are not always driven to silence, nor do they always just quietly resign themselves to it through metaphorical mysticism. It's a very ***real*** phenomenon and usually very explainable. Difficulty in learning is not mysterious, nor is silence as a result of psychological trauma or degradation. It can be explained. Like men, women are often silenced (in the metaphorical sense) because they experience a difference in language

processing. Their language development is impeded due to a neurological dysfunction. However, women are silenced (also in the metaphorical sense) more often than men as a result of psychological trauma, although a variety of causal factors may co-exist.

In response to "Experiencing Disconnection", why do the silent women who were interviewed in *Women's Ways of Knowing* not cultivate their capacities for representational thought? Are there reasons why they do not explore the power that words have for either expressing or developing thought? Not all women are able to engage in meaningful dialogue (as perceived by others) with others for a variety of reasons. "Authorities bellow but do not explain" (p.28). Tell me what representational thought is within the context of this vignette, so that I will understand why the silent women are not able to engage in this activity. Many silent women seem to be "stuck" in a level of development. "Thought is truly representational (symbolic); and behavior sequences can be played out in the head rather than only in real physical events" (Wadsworth, 1984, p.109). "Representational thought is carried out more rapidly than thought through movement because the former is not tied to direct experience" (Wadsworth, 1984, p.75). Some learners need to be *doing while thinking* in order for the concept to make sense. The inner language meaning must manifest itself physically as well as mentally in order to be understood by the experiencer. They may by preference or cognitive style be experiential learners; they may be individuals who must kinesthetically experience a concept in order to make connections in their learning. This process may be a personal, cultural norm and/or a personal style of thinking, learning, or functioning. It seems that representational thought more constricting in the sense that one is expected to think symbolically, and not simultaneously experience the idea through movement? Is the abstract thought and the language connected to that symbolic structure difficult for some learners? If there are such phenomena as learning differences and language deficits, then the answer is most definitely, yes.

> Educators trying to apply Piaget tend to ignore the fact that he made no claim to having presented any theory of learning, nor explanation of how the brain functions in terms of its physical structure or evolutionary history. He did drive home the tremendously important point that children always develop their understanding of the world gradually. We know that each student moves through the stages of development on a private schedule, and is not necessarily consistently in one stage, nor in the same stage in all matters simultaneously.
> (Hart, 1983, p.113)

If this is true of childhood development then it can certainly apply to women's language development. As adults, we are not all in the same stages of development for each and every task we must perform, or for each emotion with which we must contend and survive. Indeed, we "all do hear a different drummer"(Thoreau). We learn and function from that frame of reference in terms of our personal preferences, level of development, cultural contributions and neurobiological makeups.

> Speech is used in different ways among different groups of people. Each group has its own norms of linguistic behavior. For example, a particular group may not encourage talking for the sake of talking, and members of such a group may appear to be quite taciturn to outsiders who relish talk. . .
> (Wardhaugh, 1992, p.239)

If a silent woman's ability to articulate thought in oral speech or in written expression is impeded by any means, then the level of frustration and development of further ideas is impeded as well. Overt verbalization skills may be pushed further underground (Rudel & Holmes, 1984) as a result of stress. The richness of thought cannot be conveyed fully, unless a facilitator familiar with language processing is able to assist in

the painstaking procedure of translating thought to speech, and eventually to written expression, creating a literacy. In my experience teaching women with LD learning strategies/academic survival skills, it often becomes necessary to create very individual processes in order for each woman to first organize her thoughts in relation to the concept or task at hand, and then articulate this in spoken language while a facilitator/mentor records her thoughts in a cognitive map, outline, or list. Next, the student/client and her facilitator discuss the written organization, possibly reorganizing the language if it does not match the student's/client's intended thoughts and ideas. Lastly, the reorganization is transferred to written expression, completing the process of total literacy. In between these basic steps lie language-based concerns which must be consistenly addressed throughout the process, such as spelling, grammar, vocabulary and syntactical organization, to name a few. These are very concrete reasons why some women with LD are silent; they have difficulty being otherwise as a result of neurobiological deficits.

For other women who are LD, their silence is almost inflicted upon them as a necessity for survival. Some women experienced such humiliations as a result of poor teaching and insenstive treatment by peers, family members, educators and other professionals that they are driven to silence in order to protect themselves. Their cognitive style becomes role-based. They are functioning both in and out of the classroom environment in a survival mode. They are always thinking, always scanning, in order to problem-solve without running the risk of humiliation. As a result, their cognitive abilites may remain hidden, waiting for a time when it is safe to reveal their quality and style of thinking.

The Neurobiological Aspect

As with all the other variables which exist to impact the silence of women with LD, the neurobiological aspect may be identified in isolation or viewed as it integrates and manifests itself into every other aspect of women who are LD. Women's silence, or loss of

voice, may occur because individual trauma histories have inflicted a paralyzing fear into some women's abilities to communicate their thoughts, feelings, and intellectual reasoning. Because some women have become aware of their physical, social, emotional, and cultural consequences, the risk in expressing themselves is not worth the effort. Learned helplessness is preferable for human survival. Lack of self-esteem may be a small price to pay. Silence may be bliss.

Some women are not able to express themselves in spoken or written language because they have not acquired the skills or confidence to express themselves in words. They may have been culturally deprived in terms of not being appropriately and deservedly cared for within their family or school culture, or unable to continue or complete their schooling for socio-economic and/or cultural reasons. The best way to acquire and feel comfortable with language, is to hear it, use it, and reuse it. Children watch language being used. They not only listen to the words but observe the behaviors and relationships that co-exist with the language. They learn language and practice it in a social context (Edelsky, Altwerger & Flores, 1991). Children do not learn language for the sake of being able to use the words properly. They learn it because they need to communicate within the social microcosms of their families and peers. They need to convey their feelings and their needs to be acknowledged as a contributing member of the family or community. For some, the transition from inner speech (Vygotsky, 1986) to spoken expression becomes difficult, specifically if learning disabilities are present. If negative variables interrupt these processes, then children's, and eventually, women's language development, will become impeded. Silence will prevail.

> Many children, otherwise normal or close to normal, demonstrate selective difficulties in the learning of language. Sometimes the difficulty seems to inhere chiefly in auditory discrimination: because these children experience difficulty in decoding a rapid string of phonemes, they not only have problems

> in comprehension but may also articulate improperly.
> (Gardner, 1985, p.84)

It is important within the context of the neurobiological perspective, to consider the implications of cross-cultural studies and their relationship to language development and women's silence. What has been termed internationally as hyperactivity (in the U.S. and U.K.) emerges as a major difference in defining populations of students as having ADD (Attention Deficit Disorder). U.S. numbers are much higher, whereas U.K. students may be referred to as "conduct disordered". U.S. school systems have historically overrepresented black children and other groups who use nonstandard English in special education. A study by Farnham-Diggory (1978) indicated that black children preferred a visually-based strategy in language-learning, whereas white students preferred phonetically-based methodology (Kavanaugh & Truss, 1988, p.125). Although simplistic in its presentation, and the predecessor to more thorough research, the study offers an enticement to look deeper into cultural norms of specific groups as well as into individual and collective learning profiles on the WISC-III, WAIS-R and other supportive neurological testing. Do specific cultural groups demonstrate significantly higher scores on the Performance modes of intelligence? What are the further implications? What does the neurobiological aspect indicate in terms of appropriate teaching methodology?

In order to further address the idea of women's voice and silence, I refer to Belenky, Clinchy, Goldberger and Tarule (1986). In chapter I, "Silence", in *Women's Ways of Knowing*, a short excerpt from a woman's life is offered. This woman evolved into an articulate advocate for others' journeys to metacognitive awareness. In earlier schooling, this person found speech difficult to understand; auditory comprehension was a struggle. She reported feeling "dumb" when she had to speak with others, trying to make herself understood. Receptive and expressive language were challenging to the point where her self-esteem became damaged, diminishing her ability and motivation to push

forward, eventually creating a learned helplessness. This individual, like others interviewed in this book, was referred to as a *silent* woman. Her silence is explainable as being the effect of very unpleasant personal and academic experiences, driving her into a fear of expression, possibly a disability in language. More than likely her abilities in auditory processing and internal organization were neurologically or genetically impaired, creating a greater challenge in language reception and expression than was caused by more subtle or insidious forms of silence-rendering. Silence is the effect of not only women's oppression, lack of voice (in the metaphorical sense), but can also be attributed to neurobiologically-based difficulties which place insurmountable obstacles in the way of women's comprehension, expression and knowing. These difficulties may exist in isolation or co-exist with trauma histories and cultural expections or restrictions, rendering a woman helpless and voiceless, metaphorically and neurologically.

In "Deaf and Dumb", a section in the same book, two themes paradoxically exist, contradicting each concept presented. One is the idea that the silent women felt powerless, that "words were used to separate and diminish people." Their quotes convey feelings of low self-esteem and dysfunctional behaviors, strongly indicating psychological trauma histories. In the same chapter the following was expressed:

> They felt "deaf" because they assumed they could not learn from the words of others, "dumb" because they felt so voiceless. As one person said, "Someone has to show me - not tell me - or I can't get it."

This indicates a reason for silence very different from the causal factors of trauma histories, not that the two conditions or histories do not often co-exist. "Someone has to show me - not tell me", speaks of learning process, ways of knowing that require different methodology, different intellectual compensatory skills, because there is a fundamental difference in the way information is entering the organism and becoming accommodated.

What is not addressed here, and what is important in the recognition of women's psychological and academic survival in language development, is the fact that women who experience(d) learning difficulties have been driven into the background, driven into silence, both literally and in the metaphorical sense, by the shame they have borne because they have felt "dumb". Women are silenced not only because of these variables which exist within their cognitive development, but also because these variables all exist within the context of women's socio-cultural struggles at home, in the work place and on the educational front.

It is necessary to be inclusive of the psychological, neurobiological, and socio-cultural perspectives of the functioning of women who are LD in order to understand their silence. Even though one component may outweigh another, one does not exist without the other. Women's intellects do not exist purely in the metaphorical sense, and in an emotional and psychological context, but exist biologically, neurologically and culturally as well. The integration of these components determines the way all human beings learn and develop language, and whether or not women experience a loss of voice, or feel silenced.

The Social Aspect

The cognitive, neurobiological and social aspects are in a constant flux, moving in and out of each other's arenas, one often shifting to the forefront while the other variables become the supporting aspects, and sometimes the secondary or tertiary factors in behavior and contributors to the silence of women who are LD. The social contribution to LD the silence of women who are LD may be viewed in terms of interpersonal relationships, communication skills, or in this case, the ability to successfully read and sense another person's speech and expression. This cycle includes the internal processing of what is read

and sensed, and the response that each person puts forth. It becomes a cycle which is driven by a reciprocity in understanding, interpreting and appropriate behavior. The examples I will use are based on experiences from a group of women with LD whom I have facilitated, and on classroom experiences as reported by various women who are LD.

Hypothetically speaking, within a group of 5 women who are LD there may be 3 women who experience varying degrees of difficulty with expressive language. Two of these women may demonstrate a significant discrepancy on the WAIS-R between the Verbal and Performance modes of intelligence, the Verbal subtests being lower with intra-test scatter as well. These 2 women have difficulty generating language, possibly retrieving the kind of language they are internally seeking in order to express themselves in a way which they perceive as adequate. They cannot "jump in" to conversations which are group-oriented in order to participate in a lively kind of banter. They may fall into the background, become silent, responding only when a peer has coaxed them into participation. Their silence exists in this manner in a group and often in the classroom situation, but can often be ameliorated with peers and a facilitator who is senstive to the need and willing to monitor the monopolizers in the group or classroom.

The third woman who has difficulty with expressive language may not necessarily demonstrate a similar significant discrepancy between the Verbal and Performance modes of intelligence on the WAIS-R. She may have a profile in which the Performance scores are significantly lower and exhibit intra-test scatter as well; her Verbal subtests may be within the average range (or higher) without much scatter. I have noticed that this profile is not unusual for women who also have significant psychological trauma histories, beyond that which they have experienced in the classroom environment. It has been my experience that these women are silent in a group or in the classroom because they have *learned* that they do not always respond appropriately to the nuances in other people's expressive language; they cannot successfully read and interpret others' verbal and nonverbal language. Therefore their responses, when they are made, are usually

inappropriate, appear tactless, and often sound to others as if they are irrelevant to the question or issue at hand. Some women will continue through life responding in this manner because they are not able to read others' disapproval of them. But this particular woman I am describing is able to recognize that she doesn't "get a joke", is not able to respond as expected by others, and is often accused of being rude or tactless in a group conversation. Her silence is a deliberate choice; she stays out of trouble with her silence, and may be able to maintain a few one-to-one relationships where she can better concentrate on people's communication cues.

The 2 remaining women with LD in the group of 5 may not exhibit any significant discrepancy between the Verbal and Performance modes of intelligence, although there may be intra-test scatter in both modes. This may indicate difficulty with internal organizational skills which may manifest themselves not only in academic endeavors, but in daily functioning as well. Often, this profile indicates significant trauma history similar to the profile where lower scores are exhibited in the Performance mode of the WAIS-R. These 2 women may be silent, in the literal sense, or generate a great deal of language which doesn't offer valuable information to the receiver.

Socialization in the classroom poses great threat to some children and adults who are LD. They are expected to 1.) effectively communicate and participate in classroom activities alone, and/or with a group 2.) be able to read and sense the teacher's verbal and nonverbal expression, 3.) be able to read and sense peers' verbal and nonverbal expressions. Younger students may not be cognizant of the underlying reasons for the feelings they experience about interpersonal communications and relationships. They may have instinctively developed their own repertoire of strategies ranging from camouflaging themselves so that they are not singled out for classroom interactions, to a willingness to take a failing grade instead of presenting material to the class in a manner which is understandable to others. Older LD students' survival strategies have evolved into some

very difficult-to-detect compensations which all contribute to their silence in and out of the classroom enviroment.

The quality of expression and the ability to generate language itself become obstacles for most women with LD. This specific deficit impedes their ability to become effective self-advocates, and to make their feelings and academic difficulties understood by others. If this area of concern is coupled with social deficits, or a defective system in reading people and situations, then relationships on virtually every level may become troublesome, both individually and in group situations.

> For many adult with learning disabilities, their social skills are their strong suit. In fact, many develop strong social skills precisely because they are learning disabled, as a way of compensating for (and sometimes saving themselves from) failure in school or on the job. They learn how to make good friends and develop active social lives.
> However, other people with learning disabilities falter socially. Their timing is off. They put their feet into their mouths. They produce one malapropism or faux pas after another. They say whatever comes to mind, without any screening whatsoever. They embarass and bewilder their families and friends as well as themselves.
> (Smith, 1991, p.167)

With the presence of an expressive language disorder silence may permeate the lives of women with LD. With the presence of a variety of possible learning profiles coupled with a significant trauma history, women who are LD may be driven to silence. And lastly, when threat and humiliation have taken place in the lives of these women as a direct result of their learning disabilities, then silence is a welcome and safe retreat.

There are many women, feminist and non-, who do not "fit" the descriptors provided by women's developmental/psychological theory. And if their profiles do appear

to "fit" it may not be because that is who they really are, but rather who they have become out of necessity in order to survive. This is an effective and insidious means of silencing. Gregorc (1986) writes of "mind styles": people function in a natural-based style and/or in a role-based style. Many women shift smoothly (and not-so-smoothly) from one to the other in order to cope, to survive, to succeed, to achieve. Only after we peel away all of the behaviors and attributes that are not "real", can we describe and identify who women are collectively, individually, what their natural-based styles are, and how and why they may have been silenced.

Women who experience learning difficulties (learning disabilities) are a culture in and of themselves. Their expressive language may be troublesome; it may be a struggle to generate language in order to effectively communicate in a way that they individually perceive as being adequate. Their silences collectively, and individually as well, may be deep. Paradoxically, their silence is a protection, a safe place to hide the shame they have been carrying for so long. Often, they will seek affirmation for what they may see as a choice to remain silent, as speaking out presents the risk of personal humiliation. They may need to be told that it *is* acceptable to be quiet, to not respond, to not speak so that others may not have the opportunity to ridicule, criticize. Like the Apache culture of silence, many women who are LD feel an intrinsic need to be silent so that they may not worsen their current situation or dilemma. They may need to be guided through a familiarization process of their emotional selves, so that they may be able to speak out some day, without the threat or fear of humiliation.

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The Silent Journey begins early in life, sometimes at home when fear or humiliation can render an individual silent. In school silence may be an effective coping and adpating mechanism in order to be less noticed, less vulnerable to being singled out, made an example of, less available for exposure. For some, the silence becomes a permanent kind

of existence, a safe place to live in, work from, retreat to. For others, the silence has built up over extended amounts of time to create a frustration and fury that are unmatched by other emotions. A virtual explosion and/or implosion may occur, sometimes in childhood when school systems have defined children as "difficult", "uncooperative", "aggressive", "out-of-control", or "inappropriate for the regular classroom." This spewing forth of fury may wait until adulthood when the silence has mounted to deafening tone, beating down the doors of tranquility and stability. Silence is only quiet to the onlookers.

The beginning of the silent journey includes layers of humiliation, leading to shame. Shame precipitates secret-keeping, a burden so heavy it becomes spine-bending, although women have learned to carry themselves tall so that the outsiders cannot guess what the secret, the burden really is. At this point silence may become a comfortable nesting-place, an insulated place from which to function on a daily basis. However, for some women the silence leads to eventual disclosure of pent-up unconsious emotions, lashing out at families, school systems and all others who have misunderstood, misdiagnosed and disregarded their struggles with learning and functioning. For some, this is where the silent journey ends.

The Impact of Psychological Trauma on Learning and Functioning in Women with Learning Disabilities

Women with LD have carried the extra burden of competing for jobs and opportunities with not only men, but also with women who have demonstrated greater expertise in specific kinds of skills which may be deemed necessary for certain jobs or careers. Women with LD share the same kinds of self-esteem struggles as their non-LD sisters, but their issues with poor self-esteem, self-motivation, confidence, anger, shame and depression are compounded by the presence of a learning disability. Their load is heavier, their struggle is greater, and their emotional selves have endured more bruising both in and out of the classroom environment.

By the very fact that some women are learning disabled, I make the assumption that they have also experienced psychological trauma. This is an assumption I have made because I have observed and listened deeply to the women, and to their educational and trauma histories. It's stressful and often traumatic to feel unequal to peers whether it's in a classroom setting being called upon to read out loud or in a restaurant ordering dinner. The feeling is always there, like some kind of unwelcome ghost who appears at the most inopportune moments. Some women who are LD may wonder , "Can anyone else see it, or am I the only one who knows it's here?" Most women with LD recall childhood experiences in the classroom where they learned creative coping and adaptive skills in order to survive the kinds of humiliation to which they were subjected. For some, this occurred daily. Yet others were spared some of this maltreatment because they were fortunate enough to have been mentored by caring and able professionals. Psychological trauma and the mere existence of a learning disability impacts learning and functioning. Learning takes place in school, at home, on the job, and in social situations. Each task performed is a function which requires learned skills ranging from rote memory to conceptual intuition.

One person's stressful situation may be someone else's traumatic event. According to Flannery (1993), no matter how hard an individual may try it is impossible to respond to certain traumatic events in an effective way; when viewed in this perspective it becomes clear that psychological trauma, like learning disabilities, knows no boundaries of discrimination. A traumatized person is rendered helpless whether he or she actually experiences the event, or has witnessed it as an "on-looker." When women who are LD speak of classroom trauma, they often report that they felt "helpless" or "powerless" when they were called upon to perform a task which they knew would expose their secret. In addition, they felt the same kind of helplessness and distress when they witnessed one of their peers suffering through a similar situation in the classroom. Their empathy was deep rooted; their trauma imprints were like bruises that never healed. Every time an event occurred which was reminiscent of the original traumatic episode, whether it happened to them or whether they were witness to another person's ordeal, then the same kinds of feelings emerged. The bruise was touched and they would again wince with the familiar pain.

Stressful situations are not synonymous with traumatic exposure, although everyone's tolerance and perception of what it is that is experienced as traumatic is different. Stress may be defined in terms of stimulus-based reactions or neurological responses. Each individual is affected differently by stressful situations; no one's experience can be minimized, invalidated. If viewed on a continuum, the stress phenomenon may acknowledge an external event which interferes with learning and functioning; on the opposite end of the continuum is an external event which leaves the victim rendered helpless. It is important to distinguish between those events which cause distress or unhappiness and those events which stand as traumatic landmarks, impeding development, learning, and causing changes in affective responses and emotional well being.

When considering the relationship between women who are LD and psychological trauma, it is important to consider the impact that post traumatic stress disorder (PTSD, as a result of psychological traumatic exposure) has upon women's silence. Have you ever felt frozen or "speechless"? Our urges and needs for fight or flight originate in the brain and are theorized and researched by people such as Leslie Hart (1983), Robert Ornstein (1984) and others. Since that time, but with the inclusion of these theories, comes the recognition of PTSD which when viewed simplistically is the aftermath of a psychological traumatic exposure (Flannery, 1993). However, nothing in the world of trauma is simplistic, especially when considering psychological and/or physiological symptomotology and the survival of a human heart and soul.

Many women who suffer from the aftermath of psychological trauma keep re-enacting the event, re-stimulating the brain in order to repeat the endorphin release. Freud may have referred to this phenomenon as a "fixation" on the trauma. "The severe life stress of psychological trauma can clearly alter our normal psychological processes for coping in very fundamental ways" (Flannery, 1993, p.25). Is it any wonder, considering how the mind and body copes and adapts in seemingly unconscious ways in order to survive life's unpredictable traumatic twists and turns, that learning and functioning are impeded? Indeed not, and it is also no surprise that women with LD have been repeatedly rendered "speechless", or silent as a result of specific types of trauma within the initial recovery stages, and in the years that follow which may bring reminiscent feelings of original traumatic exposures.

Women with LD encounter a special kind of struggle in order to survive the abuse which has been dealt them both in and out of the classroom environment. Their coping and adaptive skills are finely tuned; their mental scanning for potentially dangerous and threatening situations is acute. When these experiences have been compounded by the existence of other types of psychological trauma such as physical or sexual abuse, then their hypervigilance is always at a peak. There is no rest. When a child or adult must invest that much energy into surviving from day to day, always on guard for trouble, then it becomes not only physically and emotionally wearing, but it often becomes too taxing to concentrate in the classroom. Gaps in learning occur. Short term memory suffers. Learning becomes a tumultuous storm which is exacerbated by cognitive deficits and consistent downshifting in the brain (Hart, 1983).

Classroom Trauma as a Psychological Trauma

Recognizing classroom trauma as a psychological trauma is part of the statement of the problem. It is so because the experiences within educational systems and within the social microcosm of the classroom have created situations which demand acknowledgement and attention, and demand re-evaluation and problem-solving. Classroom trauma is the reason why I have embarked on this research. The most effective way to describe this component of the statement of the problem is to refer to prior descriptions of psycholgocial trauma and to listen to the stories which the women tell. It is through the qualitative method of informing others that the women are able to explain what classroom trauma is, and why it deserves attention.

An extremely stressful or traumatic event can literally knock someone off their feet. For a period of time an individual may experience a variety of physiological symptoms in response to these events ranging from dizziness, headaches and upset stomachs to panic attacks, memory loss and other symptoms common to PTSD. Psychological trauma may occur as a result of witnessing a violent death, experiencing rape or assault, or from

enduring repeated human degradations and humiliations. These events may occur in isolation or for some people they may have occurred repetitively throughout childhood and/or adolescence. One person's stress may be another person's trauma. We are not all created equal when it comes to how we are internally equipped to cope and adapt to intrusive kinds of stimuli.

> A psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning" (Herman, 1992, p.33).

Because I have listened to and observed so many women with LD over the past twelve years, I have identified the severe and repeated classroom abuses which have been endured by this population as classroom traumas, a distinct type of psychological trauma. A classroom trauma is a significantly unpleasant (or horrific) external event or stressor which occurs within the confines of an educational environment (e.g., a traditional or nontraditional classroom, a small group or a one-to-one tutorial). This type of trauma, which is a psychological trauma, may leave the student with diminished self-esteem and in a state of fear, humiliation or learned helplessness to the degree where similar situation(s) will be avoided by the student in the future. The specific and original cause may be a person (such as a teacher, facilitator or peer(s)), although with each repetition, a perpetrator is not necessary to induce fear or humiliation. A situation which is just reminiscent of the original classroom trauma is sufficient to resurrect feelings of fear or humilaition which may impede learning and functioning. This type of trauma may occur repetitively, especially in students with learning disabilities.

The following dialogue describes the ways in which women with LD define psychological trauma, and ultimately classroom trauma. I began this particular segment of the questioning by asking each woman how she would define psychological trauma; the conversation in each case led into further conversations about how this plays out in the classroom and various other learning situations.

Bryanna said that psychological trauma is something that "would cause somebody harm or damage." She immediately moved into a dialogue about her learning disability.

"It was traumatic for me to go to the classes and be read to like I was five years old. I always needed someone to hold my hand, so to speak. I never felt good enough to go to college. I thought that I was stupid. If someone was talking, and I couldn't understand what they were saying, I was ashamed to have them repeat it for me for fear they would think I was stupid."

"Classroom trauma. Well, I would think that the teacher maybe knew that you had a problem with something, but then they kept calling on you for the answer. And you couldn't give them an answer. That was traumatic because your friends knew. People talk. You know, each time the teacher calls on you and you don't have the right answer then they are going to think that you are stupid too. And that can really hurt."

Bryanna never spoke of herself in the first person, but in the second. During the interviewing sessions, the women tried at various points to distance themselves from the memories by a de-personalization, or dissociating themselves from the event. Her feelings of shame and self-worth were always in question which further necessitated her separation from the experience she was describing in order to make herself understood.

Jean and I had talked at great length about psychological trauma. She immediately went into a description of what she termed as an example of classroom trauma.

"In my jr. high school math class my teacher called on me. I had just been moved from special education classes to regular classes, and I was scared. I was paranoid. I said 'please don't call on me because I can hardly read' - like they didn't know! And then she called on me, and I just started shaking. The word was "number", N-U-M-B-E-R. I was so paranoid I couldn't sound it out. I said that I didn't know. It was easier to say that because it was just too much of a struggle. She said, 'Get up here! Get up here right now!', and she took my hand and made my hand form the letters on the board. She said 'Now do you know what that word is? What is it class? It's NUMBER!' "

"I was so embarassed I could have died. I thought she knew what she was doing because she was the teacher and she was older. I remember thinking to myself, that this is what it's like when you're picked on when you're a kid, and did she pick on me because of my color? Did she pick on me because I couldn't read? I was thinking of all of these reasons why somebody would pick on me when I had already told her that I couldn't read very well, and to please not call on me. I told her I would raise my hand if I could read the sentence. It was real clear that she violated me. She still went after me."

Together Darleen and I tried to define psychological trauma. It was difficult for her to articulate what she was feeling. Finally she said, "*Something that happened in your childhood - it stopped me from processing.*" She began by using the second person, and ended her statement by personalizing her experience in the first person. Classroom trauma was easier for her to describe.

"It's kids laughing at me. I used to get laughed at when I didn't know all the words. I would always get a D on my spelling tests, and the kids would laugh. The papers weren't passed out individually; they were passed back in the row."

"If I were asked questions I never raised my hand because I never knew the answer. And the teacher would pick on me, and I would just stand there. And the kids again, laughing at me. I remember it hurt, I cried."

Stacey and I talked about her experience with her French teacher in elementary school. *"I remember in French class the teacher would hold up a clock and she would move the hands and scream at me because I could not do the time. I couldn't tell her in French, but I couldn't have told her in English either. And it was horrible. I can remember her turning the thing and talking about me not trying. The numbers were all over the place."*

I asked her if she could define psychological trauma.

"Well, the first thing in my head is anything I didn't ask for or anticipate or want affecting me in a negative way. And to some degree it can be damaging. And anything that stops me and changes me from being able to go where I naturally would is damaging. Things that have made me not grow. Anything that would make me be different than who I am is wrong - if I didn't want it- I think."

She was very thoughtful about this question. Then I asked her to talk about classroom trauma. She was deep in thought again, and then shook her head, sadly.

"For me it was every experience that made me stand out from everyone else - in a negative way. Walking in the class and getting my desk dumped is like the most vivid memory. Sitting in the circle and waiting for my turn to read, whether my turn was going to come or not, was not a safe place. It was traumatic even if I wasn't being pointed out. That anticipation was not safe - ever! "

"And any teacher expecting that I could do something that I didn't have the ability to do was traumatic. Being locked out of the room weekly to this other room to write was continually traumatic. But, the other experience I remember is when the bell rang in the 4th or 5th grade to go home, the teacher telling me every day that I had to stay after. And then he would sit me in these big orange chairs in the hallway in front of the principal's office, and when all the kids would leave they would all walk by me, and he would be there yelling at me."

Maria sat before me, regarding me angrily after I asked her to define psycholgical trauma. She shrugged her shoulders. I then asked her if she could define classroom trauma. Her response was immediate.

"Classroom trauma is when a teacher who has no understanding of what a child is going through or what handicap, for lack of a better word, has, to put them in a corner with a dunce hat on their head. That is trauma. That is anger and rightfully so. For someone to say you are stupid in the classroom is trauma! For a teacher not to have any understanding as to where her students are coming from in that classroom is trauma. And a child gets frustrated when trying to get whatever they need in the classroom. That is traumatic."

Maria is a passionate advocate, and an activist.

Louise said she preferred to define psychological trauma combined as an experience and a feeling. She turned her head away from me to concentrate. When she spoke, each word seemed carefully measured.

"I would say it's an experience that leaves you marked, scarred, that makes you shake and sweat, and have all these weird physiological things like ringing in your head." She was thoughtful again before she spoke.

"When I felt traumatized in the classroom the males had this thing where they would have a "rumble." The boys would pass notes around the room and say that at 5 ticks past one o'clock we will do it. And of course I would see the note so I knew what was going to happen. I can remember the clock ticking and then this craziness would erupt in the classroom. People would be fighting. It was very violent, chaotic craziness. And I would be scared out of my wits. That was trauma to me."

"Another one is sitting there and being publicly ridiculed by a teacher. That was trauma. I remember in chemistry . . . he would call out my name and say, 'I remember

you, you never know the answer. Next!' He would laugh. I would think that I was getting sick and have to go to the nurse a lot. That was traumatic."

Louise began to talk about her experiences in elementary school. She remembered the incident of "the wooden shoe."

"I had to sit in a wooden shoe in kindergarden. I had to do it a lot. It seemed huge at the time - it was giant - this wooden shoe. It was a one-dimensional cut-out. And there was a little door with a chair. That is where you sat when you were bad. And you could be bad for many - I was never disruptive, but I was obviously doing something wrong and I was in there a lot - sitting in the shoe. I remember being there for long periods of time. People would come and go and they would see you in there because it was a huge room. And a lot of times it was a walkway for people to go to another room in the building or something like that. So, people would pass through and there I would be. They could view you. Either that or the dunce cap. It was the same kind of thing, but this was a shoe."

Louise talked for a long time about the kind of humiliation she experienced, the shame, the feeling of exposure. She linked her posttraumatic stress symptoms from those earlier periods in time to her present life.

Myra was educated on a small island off the coast of Puerto Rico. She came to this country about ten years ago, but still has vivid recollections of her experiences in the classroom. I asked her if she could define psychological trauma.

"Yes, it is really when something outside comes in and hurts you. It hurts you in a way where it can hurt your feelings terribly or it can make you feel very stressed or it can damage you in some way. It is an event that occurs that really throws you off your track. I can give you some examples of what that means, if that will help. If someone has been beaten, that is a physical trauma, but it can also cause psychological trauma and

emotionally, you are hurt. You are thrown off. Does that give you an idea of what that means?"

I told Myra that she gave me a very clear definition - there was not a way I could have described or defined it better. I asked her if she could describe classroom trauma.

"I have to work extra hard to catch up. I can take the same test as my friend, and she will get a better grade. I think that I am trying my best because I study. I go home and ask for help. I have tutors. That is trauma."

I asked her how she felt when those things happened to her.

"I just feel sad and I feel like what's the use! But then I pray to God to help me."

We began to discuss earlier classroom experiences on the island.

"The teachers would beat you. The schools were very strict, and were more disciplined. It is not like here in America. The teachers are not scared there. If you are bad, they will beat you. They don't care. I could not spell a word and my teacher beat me. I couldn't spell it correctly so she beat me for that. I thought I was stupid."

" Me and my friend were in the same class - they call it dunce class. Dunce means you are not so smart. The teachers wouldn't say that, but the kids would. My friend and I used to help each other in class, and she moved to a higher class, and I was always wondering why they didn't move me, too. I had to stay there. I hated that. I thought she was on the same level as me, but one day they moved her into a higher level class and I was still in that same thing, and I had to find all new friends and all of that so I was kind of upset."

In our conversations, Myra moved back and forth from narrating in the first person to the second. If a memory was painful to her, she shifted to the second person. When she needed to be emphatic about a point, she spoke in the first person.

Ellen was educated in Western Europe in the 1950's and 60's. She reported that she had experienced huge gaps in her memories of school, but that there were pieces she was able to put together.

"The first experience I remember is when I was four. One day I said a bad word in class and the teacher went to the headmaster and told him what I said. And he got a stick and gave me 9 slaps. And my sisters were crying. He told them that if they didn't stop he would kick them to home and back again. I know that they kept me - my father kept me home from school for another year after he was told what happened to me. He kept me home until I was 5. We had the same headmaster until I was 13."

"I don't ever remember going back. I remember getting slapped. That is all I remember. I remember the first day of school. I don't remember the last day. He beat us all of the time. We all got it - not just me. Everybody got it. If our parents went to him he would put us in the back of the school and not teach us at all. Everybody looked up to a school teacher at that time."

"When any of us would tell his (the headmaster) wife - when any of us were beaten badly she would make us cakes or something and give it to us the next day. She had no control I guess, with him."

Despite the difficulty of our conversation, and the many breaks we took, Ellen consistently spoke in the first person. She was very determined to tell her story, as fully and as accurately as she could manage.

"Plus he - as we were growing up he (the headmaster) sexually abused us by feeling our breasts. Every single girl got it. Every single girl. Not just me. He didn't just pick me. And nobody ever knew it. Not one of our parents knew it. We didn't discuss it - none of the girls in school- none of us discussed it. It was like an embarassment to us."

"Before my mother died I told her and she said 'oh, thank God you never told me.' Because she couldn't do anything about it. Nobody would stand beside her. He would get off. Times have changed. When my generation, the ones who didn't immigrate, got

married and had children - when it came time for him to teach their children they got him out. They wouldn't allow him to teach their children."

After I had listened to Ellen's story, I asked her if she could define psychological trauma. I encouraged her, as I did every woman, to use whatever language she was comfortable with.

"Well, I think that our teacher definitely traumatized me. That every day - I could not eat in the morning. My mother use to be so worried. I couldn't eat because if I did I would be sick. I would be throwing up."

I asked her about classroom trauma.

"Well, one day he (the headmaster) was beating his own daughter, and I was crying for his daughter. In front of everybody. He beat her and beat her and beat her. And she was crying and crying and I ended up crying. I don't even remember the person next to me. Was that person crying? Because we were also afraid to look - we couldn't look at each other ."

Ellen's learning was impeded for many reasons. Her learning disability was an obstacle to her reading, but the various types of abuse to which she was repeatedly subjected left her constantly battling emotional states and physiological symptoms which affected her functioning both in and out of the classroom environment.

Harriet was educated in parochial schools for most of her academic life. She began by telling me about her suspension in the fourth grade.

"I got kicked out of school. I was a prostitute at age 9. I had a fourth grade teacher, a nun, who talked about rotten death all the time. She told us in class that the end of the world was coming tonight and God would have our names written down in books and if we were good we would go to heaven, and if not we would go to hell. I was on the streets at age nine because my parents wanted to know why I needed so much money for pencils, pens, erasers, notebook paper and a notebook. They thought the school provided

it but they didn't. In a Catholic school they don't supply it so to make money I went across the street from the school - I knew it was a place where the hookers went. I made my own money to buy my own stuff at school."

Harriet continued on her own, remembering specific events.

"I didn't understand the meaning of words. I had a difficult time in math because I had a nun who - I went to the blackboard to put down an answer because it took 10 minutes to write down an answer to a problem and it took other kids 3 minutes to do it; I got the yardstick on my knuckles. I had to sit in a corner with a dunce cap on. I had to sit facing the wall, not facing the students."

Her facial expression told the tale of her isolation and humiliation. I asked her if she could define psychological trauma.

"Well, for me it is damage to a person's body. O.K., so it's physical abuse, incest, psychological abuse, emotional abuse, neglect."

I asked her about classroom trauma. She thought about it for a while.

"Other kids got beaten too at that school, in the classroom or in the hallway. They got beaten between their parents and the nuns. I felt rejected. I felt like I wasn't accepted."

Harriet's learning disability placed her in the precarious state of being trauma-vulnerable. Her need for acceptance was present not only in the home, but in the classroom as well; acceptance is rarely sought in just one arena.

Claire was educated internationally. Her early years were spent in the U.S. while a significant amount of time was spent abroad in a variety of countries, making learning, and more specifically reading, an even greater challenge beyond her diagnosed learning disability. I asked her if she would define psychological trauma in her own words.

"It would be something that causes pain. Trauma is something where there is usually a victim. I can't define it. This is horrible."

I asked her to try to define classroom trauma. She looked relieved.

"A classroom trauma would be one where in front of people you are embarassed. You are ashamed. You are made to read aloud. Where a teacher doesn't think you know something when you know it. When someone says you haven't been paying attention when you have."

"So, things that are like spelling bees and things like that where a measure of the moment is used to judge you as a person. A piece is signifying a whole. A little piece of your inability to do something then is mushroomed into an entire thing to define who you are. Being put into slow groups, being labeled, being stigmatized, being seen as a trouble maker, and the result of that is that it makes other people not want to be around you or be associated with you. You know you get labled, and anything that goes wrong you get blamed for it. Or you are never expected to do better because they don't think you are capable of it."

"And it's really just not being able to get ideas out. Like knowing exactly what the answer is, but just not being able to explain it or not being able to get it out."

I asked Claire to describe her feelings around this particular issue.

"It is beyond frustrating! Again, I go to all of these physical descriptions. It feels like you are a blind person with - it feels tortured! It you can imagine a blind kid out on the playground and they have something on that makes them look dumb and they weren't told that they have this silly, striped clown outfit on and they walk out onto the playground and all of the kids circle around them and say, 'nah, nah, nah, nah! Look at that! Look at that!' And you have no idea. You are trying to feel it, and it is what you had on that day. It feels comfortable to you, but, yet people are saying it is wrong."

She was exhausted when she finished speaking. She kept shaking her head, and finally just looked at me and sighed. She had built such strong bridges between classroom trauma and her learning disability. Her understanding of the phenomena was deep; her experience told the truths.

Chapter III.

THE STORIES

Listen . . .

Listen to me.
Listen to the stories.
Let me reach inside your soul,
touch your spirit,
and have you walk with me.
Let me take you by the hand, and
together we will travel
back in time,
gathering wool,
making sense,
remembering,
healing the pains,
the bruises,
the imprints
of past traumas.
Remember those who suffered . . .
while so many didn't know,
didn't notice,
didn't understand.
Listen to me.
Listen to the stories.

-J.U.Adelizzi '95

The Researcher's Story

For some reason, the automatic responses I have always experienced when faced with a situation which is anxiety-provoking, or intensely traumatic, have always made me visualize a gyroscope in my head with which some unknown force has tampered. It happens quickly, usually without warning, and takes considerable concentration and practice to maintain the equilibrium I require to function without "tipping over", both physically and emotionally. I have explained it in this way to others, and also have referred to it as my knee-jerk response to old stimuli-memorabilia. In other words, the response to certain environmental stimuli, unconditional stimuli, becomes an automatic, or conditioned response. Eventually, any stimuli closely related to the original trauma will produce a conditioned respose (Greenberg, cited by Van Der Kolk, 1987). Piaget might have described it as my *equilibration,* or the "balance between the processes of assimilation and accommodation" (Singer & Revenson, 1978, p.16). It's a difficult phenomenon to articulate. Let's face it. Not everyone is interested in individual personal responses to each and every anxiety or trauma which flood our lives on a daily basis.

What I have come to realize is my insatiable need to identify the causal relationships between trauma(s) and its impact on learning. Does an individual's stage of development determine how and if recovery from trauma will occur? Can a traumatized victim regress in development in order to cope with the shock or accommodate the consequential conditions? Earlier coping mechanisms are activated and repeated to ensure the safety of sameness (Van Der Kolk, 1987, p.96). What happens in the brain when trauma makes its assault upon the senses, including the psychic sense? In other words, when the gyroscope begins to tip, from the beginning of the process to the end, when it re-establishes equilibrium, what exactly takes place in the body, mind and brain? "Trauma, or memory of trauma, interrupts development, another element of *fixation on the trauma*" (Van Der Kolk, 1987, p.96). An internal breakdown occurs in the brain during trauma which releases massive amounts of

neurotransmitters, resulting in loss of chemical equilibrium (Terr, 1990). That's the speculation of just one theorist. The best place for me to begin connecting theory to experience is with a personal trauma, a kind of mystery to me even after almost thirty years, in which many different cause and effect relationships may be identified.

In the spring of 1964, when I was seventeen years old, I awoke about 3 a.m. to very loud gasping and sucking sounds. My mother rose from the other bed in my room and rushed quickly down the hall. She had been sleeping in my room since my father's arrival home from the hospital. I followed her into my father's room, and remember feeling my heart beat rapidly, my face feel hot, and my palms feel sweaty. She turned the light on and I stood and watched my father writhing on the bed. His legs were kicking, his arms were restless, and he appeared to be gasping and choking. As I walked closer I could see his eyes rolling back into his head. At some point I remember my legs began to shake. My whole body began to tremble and feel weak. There does not seem to be a cultural or gender bias in the way young children or adolescents exhibit their panic. Often they look dazed, not necessarily hysterical . . . *too scared to cry* (Terr, 1990).

I think my mother told me to call the doctor, meaning our neighbor who lived a few doors away. I did. I told him to hurry because I didn't know what was wrong with my father. Then I climbed up on the bed next to my father, and knelt down beside him. I took his hand. He squeezed my hand so hard that I remember it hurt me. I was very, very frightened. I asked my mother to give me his nitro glycerin tablets. Nervously, I placed one under his tongue when his head was still enough. I tried another. He just kept gasping, and making sucking noises. He kicked and flailed. I thought in my seventeen year old mind, that he must be having an epileptic seizure.

I remember calling the doctor again, and telling him to hurry, because I didn't know what to do. Removing my hand from my father's was difficult. He had such a grip on it, a death grip. I stayed on the bed with him, and watched him continue this awful thing that

he was doing. I was afaid he would hurt himself with all the kicking and struggling that was going on. I felt nauteous, and know that my own breathing became labored.

> You are so surprised, so overwhelmed, that you feel lucky not
> to die with a crazy heart rhythm or a burst blood vessel.
> However, the overall mechanics of the human body almost
> always can withstand sudden horrors. . . . the brunt of single,
> shocking episodes tends to fall upon the mind alone.
> (Terr, 1990, p.8)

Visualization is a powerful gift. Sometimes I regret such gifts. At that moment I began to visualize a picture of myself on the front page of our local newpaper. The previous fall, my father had been so proud of me as I posed for the photographer. I was giving CPR to a life-sized doll in our high school auditorium. What an upstanding student and young citizen! I should have been saving my father. Why wasn't I? The thought raced through my mind, repeatedly. My body felt like pins and needles, my mouth was so dry. I was very thirsty. The sheets and blankets beneath my bare legs felt rough. My skin hurt. My sense of touch, my kinesthesia, had become magnified. I felt like Alice In Wonderland, a sense of distortion surrounding me.

How much time passed, I'm not sure. What seemed like hours, was minutes, I learned later. Eventually, the violent throes of death diminished, then stopped. The room was quiet. He lay there, still, his limbs finally at rest. His mouth was open and his blue eyes were staring at the ceiling as if in disbelief and shock. I wanted to close his eyes but I was afraid to. Removing my hand from his was more difficult this time; his grip was even tighter. It was frightening to me. All I remember hearing was my mother crying, as she paced the floor on the other side of the bed.

The doctor arrived, and conducted a brief examination. He closed my father's eyes, and I was grateful. I knew he was dead. Dead wasn't the word the doctor used. He said "gone". My mother wept. My cousin came into the room. I said, "He's dead." Then

I went downstairs, lit a cigarette, and leaned against the kitchen counter. My father refused to give me permission to smoke in the house. But now he was "gone". It was about 3:30 a.m.

The undertaker arrived around dawn. The doctor had the family wait in the living room with the door closed so that we would not see the staircase as they brought my father down, and into the hearse. I remember a euphoric kind of numbness take over my body, and my mind. I kept smoking cigarettes, and waiting. Soon I heard people stumbling around upstairs, overhead. They had a great deal of trouble bringing my father down the winding staircase; he was a heavy man. I heard the smack of wood against wood, comments exchanged, short silences, then more bumping sounds. Light began to come through the living room windows. I felt like I was in a surrealistic painting. Nothing looked right, everything felt out of perspective. Sounds weren't the same. All my senses were distorted.

I passed through the next several days in and out of numbness. "A person who appears stunned and immobile to the outside observer may be processing data, calculating relationships, and working to build novel and manageable structures to deal with information overflow" (Fish-Murray, cited by Van Der Kolk, 1987, p.96). I cried, but I wasn't crying from grief. I couldn't identify my own feelings, or needs for that matter. Countless friends and relatives told me I had to be strong for my mother. I remember how my head screamed inside "What about me?". But I felt too selfish to say it out loud. How self-centered that would have looked to others. My head felt like that for many, many months. I was not aware that I was entitled to have these very basic needs met. There was a need for life to march on, a need to regain my equilibrium. What was missing was a source of strength, outside of myself, from another caregiver. According to Van Der Kolk (1987), following a trauma, there is a need for attachment which allows the victim to rely on another trusted person when their own resources become depleted.

Daily, hourly, for well over a year, the death scene revisited me. It would happen while I was showering, having dinner, dating, conversing with a friend about teenage "stuff". When no one was looking I would squeeze my eyes shut and cover my ears. I needed to stop seeing it, hearing the death noises. I would come home from school, smell my father's cigarette, hear him moving around in his favorite chair, or in the cellar at his workbench, and yell "Daddy?" Then I would remember. Often, this was coupled with the visual of myself on the front page of the local newspaper, giving CPR to a doll.

> Erickson has stressed the severe psychic consequences of inactivation as opposed to the capacity for activity in any threatening situation. One feels responsible for what one has not done, for what one has not felt, and above all for the gap between that physical and psychic inactivation and what one felt called upon to do and feel . . . The image keeps recurring, in dreams and waking life, precisely because it has never been adequately enacted.
> (Wilson et al, 1988)

Repeatedly I would question my inability to save him, my frozen state; the syndrome of survivor guilt crept into my life (Flannery, 1993). " Feelings of guilt are especially severe when the survivor has been a witness to the suffering or death of other people. . . witnessing the death of a family member is one of the events most likely to leave the survivor with an intractable, long-lasting traumatic syndrome" (Herman, 1992, 54). When I questioned myself I, of course, would trigger the visual death image again, the noises in my head. Interruptive flashbacks of traumatic events seem to be characteristic of late adolescent and adult experiences. "A tragedy - unexpected and sudden - occurs. Somebody dies. A survivor goes on to hear the screams, smell the smells, or see the terrible sights, day after day, week after week"(Terr, 1990, p.140). Wilson, Harel and Kahana (1988) refer to this as the anxiety phase of post-traumatic stress disorder, where

the physiological arousal state is intensified, leading to autonomic nervous system responses. How can a child, an adolescent, an adult, resume life as normal, return to the classroom, function, learn, when trauma has tipped the human gyroscope?

In school I found it impossible to concentrate. According to Judith Herman (1992), the intrusive nature of trauma's persistent revisitiation can directly affect development. This may force coping mechanisms to revert back to a time when developmentally, the stimuli can be accommodated. If I could not "fit" the information into my present mode of coping, then I would accommodate it another way, probably in a way that I had become familiarized with in the past, at a younger age. Also, I realized, but could not verbalize, that I was not the same person that I was minutes, hours, before my father's death. My self, my identity, my development, had been altered. I knew I would react to things very differently than I had before. I didn't want to be in the classroom. I found that the voices in the classroom, in the hallways, made me confused, disoriented. I couldn't study, I couldn't take a test. My memory suffered to the point where I was often not sure what day of the week it was. "Studies in the psychobiology of memory point the way to understanding the psychobiological processes undergirding the recognizing, the assimilating, the intergrating, and transforming of traumatic memories" (Rice-Smith, 1993). According to psychiatrist Bessell Van Der Kolk, " . . . trauma may permanently alter the neurobiology that integrates cognitive memory and emotional arousal . . ." (Wylie,1993,p. 43)

The limbic system, a group of cellular structures in the brain, and also referred to as the mammalian brain, is strongly involved in our emotional reactions which are related to survival, and in maintaining homeostasis (Ornstein, Thompson, Macaulay, 1984; Ornstein, Sobel, 1987). This system directly affects memory, and its output affects somatic motor effectors (Diamond, Scheibel, Elson, 1985). The hippocampus is the oldest cortical portion of the limbic system. When this system is disrupted by trauma, information is not easily accommodated and integrated. Within the limbic system, the

hypothalamus, "the brain of the brain", regulates many human functions, emotions being one of many. The limbic system plays a vital role in the experiencing of trauma, and in its recovery, during post-traumatic stress disorder.

The process of kindling in the brain follows intermittent episodes of trauma; "repeated electrical stimulation of the amygdala causes long-term alterations in neuronal excitability" (Van Der Kolk, 1987, p.68). The norepinephrine produced by the brain may produce a response as intense as the original traumatizing episode. A vigilant alertness is the effect; the changes which have occurred in the limbic system as a result, in turn, cause even minor anxiety-provoking events to be responded to with the intensity of the original traumatic event. The vicitim, or survivor, may reside in an almost constant state of hyperarousal, hypervigilance; human radar seems to be constantly at work. Symbolic reminders of original traumas, both positive and negative, will trigger kindling . The cycle of kindling continues when the triggering events, or traumatic events, have diminished or passed. A withdrawal in endorphins and norepinephrine is experienced, creating flu-like symptoms which cause frightening feelings (e.g. "what is happening to me?"). When fear registers, then norepinephrine increases once again, reactivating the process (Flannery, 1993).

> 'The emotional sensations related to trauma are remembered through a different memory, either as bodily sensations or visual images' says Van Der Kolk. 'At subsequent moments of very high arousal, the trauma comes back - not as words, not as memories - but as flashbacks or nightmare or visual image, and the person experiences it again; but the words are simply not there because it has not been integrated into the totality of his or her experience.'
> (from Wylie, 1993, p.43)

The ability to remember, to learn, involves emotion. "By and large, the newest brain makes the "cognitive" decision as to what circumstances are being dealt with and what needs to be done, and the old mammalian brain (limbic system) resets the biases appropriately" (Hart, 1983, p.106). When threat is pending, the newer brain, the neocortex, is abandoned for the simpler resources of the mammalian brain which calls the limbic system into affect, causing somatic responses, or the physiological symptoms which accompany severe anxiety, panic or trauma.

Within a month of my father's death I gave up doing homework. I didn't care if I failed. My teachers, and especially my guidance couselor, were at a loss. My English teacher failed me for the final term. I cried, but it really didn't matter to me. It was my favorite subject, but I just couldn't do the work. The trauma survivor's vulnerability or sensitivity to further trauma or threat impedes learning, especially if a classroom teacher is ignorant or indifferent to the student's situation. Under threat, "the cerebrum downshifts - in effect, to greater or lesser extent, it simply ceases to operate" (Hart, 1983, p. 109). The downshifting to which Hart refers involves the limbic system, and may leave a student speechless, and/or unable to understand what others may be saying. I couldn't fit another morsel into my mind; it was crammed full of chatter and noises that just frightened me to death.

According to Terr (1990), adolescents usually do not experience failure in the classroom as a direct result of trauma. Possibly for the first year following the traumatic event, failure in the classroom may occur, but not because of an arrestation in learning, but because of fear. Following a trauma, severe emotional stimulation triggers what seems to be a revisitiation of that trauma. The ability to assimilate and accommodate new information may be affected as well as an individual's cognitive organization. In educational settings "not enough attention is paid to the traumatic elements that interfere with perception and cognition" (Van Der Kolk, 1987, p.18). Somehow I made it to the end of the term and graduated. I still wonder how I managed.

With each revisit of the trauma came the re-experiencing of the hypersensitivity of my senses, especially what I *heard* in my head. But my body suffered as well. I was extremely fatigued, all of the time, but couldn't get enough sleep. When I finally did sleep, I didn't want to get up, face the day, keep living through it again and again. It took a great deal of energy to deal with reliving the death scene in my head, and pretending to the outside world that everything was fine, and that my mind and body did not feel like a war zone. According to Brett and Ostroff (1985), "experience (trauma) is organized on a somatosensory or iconic level of memory, and remembered through somatic sensations, behavioral reenactments, nightmares, and flashbacks" (Rice-Smith, 1993, p. 119). I noticed immediately that my body coordination deteriorated. I didn't want to take gym because I had been tripping a lot, bumping into things. I was afraid I would hurt myself. I fell a few times, dropped books frequently, and was generally disoriented. Normally, I had a good sense of rhythm, enjoyed music and dancing. I became afraid to take part in any of these activities, because I knew what would happen. I became very, very clumsy. Lenore Terr (1990) refers to the return of these trauma-related feelings as psychophysiologic reenactments.

It was several months before I felt my body return to normal. My internal gyroscope felt as if it was beginning to gain a sense of equilibrium again. At around the same time my head began to quiet a little, although I still awoke to the death noises in my head. They seemed to become part of me, part of my schema. I felt sure they would always be with me. And they were, for many, many years to follow.

Even today, almost thirty years later, I jump at certain sounds. My startle response is still more senstive than probably the norm, although it does depend upon my general state of anxiety. Throughout my life, with each new trauma, or severe state of anxiety, I feel my gyroscope losing its stability, and I know how my body and mind will react. It's an awareness I have that is sometimes present during the upset, and sometimes it follows an event, during the period of time when I am puzzling over my clumsy behavior that day,

or wondering why my kinesthesia was super-sensitive, or the sense of nausea I experienced earlier, coupled with rapid heartbeat, lingered hours after an anxiety-provoking episode.

> No matter how "mental" the origins of post-traumatic psychophysiologic reenactment may be, however, the pains and bodily sensations that the victim feels are absolutely real. The link between body and mind remains unconscious to the victim. The body responds to the trauma. And the mind - the unconscious mind, that is - drives this response. (Terr, 1990, p.272)

It remains difficult for me to sit through most movies for a variety of reasons, but chiefly because there is not a way for me to effectively censor each film before I subject myself to the sights and sounds. Some movie themes may remain a struggle for me, but most of the time the noises connected to violence linger to haunt me for days, weeks sometimes. Death scenes, and the people on the screen (and sometimes in a book) who suffer with the dying, bring me back in time, make me see, feel and hear it again. There is definitely an eerie quality about the whole experience, something very inexplicable.

> It also appears that traumatized people cannot "tune out" repetitive stimuli that other people would find merely annoying; rather, they respond to each repetition as though it were a new, and dangerous surprise. The increase in arousal persists during sleep as well as in the waking state . . . (Herman, 1992, p. 36)

When our gyroscopes are thrown off balance by some force, then we are thrown off balance as well. We all behave differently in these situations. We all react differently to trauma. We all develop a different awareness of what traumatizes us, and how we cope

with the residual effects. There isn't a way to escape trauma, as we experience it in our daily lives to one degree or another, some reacting more intensely than others. We also all traumatize one another, sometimes deliberately, most often inadvertently. With each trauma comes a series of neurological and physiological reactions which cause us to *feel* differently, physically and emotionally. We may change the way we normally behave in order to cope with the situation at hand. And if we live in situations where we must remain consistently vigilant about our well-being, then we develop our own personal, innovative, coping mechanisms in order to survive. Our concentration is affected, as well as our memories and our ability to feel. Sitting in a classroom becomes a challenge. Learning becomes a struggle.

The Reading Circle

For some individuals, the fact that a learning disability may impede reading is stressful or traumatic in itself. There are some women who as children and adolescents experienced some difficulty reading, and had to work twice as hard in their academic endeavors. Often the rewards were satisfying to them; their grades were commeasurate with their efforts. For others, however, there may have existed such a severe reading disability that fear and humiliation became part of everyday life in the classroom. For this population, the reading circle became a dreadful and horrific event which had to be lived and lived again, daily. The fears, humiliation, aches, pains and frozen immobility were enemies which were hiding behind every desk, every bookshelf. Often the only relief was to find ways to escape, to not go to school, to be "not there." The memories of these experiences followed these women into adulthood, like shadows which are always attached to one's being, and only disappear in the light of hope.

Women who are LD have lived lives trying to catch up and keep up. If their disabilities are found in reading, then they are at great risk for being exposed as being

nonreaders or poor readers. As children they have been accused of not paying attention, being lazy or not trying hard enough. When I interviewed the subjects for my study, many of these women recalled their experiences in the "reading circle." This was an arena where everyone was expected to take the same risks regardless of their various levels of ability or self-esteem. For those students who were able to visually follow the words in sequence, recognize and hear sounds, and who possessed a "sense" of language, the reading circle was not a dreadful place to be visited each day. But for those students who diligently followed each word with their fingers, afraid to stop in a place that looked unfamiliar, the reading circle was an activity which threatened to again display them for ridicule. Their internal gyroscopes were at risk for being kicked over which meant that their mental and physiological beings had to scurry in order to regain a sense of equilibrium. Human dignity was always at stake.

Elizabeth offered a typical response when asked about her experiences in the reading circle. *"The teacher would call you funny little names - you know, he was yelling at you, calling you 'banana head'. I can remember the teacher screaming and yelling at me; I would cringe and feel awful. I had less confidence because I was in the lowest reading group. I was very nervous reading out loud, and a lot of times I would stumble. I was just very unsure of myself which made others listen and look. I can remember feeling very inadequate."*

I will offer several stories told by the women in my study in order to demonstrate the universality of specific unconscious emotions and physiological symptoms as a result of classroom trauma within the reading circle. The following stories will be told in the present tense to create a feeling of the "here and now" for the reader.

Louise

Imagine if you will a classroom from the 1950's or 60's in a traditional public school in a small city in New England. It might be rectangular in shape, with brown or

green tiled floors. Probably there are no rugs. The windows are tall, and the woodwork is dark and splintery looking. The pencil shapener is screwed into the corner of one of the window sills, and there is a girl standing there, yellow pencil in hand, idly staring out of the window. She looks about 7 or 8 years old.

As you look around the room there are about ten boys and girls scattered about in little wooden desks. They look busy, although a few appear to be daydreaming like the girl at the pencil sharpener. Their teacher is not in her usual place behind her big wooden desk which is located at the front and center of the classroom. But if you listen carefully, you can hear her voice at the back of the room.

Miss Killam is sitting in a little red chair, her knees up around her chin, holding an open book. Eight other children are sitting around her in a circle. Louise keeps glancing up at Miss Killam nervously. She is holding tightly onto her little book, her face intent on the words printed before her, her forehead wrinkled in concentration.

Finally Miss Killam spoke. "Louise, next paragraph please."

Louise looks up at her teacher, and then around at the reading circle. Some of the children look at Louise expectantly, some look down at their books. She begins to read slowly, hesitantly. Little beads of sweat break out on her flushed face. She appears to be in some kind of pain. When she mispronounces a word, or misses one entirely, Miss Killam asks one of the other children to read the word correctly. Once or twice Miss Killam asks Louise to "sound it out", to "try harder."

Louise misses several words, and Miss Killam sighs deeply.

"Go back to the first sentence Louise."

Louise is silent. She stares at her book. Miss Killam's voice begins to rise as she asks Louise again to repeat the first sentence.

Louise can't find her place. She searches frantically from one page to the next.

Over 30 years later Louise reflects on what the reading circle was like for her.

"I can remember what it looked like. I can remember the position I was in in the circle. What I remember is that I never quite knew where I was in the book. If I had to follow somebody, I didn't know what was going on."

"When I was called on I felt kind of shocked. I mean like a physical feeling. I felt nervous, scared, because I didn't know what was going on. When I was called on to read I felt exposed. I was uncovered."

I asked Louise to think about how she felt physiologically at that time as well.

"I would begin to feel racy, like my heart would be racing or that weird feeling I sometimes still get like a tunnel, and my head goes black, and it's just like my peripheral vision is almost not there. I remember a ringing in my head. That still happens to me. When my head rings it feels like everything is all tight. I can hear, but it's almost like my head is in a vice and there is pressure. The ringing is high-pitched, almost locking things out around me. Sometimes, I wonder if it's like a kind of protection for me. Sounds are muffled."

I asked Louise how she responded to the yelling.

"When the teacher would yell my body would just get really tight and rigid. The ringing thing would start, and I would get really confused and scared. I would almost start to cry, and would have to hold it back. I felt totally ridiculed and wanted to hide or disappear. I wanted to vanish like vapor or something. It would have been wonderful if that could have happened."

Claire

Try to picture a classroom in the 1970's in a midwestern town. The windows are plentiful; the room is bright. The teacher's desk is in the middle of the room with small groups of students' desks surrounding it. In a corner of the room near a window are two hampster cages with the tawny colored balls of fur spinning furiously on their wheels. There is a warm-colored area rug at the back of the room. On the rug are placed several

brightly colored metal chairs, arranged in a circle. Mr. Lions seats himself first, the children filling the other seats after him. The kids are 11 to 12 years old.

One boy leaps into his seat, sending it sliding backwards about 6 inches. One girl quietly seats herself as far away from Mr. Lions as she can. Another girl, Claire, jauntily skips into the circle, twirling around to see what seats are vacant. She chooses her chair, opens her book and glances up at the teacher. The subject is social studies, her favorite.

Claire begins to unconsciously tap her foot on the floor, in time to her internal ryhthm. She keeps a careful count of who is reading and trying to estimate what paragraph will be hers so that she can silently practice the words. As she begins this ritual which is all too familiar to her, she is struck by the thought that Mr. Lions may skip a person, or somehow throw off the sequence so that she won't be prepared. Desperately Claire tries to follow the visual sequence of the words as they are read. They're going too fast. One thought leads to another, to another , to panic . . . . . until she is only concentrating on the whirring and humming noise the hampsters' wheels are making.

"Claire, it's your turn." There is a pause. "Claire, wake up!"

Quickly Claire brings herself back into focus, discovering that she had lost her place. Her breathing becomes labored, her face flushes. Frantically, she scans the pages of her open book. The words are just letters now. They 're unrecognizeable; they don't make any sense.

I asked Claire thirty years later to recall the reading circle. She winced and groaned. For a while she didn't speak, but seemed to be conjuring up mental images. I watched her in her silence and stillness, states I was not used to observing in her. After a few minutes she turned to look at me, and began.

"I always did really well in social studies and history. . . unless I had to read it. One day when I was asked to read I couldn't find my place in a hurry. I think some of it was because I was kind of spacing out. I couldn't read fast enough. We were going

around the room and I couldn't find my place fast enough, and he started to yell at me for not paying attention. Then I started to read it after he finished yelling at me. I was reading slowly, and he cut me off in the middle, and then asked someone else to take over. And the way he treated me - it was as if I was lying or something. It made me feel dishonest, like I had stolen something, done something wrong. I could see the teacher's anxiety and frustration level rising, but I couldn't make myself read any faster in order to make him calm down. Ultimately, I felt responsible for his frustrations. He treated me like a second class citizen."

"I didn't know that I had a learning disability. I was always in slow reading groups because reading was hard for me. But when you are trying to read it quickly enough to find out where the last person left off, and then to be told you're not trying or not paying attention. . . . . There is no defense against that when you're a kid!"

Talking about the reading circle was distressing for Claire. Her face flushed much as it probably did sitting in that circle struggling to find her place, trying to read the passage as quickly as she could, only to be cut off. There was a noticeable change in her respiration as she continued her story.

"Once you screw up with the reading you get labeled. So then you have to concentrate so hard trying to make sure that you keep your fingers in the book. Then you have to pay attention, pay attention, pay attention in case he calls on you again! You get yelled at no matter what."

"When a teacher yells at you, the kids don't think the teacher is an idiot. They watch you move your finger along the page trying to read. Then they move their desks away from you because you were the one that was being yelled at. No one wants to be associated with you! And it carries out into the playground. It's like you are marked. Like you're wearing a dunce cap or something. So, it goes beyond the classroom and into the social circle. The botton line is that I didn't perform."

I asked Claire if she recalled any physiological symptoms during these episodes.

" I remember shaking. And having a rapid heart beat. Today I get the same kind of performance anxiety where my ears ring. The pressure in my head gets so bad that it creates some sort of pressurized noise. It feels like there's a bomb inside of me. And then there's that trapped anxiety feeling."

Claire and I began to discuss physiological symptoms connected to traumatic events she experienced in the classroom. Both Claire and Louise defined these episodes as psychological traumas. Claire described this phenomenon as her "body signs", and talked about the fact that her physiological symptoms seemed to appear before she was cognizant of the actual episode.

"The key is paying attention to some of the body signs. So many times I don't want to *listen* to them. It's like a dismissal cycle - my body might be trying to tell me something, but I want to dismiss it. I want to ignore my body signs because I want to ignore what has happened. I want to get away from it because it will try to suck me in."

Her description of her emotional reactions and physiological symptoms as a child in the reading circle were parallel to her experiences as an adult when placed in similar circumstances, even when a particular event was vaguely reminiscent of the childhood classroom traumas. Throughout the life cycle the response to these events often resulted in a series of panic attacks.

Her anxiety level increased as she continued to talk. Her face was flushed, and she began to put her whole body into the expression of her feelings. She was out of her seat, pacing as she spoke.

"This may not be as traumatic as some others, but in those reading groups I can always remember feeling so shamed and awful that there was only myself and one other person who hadn't moved out of the second or third color from the botton. They had yellow, and green and blue and the advanced levels go into all of these other things."

I asked her to describe her feelings about that experience.

"Ugh! You just didn't want to be in there. Not only was it embarassing, and you were different, but also like you would never get out of there because look at how far you had to go. It is great for the kids that are at the top because they see, oh, look at all of these stairs that I have climbed! It is like putting someone down at the bottom of a wheelchair and saying, 'o.k., you have to climb these stairs.' And it is not that it is impossible . . . it's discouraging when you are with a group of people who have legs! It feels so hopeless!"

Ellen

In an English speaking Western European village in 1950 there exists a small stucco schoolhouse that sits on the edge of the cobblestoned street, neatly tucked among the houses. The community is small and serves as an extended family for most of the children in the school. Every day 7 year old Ellen begs not to go to school. She moves through this ritual each and every day. It has been this way since she started school two years ago, and it continues until she becomes 13, and is moved to another level of schooling located in another community.

"Please, please can I stay home? Please don't make me go."

Her stomach churns and twists at the thought of spending another day in "that place." Her older sister waits patiently by the door for her while Ellen's mother spoons cream into her mouth, just so that she would have something on her stomach. The walk to school is not far; she wishes it was. She holds on tightly to her lunch with one hand, her sister with the other.

Her classroom accommodates children from grades 3 to 7. There are very tall widows on both sides of the room, and six long benches are symmetrically placed in the room. Ellen moves to her bench which is like a very long desk, made for sharing with several other students. Soon the others are seated quietly, all eyes at the head of the room.

There is a tension in the air, an expectancy. The Headmaster appears, takes attendance, and begins to assign the reading lesson for the day.

Ellen looks straight ahead. She doesn't see anything to either side of her. She doesn't see the faces of her friends, her cousins. She just sees him, and hears her name called to join the reading group at the back of the room.

"Ellen!!"

She feels stuck to the bench, unable to move. Her little body is soaked with sweat, her heart is pounding in her ears. Somewhere in her chaotic thoughts she thinks of her mother, the security of the house, the kitchen. Slowly she slides off the bench and moves to the back of the classroom. Ellen looks down at her right hand and notices that she is clenching her book. She doesn't even remember opening it, or feeling it in her hand.

Several students her age are standing at the back of the room with their books held up in front of their faces. She takes her place, and begins to pray.

"Please God, don't let me make mistakes."

She looks hard at the page, waiting to see who will be called on first.

"Ellen, first passage please."

She freezes. Her face flushes. Ellen's knees begin to tremble. The words all look alike. They don't say anything. Again, she tries.

"Please God, don't let me make mistakes."

She staggers forward from the impact of the slap on her shoulders.

"Ellen! Read the first passage please!" he yells.

Everyone is very quiet. The air feels thick. This time Ellen reels backwards from the slap she receives on her left arm. She doesn't feel or remember anything after that.

Ellen sat across from me as a grown woman who has returned to school in order to complete a college degree. She recalled that time in her life. It seemed like another life. She told me that she had enormous memory gaps surrounding these episodes. The abuse in the classroom progressed far beyond the slaps she received.

When I asked her how she remembered feeling when called upon to read, she said,

"I was always panicking. Always, because if I mispronounced a word or didn't know one, I would get slapped. I was afraid to read. I was petrified. I was scared that I wasn't going to say the words right or that I wouldn't be concentrating when he called on me, and then I would get hit."

When I asked Ellen if she could recall the physiological symptoms which may have accompanied her fear, her first thought was of never being able to eat, to swallow.

" I could never eat until after school was over every day. We brought our lunch but I couldn't eat it. I just brought it home or threw it away. I couldn't eat breakfast if I knew I had to go to school. That was why my mother fed me cream, or sometimes candy so that my stomach wasn't empty "

She was thoughtful. "When I know that I have to go to class now, I can't eat. I have to wait until I get home. And I get so hot and sweaty in class I have to take my coat off and my sweater. Especially if I'm taking an exam. I can't have too much touching me. My skin feels like it's burning."

I asked Ellen how she felt when the Headmaster yelled at her. She brought her response into the present.

"I can't stand yelling. I can't stand yelling. I shiver! I shake! I fall! I just can't deal with yelling. It makes me feel really, really scared, and I feel as if I can't walk. My knees just go."

"When I was in school I couldn't move when I was scared."

I asked her again about the reading. She was quiet for a while, but kept picking her head up to look directly into my eyes.

"Well, even now I can't read aloud. If someone is listening to me, I can't read it at all. And I mean the words aren't too hard or anything. I can read the newspaper, but if you ask me to read it out loud to you, I wouldn't be able to do it."

I asked her if she felt safe reading with anyone. She said no.

Jean

On the Northeast coast of the U.S. there is a rural community which is growing in diversity in the 1960's. Despite the demographic transitions of the 60's the student population in the elementary and jr. high school is predominantly white. The special education facility of the elementary school is housed in one room. There are about 15 students ranging in age from 6 to 12; there are only 3 girls. Of the 15 students 2 are profoundly deaf, 8 are described by the classroom teacher as being "slow", 2 are physically handicapped, 2 are mentally retarded, and one is Jean. She is the only student of color in the class, and fairly new to the rural system as she moved to the area from the inner city. Her learning "problem" was never clearly defined for her, for her teachers, for her family. To the system, she was an enigma.

The school was newly built five years ago, and boasts shining beige tile floors, orange desks, green chairs, and lots of glistening windows. The "special" room is located on the basement level, far enough away from the main entrance so that the students were not seen by visitors in the main lobby. Jean is sitting in a corner with a girl her age. The other girl is reading to Jean. She passes the book to Jean who leafs through the pages, unable to make sense of the language which appears to be a scramble of letters and symbols to her. She is still recovering from her experience a few hours ago in the reading circle in her regular classroom. Jean looks around the room, watching the girl who is watching her, then shifting her gaze to the two boys fighting in the corner at the other end of the room. Jean looks down again at her book, and stares hard at the page, trying to make herself read the words in the order in which they present themselves. Out loud she tries to sound out an unfamiliar word. The girl laughs. Jean closes the book and waits for the bell to ring.

The teacher, Mr. Crupp, is a man who likes "law and order", but never seems able to achieve this state in his classroom. Some students are with him for the day, every day, while others come for a few hours, then return to their regular classes. Those who are with

him for brief periods of time are supposed to be working on specific skills which would assist them in their regular classroom work. However, there is never enough time. Those who are acting out need attention so that others might not be hurt. And then there are the needs of those in wheelchairs . . . the demands are neverending. The challenges are impossible to meet. Mr. Crupp shakes his head as he watches Jean sitting quietly, her unopened book beside her on the floor.

Over thirty years later, Jean sat in front of me, recalling those days, that classroom. I asked her if she could describe the reading circle in her regular class.

"Yes. I remember the group having about 6 kids. In the little circle there was an aide and a teacher too. I remember kids reading and trying to do sounds, and I can remember people asking me what the sound was. Then I would pronounce it differently than they told me. I struggled with hearing and seeing the letters on the book. These other people could just read it; it seemed so easy for them. I always knew what they were talking about, I always understood, but I couldn't read the written word."

" I remember in the circle we took turns. I knew when my turn was coming, because I would follow every single word and letter with my hand. The teacher would always tell us to pay attention so that we knew when our turn came. When my turn was coming my stomach would get all upset - all tense and nervous . My hands would sweat. I wanted to read but knew I couldn't read certain words."

She paused and began to cry.

"I could feel the knots in my stomach. I would pray 'Please God let her pass me by. Let her go to somebody else.' Some teachers would let you just read a few words, but some others would make you read the whole sentence out loud - make you struggle. I remember that. They would let you struggle. Waiting for your turn was hell. It was really hell because you knew that it was coming. It was like 'dad's coming home and he's going to give you a licking!'"

"I felt a lot of sadness. A lot of shame."

I asked Jean if she recalled any physiological feelings associated with her experiences in the reading circle.

"I mostly remember my stomach feeling tense, and my legs would shake. Even today when I have to write something I feel my body go through the same kind of trauma. I guess that's the word I want to use. My hands would sweat and my legs would get shivery - my stomach would be in a knot. I could feel myself get physically sick. I was so locked in my fear I couldn't move. I couldn't write a word either, because the fear was so overpowering. I was stuck. I could not move."

"I felt like a rabbit in quicksand. No matter how softly someone spoke to me, trying to explain it to me, I couldn't move. I guess that I had had a history of being so traumatized by the reading and writing that I would feel that way over and over again."

I asked Jean how she felt when she had been yelled at in school.

"A few teachers yelled at me, and I thought that they didn't like me. I thought there was something about me that aggravated them. I don't do well when people yell. I can remember that my throat would get really, really dry. I didn't feel good about myself because of the reading and spelling so that when somebody would yell at me it would be like, 'oh, my God, what did I do!' It was almost like my breath was taken away."

All four of these women were educated in different kinds of settings. They were all tested for learning disabilities at various times in their lives. Regardless of when they were tested, or whether or not they received a diagnosis and prescriptive treatment, the fact remains that they all find a way to articulate their struggle with reading as children and as adults. They were the ones who *knew.* They were the ones who worried about what was "wrong" with them.

The physiological symptoms they experienced in connection to the reading circle has carried through to their adult lives. Some of these women have made the choice to return to the classroom to prove their worth. For some, this journey is more arduous than

it is for others. Some women come back fighting, stiff and defensive, waiting for the first attack. Others, approach the task like cats, stealthily moving along, trying to maintain a sense of mysterious identity, fading into the background whenever possible. By the time the children from the reading circle have become adults they have discovered that the physiological symptoms which they experienced as a result of their past experiences have stayed with them , and revisit them when similar kinds of situations arise. Often when these women return to education they are plagued with panic attacks in conjunction with a plethora of unpleasant physical ailments.

Most of the women in this study reported that they felt a general sense of disorganization following an episode in the reading circle. Both in and out of the classroom this may result in severe difficulty in concentration, further exacerbating the already troublesome situation. For some, the threat to their physical well being was present each and every day. For all, a threat to their general sense of integrity was everpresent. Intrusive recollections of these episodes followed the women into adulthood, partially explaining the reason for the bouts of panic and distress upon their return to school. For many, the only answer to maintaining a physiological equilibrium is to avoid situations which are reminiscent of their classroom traumas, and for some this means avoiding situations in which reading aloud in any form is required. This may be inclusive of reading signs in grocery stores, ads in the paper, or directions for a recipe. The persistent and lifelong symptoms may finally take the form of hypervigilance (DSM-IV, 1994). These women have learned to be constantly scanning the environment for danger; their radar is on constant alert. It takes a great deal of psychic energy to exist in a state of hyper-awareness.

Because they suffered repetitive bruises to their dignity and ultimately to their feelings of self-worth, they approach similar situations as adults with a great deal of caution, skepticism and often cynicism. Again, they are hypervigilant about what threats await them in a classroom or in an everyday kind of scenario. They are well acquainted

with situations which look suspiciously like a "set up" or a "trap." They know when to back off, disappear, become silent, or create chaos in order to draw attention away from what they perceive to be their inadequacies. They are masters of manipulation, and could run seminars on the art of diversionary tactics. They are survivors of repeated humiliation and shame which has been lived out, often on a daily basis for many years in front of their peers, their friends, their families. They are survivors, and finally thrivers, of the finest calibre. The reading circle remains an imprint, a constant reminder of what has been, and what still threatens to be.

. . . As Adults

The trauma goes on.
The drama continues.
The rhythm,
the beat,
the patterns repeat.

-J.U.Adelizzi'95

Adults with LD are not grown up children with LD. The condition, disorder, or difference evolves into a very complex phenomenon. It goes beyond the physiological experiences as a result of psychological trauma, or more specifically classroom trauma. It insidiously manifests itself into every facet of a woman's life. Many years of coping and adapting to processing information in order to survive a class, a lecture on arts and crafts, a conversation with friends, or completing homework assignments with children, creates a diverse structure of thinking and behaving which is not a necessary routine or function for adults who have never experienced learning difficulties or differences. It goes beyond surviving the whole life experience because according to Merriam-Webster survival means literally to remain alive and existent. This quest for a state beyond survival is dependent

upon the coping and adapting skills to become the prime movers in this evolutionary process. The traumas which have been sustained as a result of learning disabilities affect learning on all levels, and everyday functioning both in and out of the classroom environment.

One of the questions I asked the women during our interviewing sessions was how they felt their learning disabilities affected their adult lives. For some women this meant primarily their experiences in the intellectual arena, for others it was inclusive of adult relationships on virtually every level. Listen to their stories.

Elizabeth searched back in her mind to when she was graduating from high school.

"I got married and had children quickly. I probably thought that like my mother I will stay home and be a housewife. That's all I guess that I can do."

Today, over twenty years later, Elizabeth is completing her undergraduate degree. Despite her hypervigilance about her learning environment and the teachers or professors with whom she interacts, she is a conscientious student and an academic achiever as an adult.

Jean had difficulty with the question at first.

"Oh God. That is such a hard one. How such a thing at such a young age that could affect my life, even today at 42 years old. I think - I know for a fact that it has stopped me from making choices in my career. It has probably stopped me from going on in areas of my education. It has been like a burden - I want to say a weight on my neck. You see a cartoon and you see a person with a chain and they have this weight - this bowling ball. But, mine is even bigger than the bowling ball. The bowling ball you can pick up. And mine - this is huge - maybe it is not huge for everybody, but for me it is huge. It is so big. Just being a huge thing that I can't even really push. I feel like it is just moving - creeping. It is not really moving and as many times as I have taken courses, and

I have had tutors. I feel like I go a couple of inches and then I am stopped. Then I go a few more inches and then I stop."

I asked her if the ball was bigger than she was.

"The ball is bigger than me on a short, little chain."

"Today I know at 42 how important it is to have the things that I don't have - the skills that I don't have. The chain seems so short because I am going into another century and everything is computers. Everything is knowing how to read and how to comprehend information that you are given."

"In my heart and soul I feel like why did I get kicked in the rear! Why didn't I get all of the pieces of the pie? Why are my brothers O.K.? Why are my sisters alright? Somebody could say, 'oh, gee, you're not literate in math because you can't do this or that'. But, I can survive that. I can do my checkbook. I can balance. I can go to the store. I can pay my bills. But, what I can't do is to sit down and have an argument with somebody, and then write a letter and send that letter off and have that letter reflect exactly what that conversation was about. That I can't do."

I asked her again for clarification if she felt that her LD had impacted her life.

"Absolutely. It leaves me half a person. It leaves me half a person."

Darleen and I had been having a lengthy discussion about the challenges and struggles she faced as a child in the classroom . I asked her how this affected her as an adult nearly fifty years later.

"Well, I am ashamed. I feel ashamed because I feel stupid. I feel that it's worse as an adult because as a kid you kind of fluff through it. I didn't want most people to get too close. I could tell my girlfriend that I couldn't spell and that was O.K., but she didn't know I couldn't read. We used to go to the movies every Saturday, and my favorite was Roy Rogers, only I couldn't read his name on the board. I would say to her, 'what is the

name of that movie? I missed it.' See, I could get away with that, but as an adult you can't do that."

I asked Stacey how her learning disability has affected her adult life.

"Well in some ways it is the best thing that has ever - it is great that I have a learning disability because it keeps me away from the high-powered, stressful, uptight world. I'm in law school now."

I wondered if she understood the contradictory nature of her statement.

"But it's also very limiting. I can't see a subtitled movie. Not that I ever wanted to before, but now I have been wanting to, but I can't. "

"I know that every time I apply for a job I have to tell them that I have a learning disability. I also don't want to be given shit for it later. I want to be able to say 'I can't write incredible briefs for you, and if you can't handle that then don't hire me.' So, in all of my interviews I have said, 'this is me', very loud. I have a mission. I have a quest in the world and I can't do these 3 things. I can do lots of other things that nobody else can do for you, but it is limiting. No matter what - if I drive into a street and turn around and go back out, I always go the wrong way."

Maria defined herself as dyslexic. I asked her how being dyslexic has affected her adult life. She was in the midst of completing an undergraduate degree.

"Sometimes I feel illiterate. I went to the Science Museum with my daughter and I hated myself. I could not read, believe it or not, some of the words that they were describing for the earth. So, I just said, 'I'm not going to read it.' And I hate that because she wants to know. And I want to be able to tell her and I can't , and that is frustrating. That is frustrating when I can't break it up into syllables and sound it out for myself so that I can read it. The other thing is that there are people standing there so in order for me to

learn I sometimes have to hear it - seeing doesn't do a lot for me so if I hear I won't forget it. But it doesn't mean I have learned it, either. Once you say it though, I won't forget it."

As an adult, Maria has become acutely aware of how her learning disability has moved with her into adult life, and how she has tried to master its manifestations in order to cope with daily living. The frustrations emerge when situations call upon her to demonstrate skills which still present themselves as major obstacles in her learning and functioning.

I asked Louise how, in retrospect, her LD had affected her adult life. Louise holds two graduate degrees and is an advocate for individuals with LD.

"It has affected my employment history for sure. I lost jobs because of it. For two reasons. One was because I was so unhappy at this one job that I use to have lots of anxiety attacks and that sort of thing so I would have to leave a lot. The other was performance. I couldn't spell. I couldn't write well, and so that would always surface. I couldn't follow directions that well - verbal directions."

"I was accused by a number of people I was involved with as being spaced-out - that I wasn't really listening to them. I didn't remember what they said - that kind of thing. I also tended, not so much anymore, but what I still do on occasion, depends on where I am in my head. I still respond strongly to people being negative or critical of me."

Myra thought about my question for a while.

"When I do certain things I sort of draw back because I don't feel I can do it. Like if I am going to apply for a job and I know I have to read and stuff - I wouldn't apply for a secretarial job. I know that I could do certain things, but you have to be a good speller. You have to speak. You have to have good communication skills. And sometimes when I am talking with somebody some of my words don't come out the way it should so I wouldn't apply for that job because I already know my deficiencies - I know what I cannot

do. I wouldn't apply because I might be embarrassed or maybe asked to read something and couldn't read it. "

"I did a work-study as a receptionist. One day a man called and asked me to read his messages over the phone to him. I was nervous and didn't want my supervisor to think I was stupid. So my strategy was if I didn't know the word I would skip over it. He wouldn't know unless he could see the message for himself."

Myra's coping skills had been artfully acquired over the years. As with many adults with LD, carefully thought out strategies are employed in order to survive from one experience to the next, waiting vigilantly for the next situation to present itself. Unfortunately, some strategic planning can cause more difficulties. For instance, if Myra had "skipped over" some vital language in the telephone messages, the meaning of the message could be altered and misinterpreted by the person calling. However, for some women with LD, risks of this nature are still worth taking in order to maintain their dignity.

Ellen responded to my question with a sigh.

"I think that it is really a shame because I think that I could be something better if we didn't have all of that trauma going to school. And I could have a better job, and my degree. It has really, really damaged me. Your self-esteem is not as high. If I get a project at work and they say, 'Ellen you do this,' and I will say 'me? I can't do that.' And then I will always get someone to show me how to do it or something. They'll say, 'you know you can do it.' And I know I can't do it. That is the way I feel. I believe I can't do it!"

The Secret

Whisper,
hide,
protect your pride.

Dignity
speaks
to the secrets inside.

-J.U.Adelizzi-95

Throughout my research project the women talked about what lengths they would go to in order to "keep the secret." By the time they reached adulthood it became a philosophical issue as well as one which required vigilance on a daily basis, constantly scanning the environment for possible "traps." To tell or not to tell about their learning differences was a dilemma which might have required a different decision for each woman, depending upon the circumstances. The "secret" for many women was something worth keeping, hiding or disguising. A great deal of psychic energy is expended in the process of keeping secrets.

> So what does the woman do when she finds the secret leaking out? She runs after it with great expenditure of energy. She beats, bundles, and burrows it back down into the dead zone again, and calls her homunculi - the inner guardians and ego defenders - to build more doors, more walls. The woman leans against her latest psychic tomb, sweating blood and breathing like a locomotive. A woman who carries a secret is an exhausted woman.
> (Estes, 1992, p.378)

Louise had made some difficult choices over the years in terms of keeping the secret. There were times when she emerged as the advocate, and other times when she knew she would have to be as inconspicuous as possible.

"It still happens off and on where I have to keep the secret. Or, I feel that I made a mistake and I told too much. Or, I probably shouldn't have said it. There is usually a lot that goes with it. Sometimes, I like to keep the secret because then I can do this, 'ha, ha, you don't know what I know.' Then I get lots of pleasure out of eventually saying it at the most opportune times. It's my chance to get rid of some of that old, wanting to get back at people, kind of feeling.'

Claire began her response to my question by standing up, pacing the room again, making exasperating kinds of noises. She too, emerges as an advocate for adults with LD.

"Well, I am unusual in the sense that I have made it my avocation and vocation that I still - I guess because it is invisible - I don't know. There is always that self-doubt. I don't know whether it is because you do have those old tapes playing - if you didn't try harder it would be O.K. It still evokes anxiety because you are then put in the same situation where you are trying to defend yourself against something that you have accepted yourself for."

"People in wheelchairs aren't questioned. It is practically seen as rude! It is rude to ask someone, 'oh, how did you end up in a wheelchair?' You don't ask those kinds of questions. No matter what - you are still going to be impeded whether you want the secret out or not because if you don't let the secret out you still have to take another path in order to understand the information or get the job done. But, if you do let it out you are going to be impeded by trying to justify it or explain it to someone. So, no matter what there is still the impediment whether you let it out or not."

"So when you finally go through years of therapy and accept it and integrate it as part of yourself you are still going to have to deal with other people's bullshit and the

anxiety and anger that that produces having to even be in that situation when you have worked so hard not to be in, and then if you don't say it then people are going to be looking at you like you are stupid."

As a noun, a mask my be defined as that which conceals or disguises. As a verb to mask means to conceal from the enemy. This of course, is all according to Merriam-Webster. According to Sally Smith (1991), the founder of the The Lab School in Washington, D.C., a mask is a carefully designed construction to present to the world in order to draw others away from what is perceived by the self to be inadequate.

> When we don't want people to see us as we are
> we put on a mask.
> When we want to hide what we're ashamed of
> we put on a mask.
> Then nobody can know the darkness
> of our secrets within.
> (Smith, 1991, p.44)

The women who were interviewed for this study talked about the many ways in which they found to "hide." For most of them the secret grew disproportionately over the years, until as Jean said, it became huge, overbearing, a big ball on the end of a very short chain which hung from her neck. Hiding the secret becomes part of life, it becomes part of a person's daily functioning.

> The wounds of trauma wear many masks: anxiety, panic, depression, multiple personalities, paranoia, anger, and sleep problems; tendencies towards suicidality, irritability, mood swings, and odd rituals; difficulty trusting people and difficult relationships; and general despair, aimlessness, and hopelessness.
> (Root, from Brown & Ballou, 1991, p.229)

. . . . . Dreams

Four of the women who were interviewed for a second time went into some detail about the patterns and nature of their dreams. Throughout the last five years, working with women who are LD in a support group setting, the discussion of "bad dreams" has been a prominent theme. Although I did not engage in discussion about dreams with all of the women in the study, I felt it was well worth exploring with a few of the women.

I asked Ellen if she had dreams about her classroom experiences or about things related to the kinds of traumas she endured during those years.

"For years and years and years and years I dreamed about that man teacher. And of course it was always a nice dream."

I was surprised, and said "A nice one? That seems very unlike what you described as what it was really like with him." She shifted the subject to her brother.

"For years and years and years and years I dreamed of my brother because he was really awful. And I was always telling him off in my dreams. In real life I never did, but in my dreams I would tell him the things I wanted to tell him."

I asked her if she thought that in her dreams she was trying to change or correct the reality of her traumas. She was thoughtful, but didn't respond. Instead she talked of how her brother, and her former teacher had died.

I asked Jean about her dreams.

"I can't ever remember a dream where I left it feeling excited or happy or laughing. Usually I have dreams about things happening that I am not expecting."

Jean is very vigilant about her personal safety. She has learned to be a very careful observer of people and of her environment in order to avoid exposure or embarrassment.

"I just want to look and see where I am (in the dreams). I guess that would be like being scared now that I think about it. You look all around. I usually don't run away from things. I like to know where I am - what is going on!"

Louise's perspective on her dreams took on a much more tangible and reality-based interpretation.

"The recurring themes are lockers. I have locker dreams. It's funny because I interviewed someone the other day and she talked about getting lost at her locker . It's always the same thing. They are gray and I go there to get my stuff, my books. And it's been ransacked. My books aren't there. I can't find what I need or I can't get into my locker. I can't get the thing open. It is a very, out-of-control feeling!"

In her interviewing, Louise talked often about feelings of confusion, feeling lost, not being able to "find her place." Her experiences with violence in the classroom still haunt her with feelings of violation and a sense of disruption in her dreams. I asked her how she felt when she awoke.

"Out of breath, tired and a little freaked out. I have them so often. They come in spurts and I just get kind of used to them and go back to sleep. Sometimes, I get really mad about them because they are annoying. It happens around school stuff or work stuff where I feel like I am pressured to perform."

"I don't recall having good dreams. I don't think that I have them. I think that I only have bad ones, actually. Disturbing ones or ones that just don't mean anything. There is no feeling in them at all."

I asked Claire what kind of dreams she had.

"Well, I just have extremely violent nightmares. I have had dreams of my head exploding, my brains being splattered across places. The other thing is if you are talking about language and integrating - I guess this is a whole other aspect of the learning

disability - emotions. That is information too, and how you process and then synthesize and then try and deal and catalog those emotions is just as hard as trying to synthesize and deal with the written word. And how that plays out."

"I don't know then if someone could just have a simple dream of someone - the teacher isn't usually hitting you with a book. It is more like you spontaneously combust in your dream or that - I have really gross nightmares! They are really disgusting - people eating other people. They are usually dreams of total consumption or total destruction or violence. It is not necessarily me chasing after people. It is usually that kind of unexplainable, hidden emotional force from somewhere that is not ever tangible. I guess that you can never put your hand on this thing. You can't ever put your hand on it."

Unpleasant dreams had become prevalent and intrusive in the lives of some of these women. Their classroom traumas played out in their dreams, sometimes in very literal interpretations, sometimes in abstract and symbolic form. Whichever way the dreams presented themselves, the dramas were recreated and revisited over and over again. Trauma, upon its return in different disguises, or in different masks, must repeat itself like an old familiar song whose theme has been rewritten and rearranged in order to suit the times. In the case of Ellen she strove through her dreams to rectify what she perceived as wrong, as evil, so that the outcome, or the script was rewritten according to her moral standards and ethics. For others, the insidiousness of their experiences took the shape of mysterious enemies to be cautious and vigilant of in consciousness and in unconsciousness as well.

> Dreams, the ordinary coping devices for warding off internal emotional conflict, do not "work" after massive horror, terror, and disgrace. Dreams simply are too weak a mental mechanism to handle this kind of intensity. The psyche will use its ordinary, old coping devices, dreams, but it cannot successfully work off a trauma this way. The mechanism overworks. The dreams

> repeat and repeat. In many instances the mechanism fails to burn out on its own, however. The traumatized dreamer may be granted a month's rest or even a year's respite. But sooner or later the posttraumatic dream will come back. Traumatic anxiety apparently does not spontaneously dissipate during one's lifetime. Once this anxiety has been set into motion, it may recur with new life stresses, especially those that carry echoes of the helplessness and loss."
> (Terr, 1990, p.214)

. . . . . *On Effects*

> The adversities faced by people with learning disabilities often give them enormous drive. Called stubborn and inflexible because of their single-mindedness, they sometimes reach their goals through sheer, dogged tenacity, at a cost that is almost beyond belief.
> (Smith, 1991, p.71)

The women easily discussed how as adults they felt their lives had been affected. However, I felt it necessary during my second interview with four of the women to ask if they felt stronger in any way as a result of their experiences as women with LD both in and out of the classroom environment.

Louise quickly answered my question with a definite "yes." I asked her to elaborate on her response.

"I feel like it's almost a gift. I also try to talk to my students about that. I feel like it's a gift because if you are driven enough or smart enough to understand that it is a gift,

you can reach pretty far. If you have peaks you can really stretch those peaks. And I think some LD people - a lot of LD people who are really successful, exceed at that."

I asked Louise if it ever felt contrary to what she had described.

"Oh yeah! I will go right back to the old script. I will quickly flip into this thing that I do where, 'poor me! I got such a late start in life. The stupid public school teachers.' You know, I can run the tape. Then I start feeling really bad, depressed, angry. It's never in the middle; it's always an extreme."

We both reflected upon how she spontaneously answered "yes" to my question until she began to talk her way through her own process. Then she realized how both negative and positive emotional responses were present within her.

Ellen was cautious before she answered. But when she made up her mind to speak, her tone was angry.

"No, I don't think my difficulties have made me stronger! I think that it has held me back because I would like to be more than I am, but I never thought that I would even be what I am now. And, I don't think I would be doing what I am if it wasn't for my boss. I didn't even go after this job; he made me do it. He just said 'give it six months', and now I am probably better than anyone else. Not better at doing it, but more conscientious."

I told Ellen that probably a lot of people cared about her and believed in her capabilities.

"Maybe, maybe. Everybody says, 'you can do it. You can do it' And it is really, really, hard. I go home and get exhausted and I say, 'why do they say I can do it. I know I can't do it!' If feels like there is so much pressure. Even my daughter does it to me. She says, 'I know you can do it', and I resent her. I resent someone telling me that they know I can do it because they are not giving me a choice to do my own thing. That is the way I feel."

"Oh, God, the pressure is so bad that sometimes I just want to sleep. I'm tired because I'm thinking, thinking, thinking! And sometimes I know I can't express myself. Like some of the words that I was thinking are simple words, and I know them, but I can't express them. I mean everything just goes out!"

In the years I have facilitated support groups for women with LD, I often heard many people complain that well-intended family members and friends say "you can do it, I know you can", not realizing the amount of pressure which is placed on the recipient of their remarks. Again, the pressure to perform, to succeed, to please, looms over them, creating a stifling effect, making them want to flee the situation or just shut down entirely. After all, if you look as if you are not capable, then people will not impose great expectations on you. The pressure is off!

Jean was anxious to tell her story. She had spent a great deal of time in her support group reflecting on how her LD and her prior classroom trauma impacted her learning and functioning.

"I would have to say 'yeah, it has made me stronger.' I guess the only thing that I know is what I have right now. I can't imagine being a good reader and speller, but I probably wouldn't be the person that I am if I was. I would be somebody different. My mother use to always say that God gives everyone talents. I think the person that I am today, even though I struggle, and I still have a lot of shame with my spelling and reading . . . but I think that I am a compassionate person. I think that I am a fair person. I think that reading is a disability and reading and spelling - because to me they are hand in hand - that they are a disability that is unseen."

"It is not like somebody who has got a seizure and then it shows up and the whole world can see it. It is not like somebody having an arm or leg missing or somebody who is blind. It is right out there. Somebody having a reading disability or learning disability is a disability that is hidden. And because it can be hidden it can be put away and you don't

have to deal with it. But then when it comes back all that emotion and stuff comes back with it. All that shame and pain comes."

"The more support groups I go into - every group has brought me to another place. Every experience has brought me to another place. So for me my disability has brought me to where I am today. With the disability I am constantly trying to find out more. I'm constantly out there trying to figure out more. Learn more. Push my own boundaries a little bit further."

"I have come to the conclusion that my writing, my spelling, is an issue that I can't beat myself up over anymore because I don't see it doing anything but tearing me down, and that I have to deal with the fact that this is my disability. I don't want to pull myself down. It might take me another 40 years before I could spell or read the way - and I have high standards for my reading and spelling. I guess that I go back to what I said earlier that I would not be the person that I am today if I had not - the only experiences that I know are the ones that I have lived."

Jean, like Louise, responded initially with a positive attitude about how her learning disability and classroom experiences had impacted her adult life. It was only after she had talked her way through her feelings that she acknowledged her historical concerns. In her adult life she had begun to integrate the positive and negative feelings associated with her LD and the experiences she remembered.

Claire, being the passionate advocate that she was, responded quickly to my question.

"Yeah, it has made me stronger. Kind of like someone in a wheelchair - do they have stronger biceps than other people? Yeah, but can they walk? No! I don't know whether the strength is because there has been so much self-repair. Yeah, it has definitely made me a lot stronger. It has probably made me a more sad person. A more regretful person, that maybe I didn't have the strength back then to really stand up and fight for

myself or that it took so many times being pushed down and a lot of mistreating of yourself, and believing other people's words to actually believe in yourself. But then there is still always the doubt. The doubt never goes away especially because the disability is so inconsistent. And also because it changes developmentally."

"You never know when you are going to fall into that black hole. And it takes a lifetime of experience. You never know what is going to trigger a depression, and it is those damn black holes that you have to fall in and brush yourself off and somehow get back up in order to understand where the next black hole is. You can just never relax."

"You absolutely never know when it is going to happen. And to this day, as aware as I am of my disability and as aware I am of other people's disabilities, and all of the intricacies and stuff- that awareness only gets you awareness. You still have to work, work, work to make sure that you never let the guard down. Because the minute you think that you can get by one day - it is like an eating disorder. You can never put your guard down. And yet you need to eat for daily life."

We reflected on relationships together.

"All of those things you had trapped in you as a child. You get filled and overcome with rage because you know that you were right and you know that you didn't misunderstand the situation. You can end up then either feeling victimized by your boss or by that friend or by that situation, saying, 'oh, God I misunderstood it again'. Or, 'why is it always me?' Or you can be extremely aggressive and completely overreact to the situation. Practically being out of control, saying, 'no, you son-of-a-bitch, you aren't going to pin this on me!' Or, 'fuck you I have fought my whole life protecting myself against people like you.' It is kind of like passing that threshold."

By this time she was breathless. She paced the room as she spoke.

"And so you say has it made me stronger? What does that really mean? Has it made my spirit stronger? Has it made my body stronger? I have had more physical problems that can't be related to anything than any single person I know that is my age.

Not unless they were raped and beaten and had every bone in their body broken and then shot at several times. It is kind of like the emotions trying to get out even though they have come from something from the outside."

"It is just that it is invisible with the person who has been emotionally abused. You can't see the gunshot holes on the outside, but if you were to turn that person inside out you would see the amount of stress and horror that that person has been caused. The scars, the riddled potholes - how their hands appear to be or their limbs appear to be fine, but they're all twisted and casted up and sewn and have metal rods and pins and false bones and everything."

I felt her anger searing through my body as we completed the interview. And again, the initial positive response ended with the acknowledgment of an inner, never ending battle, complete with graphic descriptions of the casualties and sacrifices which had been endured. These were just some of the effects . . . . .

It is important for me to explain that even through all of the tears, the anger, the resentment and the bitterness, there still remains a core of stability and truth within each woman. The joys do not surface as quickly, as spontaneously, as they might for some other women, but the ability to experience joy, to desire joy, and to impart it to others is strong within each woman. It is with a humble kind of respect for these women that I find myself repeatedly reflecting upon this during my research, and especially during my writing process.

Chapter IV

RESEARCH DESIGN, DISCUSSION AND ANALYSIS

A .Introduction

This chapter is a description of the methods which I employed in order to achieve the *qualitativetruth.* about the impact of psychological trauma on learning and functioning

in women with LD. The truth I speak of emerged as a result of the stories told by the women who were the research subjects. I will discuss the methodology employed, an analysis of my procedure. Describing my feminist approach to my research is the essence of the methodology; it is the contextual background. It is what directs each instrument, each interpretation. The results of my study will be described in The Conclusion of this chapter; the themes which emerged will be described in greater detail in other chapters throughout this dissertation.

The experience I brought to this research was inclusive of my background in working with women with LD in a support group setting, and my background in diagnostic testing as an educational therapist. In order to bring to life the research methods I employed I investigated the field of psychological trauma, thereby identifying the sub-category of classroom trauma. It is my intention to integrate the fields of psychological trauma and women with LD in order to address the relationships between these disciplines. When the themes and common grounds between these two areas are discussed and identified, then it becomes easier to recognize the impact that psychological trauma has on learning and functioning in women with LD. When the fields of psychological trauma and women with LD are investigated and connected to the subjects of my research, they are likened to the trees in the forest as they begin to stand out, take definition and meaning, making the whole picture fall into proportion and perspective. The forest begins to take the shape of a comprehensive, holistic kind of entity. The trees, each one unique in its own distinctive form and presence, are the elements which help to make up the whole, yet are able to stand alone as meaningful entities.

For a very long time before I committed myself to doctoral work I thought about the women I had worked with in support groups and in one-to-one interactions. Although they shared the common experiences of shame and humiliation, the unconscious emotions which affect learning and functioning, they were all very different human beings, each unique in her own way. They shared their struggles with learning, some with reading,

some with spelling, some with the ability to express themselves in writing, some with visual-spatial relationships, and some with interesting and comprehensive combinations of difficulties. Additionally, they all came to the groups year after year with nightmarish stories of classroom traumas which had been experienced since childhood. By the time they reached adulthood, they recognized these traumas as events which had directly affected their lives and left them fearful of returning to school, an arena in which many women longed to experience a sense of competency and success. Many group members had suffered other types of psychological trauma as well which added to their lifelong struggles both in and out of the classroom environment. For some, their learning disabilites had impeded their ability to function well in social situations; they did not "read" people well. Ultimately, they were left trauma-vulnerable, open to yet further abuse, and layer upon layer of shame and humiliation.

Historically, the problems of these women have been regarded "lightly" which encourages them to keep their secret as well hidden as humanly possible. Educational professionals do not like to think that over the years so many human beings have suffered needlessly. Still today, many educators will refer to individuals with learning differences as "lazy" or "unmotivated." Mental health professionals will often interpret the stories of these women as over-reactions to unpleasant incidents in school; school phobia; over-sensitivity. There is little in this world that can be as invalidating to a human being than that of indifference or the minimalization of another's trauma. For those who have decided that they have lived with the secret long enough, and have become advocates for others with LD/trauma histories, the road to what they perceive to be personal and academic success is paved with many battle wounds, worn with pride yet with bitterness.

Several years ago when I announced that I would be pursuing doctoral work and explained that I would be interviewing and possibly offering diagnostic testing to a number of women with LD, I had many eager volunteers from the support group which I facilitated. However, I also observed a number of women in the group who had worked

very hard at managing their LD at home, in the work place, in the classroom and in virtually all of their social interactions (surviving in relationships is very hard work). For these women, the very idea of my research was threatening. A few women felt it necessary to speak to me privately about it, assuring me that while they thought my work was valuable and would ultimately help other people, they could not even think about participating; this was *exposure*. I learned to respect their concerns, their fears.

When I was ready to conduct a search for participants for my study, I wanted women from many other settings to be included, some of whom had never experienced the benefits of interacting with other women who were LD. The search was on. I sent many letters to many settings describing my study and the participants I hoped to be able to include. I followed up with phone calls. For a while it felt as if nothing was going to happen; no one called back; no one cared about these women who I instinctively knew were out there. Then all of a sudden the calls began. One small inner city setting inquired about my study. They heard about my work from someone else who had been told by someone else. They didn't have my phone number but managed to track me down through other people. Before I knew what was happening, I was being inundated by calls from settings who intuitively knew they were caring for women with LD/trauma histories; they wanted diagnostic testing, and they wanted to become participants in the study. To say that I have established some valuable relationships as a result of my networking, is an understatement. My new comrades made me feel "rich."

As a result of my search for participants, I was able to interview 16 women. Of these 16 women, 2 entered my study with completed diagnostic testing for LD. I tested 14 of the women, establishing the presence of a learning difficulty which correlated with the educational histories they provided as part of the interviewing/intake process.

Three (3) of the women were educated in countries other than the U.S.; one woman was educated in several countries. Two (2) women reported that English was their second language; these women described great difficulties in "switching" from one

language to another, experiencing problems in both (or more) languages. One woman stated that English was her first language, but that she was more comfortable in a language other than English.

I provided 12 women with a list of ethnic/racial categories from the Traumatic Antecedents Questionnaire by Bessel van der Kolk and Judith Herman (1990). The 12 women defined themselves from the categories offered as follows:

1. *2 black southern* women
2. *1 black northern* woman
3. *3 white other* women
4. *1 white Irish* woman
5. *2 white Italian*
6. *1 white French Acadian* woman
7. *1 Cape Verdian* woman

The educational histories of the 16 women who were interviewed were as follows:

1. 4 women were in the process of obtaining their GED's
2. 3 women graduated from high school
3. 5 women completed some college work
4. 1 woman completed a 2 year college degree program
5. 1 woman completed a 4 year college degree and was beginning graduate work
6. 1 woman completed a graduate degree
7. 1 woman completed 2 graduate degrees and was contemplating doctoral work

B. *The Settings*

I was able to conduct most of the diagnostic testing and interviewing in a private office space located in a community just south of Boston, MA. Three (3) women were tested and interviewed in an urban-based community college in Massachusetts. Two (2)

women were tested and interviewed in a correctional facility in Massachusetts. Three (3) women involved in the study were from a support group for women with LD/ADD, and one woman was a former member of that group. Two (2) women were advocates for adults with LD/ADD and worked independently as well as for educational and government institutions. One participant came to the study from a state university. Another woman came from a highly respected law school, and yet another was from an inner city program which supported single mothers returning to school. Two (2) women were from Canada; one from an adult literacy program; one from her bilingual community where she was an advocate for adults and children with LD. I tested and interviewed these women in a small community in an Atlantic Province in Canada.

C. The Instruments

1. The Interview/Intake

The interviewing questions I developed became the intake. Although my questions were specific (see Appendix C-1), ample opportunity was provided for each woman to pursue other avenues of discussion which felt relevant to them during our sessions together. I wanted their responses to be spontaneous; I wanted them to feel in command of where the discussion was moving.

2. The testing: WAIS-R and other supportive testing

I administered diagnostic testing to most of the women. This was necessary in order to correlate their self reported difficulties with metacognitive profiles which may have also provided me with common areas of difficulty found in women with LD/ADD/trauma histories. Additionally, it offered the women deeper insights and explanations for some of their historical difficulties in learning and functioning.

All participants in the study were administered the Wechsler Adult Intelligence Scale, Revised (WAIS-R), a measure of intelligence potential by means of verbal and performance subtests. Some women were administered the Peabody Picture Vocabulary

Test, Revised (PPVT-R), a measure of receptive language, and the Quick Neurological Screening Test (QNST), a screening tool which gives a sample of an individual's neurological integration. I requested writing samples from each woman, and some women received informal reading assessments. The purpose of this chosen battery of tests was to obtain a learning profile of each woman, indicating her strengths and areas of concern.

3. *The Traumatic Antecedents Questionnaire (TAQ)*

As I finished my interviewing sessions with each woman, I felt it necessary to find yet another way to demonstrate the relationships between LD/ADD and psychological trauma. I consulted with Bessel vanderKolk who requested that I use the instrument he and Judith Herman had developed (see Appendix D) in order to determine to what degree an individual had experienced psychological trauma, and what the nature of that trauma was. He encouraged me to develop a component of the TAQ which would determine the existence and intensity of classroom trauma.

The TAQ is a quantitative instrument; I was encouraged to use it in that manner. However, I found it to be an effective means of triangulation for my qualitative study, and used the results to demonstrate clear correlations with the women's stories which developed as a result of the interviewing questions. The TAQ proved to be a valuable means of gleaning yet deeper information and was complimentary to my own qualitative methods.

D. *The Methodology*

As I mentioned in my description of *The Researcher*, my methodology was feminist-based; I truly wanted to be *with* them in my study as opposed to being in an authoritative role. The epistemologies of feminist empiricism, feminist standpoint theory, and post modernism state "that women can indeed be knowers and their experiences are sources of knowledge" (Campbell and Schram, 1995, p.87). In order for women to be the knowers without the validation of quantitative data, they demonstrate the truth through

expression. In this study, their expression was articulated through the telling of their experiences, their feelings, their interpretations, their truths.

Throughout my doctoral studies, and before I began my project, I thought and wrote a great deal about the relationships, both conscious and unconscious, between teachers and students. As I embarked upon my project and began interviewing women, I thought I knew what the relationship would be like. I learned that I didn't know, but that I was learning.

"Feminist methodolgists have criticized traditional approaches to data collection in which the primary goal is just to get the questions answered" (Oakley, 1988, from Campbell and Schram, 1995, p.88). At no point during the interviewing process did I feel that my goal was to "get the answers." We discussed the questions, elaborated, often sat in pensive silence together, and spontaneously moved to related issues from time to time. However, when I began administering the TAQ I immediately felt a difference. I was asking a question, and then offering a list of possibilities; the instrument became an objective test. Multiple choice questions were where many women with LD had great difficulty in identifying the nuances in expression, the similarities in language, the "tricks" in choices. Soon into this process I decided that I would ask the question, offer a list of choices, and then discuss the choices in some depth with each woman. Often this led to deeper discussions and interpretations made by each participant, and also led to distinct correlations between the responses to my questions and those on the TAQ. For example, when we discussed each woman's background information, it was pointed out to me by almost all of the women that the choices were not at all inclusive. Many of the women spent a great deal of time re-creating the list of possible answers which led to yet further discussions about their own cultural and racial identities.

The women also felt it important to inform me that the TAQ did not include a comprehensive list of choices in terms of the kinds of psychological trauma experienced (e.g., witnessing death, witnessing another's abuse, and cultural abuse).

E. *Methods of Data Collection*

1. *Gaining access*

After I began to receive responses from the letters I sent, I telephoned the director or coordinator in each setting. The people who were responsible for their settings introduced me to the women in their care, usually by telephone. We talked at least once before we had our first interviewing sessions; often it takes several telephone conversations before each woman feels comfortable talking to me face-to-face about past classroom experiences. Despite each woman's desire for diagnostic testing, the mere thought of a "test" is frightening, often conjuring up very old feelings of shame and humiliation, not to mention the fear of failure.

Gaining access to a correctional facility was much more difficult than seeking a welcome from other types of educational or therapeutic settings. I was fortunate that the administration in charge of the educational component of the women's correctional facility I contacted was very supportive. I described my research, and submitted a comprehensive outline of what the diagnostic testing and interviewing procedure included; I offered this verbally and in writing. I was then required to fill out a number of forms which were sent to a variety of prison officials. I waited for several weeks before I received a formal letter of acceptance. In the interim I had several telephone conversations with prison officials who questioned me about specific points of my research, and who reiterated the rules and regulations about audio taping devices. Several times I was asked what I hoped my research would "prove."

2. *Technological assistance*

I learned from a pilot study I conducted several years ago that I needed to invest in quality audio taping equipment. I also learned that I needed to have two tape recorders, and more than one microphone. I used a standard audio recorder which had its own microphone built into the system, and I also used a mini-cassette player; I used both pieces

of equipment simultaneously in case of unforeseen malfunctioning. At first I used an extra microphone which can be attached to clothing, but discovered that these extra kinds of devices were unnecessary. On more than one occasion one of my recorders malfunctioned; on one occasion both recorders were not functioning.

One of the many requirements which the correctional facility made clear to me was that under no circumstances was I allowed to bring taping equipment into the prison. I was allowed to bring in pens and pads of paper, but nothing else aside from my diagnostic testing equipment which was carefully scrutinized upon each arrival. Being denied the use of recorders was a frustrating experience for me as I felt a disruption of the flow in my listening and participation in the relationship when I had to make notes. Additionally, the women I interviewed in the correctional facility were very insightful about their LD/trauma histories; the data was as rich as the personal experience was for me. It was difficult to re-construct their language as it described their feelings which were expressed during our sessions because I became so emotionally immersed in our interactions.

3. *The Interview*

The initial interview questions (see Appendix C-1) were administered to16 women. Each interviewing session took anywhere from 30 to 120 minutes. After consent forms were read, discussed and signed, I made it as clear as possible to each participant that the tape recorder would be turned off when subject matter was discussed which an individual did not want disclosed outside of our private conversation. For some women this meant that the recorder was shut off frequently.

I administered a second set of questions to 4 of the women (see Appendix C-2). Again, each session took anywhere from 30 to 120 minutes. These sessions burrowed deep underneath themes and issues which surfaced during our initial sessions and/or as a result of conversations during the diagnostic testing situation.

4. *The Testing*

I administered testing to 14 women. Before the session began we talked a great deal about prior educational experiences, and talked informally about school, teachers and plans for the future. Often this kind of conversation was as productive as the actual interviewing questions. As I have done with most of my private clients, I stopped periodically during the testing session and discussed the meaning of specific subtests which I knew directly connected to behaviors and feelings experienced both in and out of the classroom environment. For instance, the Picture Arrangement subtest on the WAIS-R gave many women trouble. We discussed how this task may indicate an individual's ability to visually sequence and plan as well as "read" a social situation. This opened the door for valuable discussion about the ability to organize information on a number of levels as well the ability to survive in relationships.

Supportive testing was administered to confirm difficulties which emerged on the WAIS-R. For example, many of the women experienced trouble in both expressive and receptive language. I administered the PPVT-R in order to correlate those results with other indications as a result of the WAIS-R and our conversations. For many of the women it was important to administer some if not all of the subtests on the QNST in order to identify neurological difficulties which needed to be referred for further neuropsychological evaluation. Additionally, some subtests of the QNST correlate with findings from other testing (e.g., WAIS-R), confirming suspicions about difficulty with hemispheric integration which may interfere with a variety of tasks in learning and functioning.

Some women completed the testing in one session; for others, the testing took two sessions to complete. Each session lasted anywhere from 75 to 120 minutes. A consultation session was offered for each woman; I spoke with a few women over the telephone, but most received feedback from their testing in person with me. Additionally a written evaluation was provided as well for each participant, describing their metacognitive

profiles. We discussed their learning strengths and difficulties and the relevancy of these issues academically and socio-emotionally. The women who came to the study with their testing already completed were given an individual consultation session where we discussed their metacognitive profiles and the implications of their results.

The discussion during our consultation session where I presented each participant with feedback from their testing was in keeping with the interviewing questions which I administered. The conversations which resulted from the testing and interviewing sessions was compatible; there was a smooth flow, one overlapping and integrating with the other throughout the project.

F. *Data Analysis*

1. *Triangulation*

I knew that I needed to find more than one way to address *The Impact of Psychological Trauma on Learning and Functioning in Women with LD.* I felt that interviewing alone was not enough; this came from my own needs to look at a problem from a variety of perspectives, layering proof upon proof in order to validate my hunches. I felt strongly that I wanted to at least consider the similarities I might find on the women's diagnostic testing, specifically the WAIS-R. Additionally, I wanted validation from yet another source of inquiry of my findings from the interviewing questions.

Nearly half way through my study was when I spoke with Bessel van der Kolk, a specialist in the field of psychological trauma, and described my project to him. He asked that I include The Traumatic Antecedents Questionnaire (TAQ), an assessment tool designed by he and Judith Herman which would offer me an indication as to whether the women had actually sustained significant psychological trauma. Of course I knew that they had by the mere fact that they were LD and had been repeatedly exposed to public kinds of humiliation. Many in fact, became trauma-vulnerable as a result of their inability to read people and situations, leaving them open to further exploitation and humiliation. Despite

what I knew as a result of my observations and interviewing, I wanted to be sure. I wanted to test my hunches with yet another method.

As I studied the TAQ, I also investigated methodological triangulation, more specifically a between-methods of triangulation. "The rationale for this strategy is that the flaws of one method are often the strengths of another: and by combining methods, observers can achieve the best of each while overcoming their unique deficiencies" (Denzin, 1978, p. 302 cited by Mathison,1988, p.14). I knew then that I could look at: 1.) the women's metacognitive profiles (specifically the WAIS-R results), 2.) the themes which emerged as a result of the interviewing questions I designed, and 3.) new, and especially correlative information which presented itself as a result of the TAQ. I felt confident that I would uncover similarities in strengths and weaknesses, but that it was legitimate to do so, and would lead me to delve yet deeper into my data. I remained conscious that triangulation does not ultimately seek a single common answer, but creates pathways of discovery for further questions directly related to the initial question or hypothesis.

Even though the diagnostic testing results exist in terms of numbers and quantitative data, subtests which stood out as similarities for the majority of participants were important for me to consider and include as part of what I discovered. Additionally, the TAQ was a quantitative measure, although I felt that the correlations which I could describe and compare were far more valuable than a number I could present which would state, "Yes, she was traumatized!", a very "eureka!"-kind of response. The descriptions of the interactions and responses were far more important than the numbers I could present. Again, the truth is in the women's words, their language, their communications; not in the measurable answers which were recorded as part of a survey.

I looked at the subjects of my study through a multi-dimensional lens; at times I viewed their metacognitive profiles, their interviewing responses and their TAQ, each in

isolation. At other times they fused together, they integrated, they synthesized. Sometimes I would wake up in the morning with my research on my mind, and the three-faceted method I employed seemed to present itself as a kind of symbiotic relationship, each facet embracing and feeding the others. At times it was difficult for me to distinguish between one method and the next as they all seemed to contribute to a comprehensive picture of each woman.

> One begins to view the researcher as a builder and creator, piecing together many pieces of a complex puzzle into a coherent whole. While one can rely on certain scientific conventions (e.g., scaling, control groups, etc.) for maximizing the credibility of one's findings, the researcher using triangulation is likely to rely still more on a "feel" of the situation. (Jick, 1978, p.602)

2. *Looking at the Testing*

Their stories are truth.
The numbers mean less than.

J.U.Adelizzi'95

It is important for me to say that the women's intellectual potential in terms of IQ scores varied as widely as their educational backgrounds and socio-economic experiences. When I began to look over the test scores of all 16 women I reminded myself that I was looking at metacognitive profiles which were indicative of learning differences despite the inflation or deflation on specific subtests or on overall IQ scores. This meant that I was looking at WAIS-R profiles (because I will concentrate specifically on the WAIS-R for the purposes of this study) which either demonstrated a significant discrepancy between the verbal and performance modes of intelligence; or significant intra-test scatter which would

indicate internal disorganization. The many combinations of profiles which indicate a learning difference (or disability) may manifest themselves in expressive or receptive language difficulties or visual-spatial disorganization, just to name a few (see Appendix B).

Again, it is important to reiterate that I eliminated the WAIS-R tests of 2 of the 16 women in this study. I tested both of these women, and felt strongly that because they had been so severely physically abused throughout their lives, and had sustained permanent neurological damage as a result of battering, that their testing was not a true measure of their intellectual potential and quality of thought.

The Strengths: The Object Assembly and Comprehension subtests of the WAIS-R were two subtests where 9 out of 14 women demonstrated strengths. Object Assembly, a subtest in the Performance mode of the WAIS-R, is a visual-spatial-motor task which requires that an individual visualize parts from whole relationships; additionally, there is no visual guide offered for this task. It is considered to be simultaneous processing (holistic, right-brain), and is a "hands-on", trial-and-error task. It was interesting for me to note that this is a strength shared by individuals who have been diagnosed with ADD/ADHD; 1 woman in the study had been previously diagnosed with ADHD; I referred 2 other women in the study for further testing for ADD. Over the past 5 years I have facilitated numerous women in the support group who share the same strength and have been diagnosed with attentional difficulties.

The Comprehension subtest from the Verbal mode of the WAIS-R indicates an individual's ability in reasoning skills; the questions call for situational organization and problem-solving. Most of the women have had ample practice in spontaneously handling situations as they arise; despite any social difficulties they have experienced they are usually able to apply appropriate conscience and morality to a variety of scenarios.

The Difficulties: 14 of 14 women experienced difficulty on the Arithmetic subtest; 8 out of 14 women experienced difficulty on the Digit Symbol subtest. These are both subtests which require sequential processing. The Arithmetic subtest found in the Verbal

mode of the WAIS-R measures an individual's short term auditory memory, and long-term memory in terms of school-related learning. It is considered to be sequential processing (linear, left-brain). Difficulty in this subtest is commonly demonstrated by individuals with LD and/or ADD.

Digit Symbol, a subtest in the Performance mode of the WAIS-R, requires concentration, and like the Arithmetic subtest, is considered to be sequential processing (linear, left-brain). Often it will indicate trouble with tactile defensiveness. "The tactilely defensive child is usually hyperactive and distractible . . . the discomfort and behavioral reactions caused by this disorder do interfere with the learning process" (Ayres, 1985, p.107).

Difficulty with both the Arithmetic and Digit Symbol subtests are often found in individuals with attentional difficulties. This certainly was the case in my study, and has been found in many women in the support group over the last 5 years. Additionally, difficulty with auditory short term memory (e.g., Arithmetic and Digit Span) is often found in women who report to have been diagnosed with ADD. I am still left with the question as to whether this profile is due to LD/ADD (familial transmission) or significant psychological trauma which has been sustained over a period of time, or a combination of both genetic cause and effects of classroom trauma and/or other types of psychological trauma.

3. *The Interviewing Process*

Five (5) intake questions led into the interviewing questions (see Appendix C-1); often they overlapped, one providing valuable information for the other; often an intake question or an interviewing question became a point of reference for the women. The themes of: 1.) shame, 2.) humiliation, and 3.) the "secret" emerged from the questions as the greatest concerns. The women repeatedly returned to their issues about reading; the childhood memories of this concern were referred to by many as "the reading circle." Tales

of shame and humiliation were told through group reading experiences. The "secret" triumphed in adulthood as a resulting effect manifesting itself as a coping and adapting phenomenon.

Over the years I have heard adults with LD continue to focus their shame, humiliation and ultimately their anger, on the "reading circle" just as did the women in this study. Although each woman did not experience the "reading circle" in the literal sense, the idea of group reading was clear whether it occurred in a semi-circular collection of students seated in little chairs at the back of the room, a line-up against a wall of the classroom, or a designated cluster of students within a larger group setting. It ultimately translated into public exposure as a result of mandated oral reading; there was no negotiation, no exit. To live the experience was akin to having one's wings pinned to velvet in order to be exposed for public viewing.

As a result of the first series of questions I noticed that the women began talking about their experiences, working from the description of the actual event to an account of the feelings experienced, both emotionally and physiologically. With this in mind, I questioned four (4) of the women a second time (see Appendix C-2), asking for deeper descriptions of the "reading circle." The women spoke a great deal about being yelled at by their teachers and/or being laughed at by peers. This contributed to the conscious and unconscious decision to withdraw part of the self into secrecy; the secret part of self was the "disabled" part of self.

Additionally, the subject of dreams in childhood and adulthood came into our discussions. Although the dream accounts are open to many different kinds of interpretations, the way in which the women presented their themes from another state of consciousness is interesting regardless of the paradigm from which interpretation may be drawn.

4. The TAQ

The purpose of this tool is to determine whether an individual has experienced psychological trauma, to what extent the trauma has been experienced, and the number of perpetrators involved in each traumatic event.. There are nine (9) parts to the TAQ: Part One: Demographics; Part Two, Current Health; Part Three, Family of Origin Demographics; Part Four, Childhood Caretakers and Separations; Part Five, Peer Relationships and Childhood Strengths; Part Six, Family Alcoholism; Part Seven, Family Discipline and Conflict Resolution; Part Eight, Early Sexual Experiences, and Part Nine, Review and Summary. I designed a series of questions on Classroom Trauma (see Appendix D) and incorporated it between Part Five and Part Six; Peer Relationships questions seemed to segway smoothly into classroom experiences.

The domains of childhood traumatic experiences (up to age 18) and their variables within the TAQ were:

A. Gross Abuse
    1. physical abuse
    2. sexual abuse
    3. witnessing domestic violence
B. Gross Neglect
    1. physical neglect
    2. emotional neglect
C. Separations/Losses
    1. significant separations from caretakers
    2. losses of caretakers
D. Chaos
    1. chaos
E. Classroom Trauma
    1. emotional abuse
    2. physical abuse
    3. sexual abuse
    4. witnessing violence in the classroom

Each subject's TAQ is scored according to the number of psychological traumatic events experienced and by the number of perpetrators involved. The highest scores were found in the domain of Classroom Trauma; this was closely followed by the domain of Gross Abuse.

In the Summary, 2 women asked why the witnessing of death was not a choice. The choices of the most significant psychological traumas experienced were as follows:

3 women chose the death of someone close

1 woman chose physical abuse by someone close

2 chose the mental illness of someone close

1 chose sexual abuse; sexual assault

1 chose alcohol abuse by someone close

1 chose mental abuse

3 chose the experience of being LD

Chapter V

CONCLUSIONS

Once I was able to clearly observe the results of the three research methods I used for the study, my hypotheses became visible through the many hours and pages of theory and analysis which I employed throughout the process. The discovery of what I was trying to say felt like an old lesson from my qualitative research class: *seeing the forest through the trees.* For so long the investigation of theory became thick and heavy like a forest overgrown with vegetation; it was difficult to make the decision when it was time to stop adding to the theoretical base I had established. When I began to look through the data I had accumulated, and sat with it much as you would with a small child in a rocking chair, I began to notice growth and change in this bundle I was holding. I experienced a quietness and clarity of thought when I stood back to look at how this child I was holding was evolving. I was able to confidently say that: ***1.) Psychological trauma impacts***

learning and functioning in women with LD, and 2.) Classroom trauma is a psychological trauma.

It was so simple. It was always there. I had to let it grow and come forward on its own after I had provided the foundation, laid the groundwork. I fed this child and nurtured her. Often I tapped my foot impatiently because she just wasn't looking or growing the way I wanted her to; this came from my natural-based survival-style of controlling my environment and not allowing it to control me. When I gave myself permission to relax, sit back and observe my work, the child grew on her own, presenting to me the truth I had been searching for. Finally I began to feel like a better mother, a better qualitative researcher. The strategy of triangulation provided me with information which enabled me to paint a deeper, richer picture of what I intuitively "knew" about women with LD/trauma histories.

The Secret

The women spoke frequently about the "secret" of LD; as adults the secret had become part of who they were. Many women, as children, were not able to hide their LD. They were often left exposed to the outside world, to their peers. As adults these feelings of humiliation encouraged many women to dig a deep hole, burying the disability as thoroughly as possible. This is survival on a daily basis for many women at home and in the work place. This is how to cope, how to adapt to new and different situations as they arise. Keep the secret, hide the disability; shame can be private, but public humiliation is out there for everyone to view, again, like the "fishbowl effect." The issue of the secret was discussed during both the testing situation and the interviewing process. The "secret" was the residual effect of classroom trauma; it became the cumbersome emotional baggage carried throughout the arduous journey into adult life.

Anger

As I studied the effects which trauma presented to the adult with LD, I became acutely aware of the waxing and waning presence of anger. Although I chose not to bring forth the theme of anger as a prominent issue in this study, I felt it necessary to acknowledge the connections I observed while working with each research method. During the testing situation, most of the women experienced some degree of frustration with at least one or two subtests. For several women, frustration evolved into anger. Often it was necessary to stop the testing and talk about how a particular task resembled certain other tasks which historically presented difficulty to an individual. The process of reflection presented the women with issues reminiscent of old pain, old traumas which were experienced in the classroom. Even during our discussion of the task and the memory to which it may have been connected, some women sighed deeply, complained of rapid heartbeat, sweaty palms, and had a need to get up and move around the area. Their responses to our reflections were similar to their responses of past situations which caused them extreme stress or panic.

The interviewing questions evoked many of the same kinds of responses, both emotionally and physiologically. Each question asked left ample room to move around in conversation, spontaneously touching upon memories which connected to a specific question. As we began the TAQ, the issue of anger emerged numerous times, but never as severely as when I questioned the women as to whether as adults they had been involved in physical fights.

The TAQ asked: "Since the age of 16 were you ever involved in a physical fight that included hitting, punching, or use of a weapon?" Eight (8) out of 10 women responded "yes" to that question. Following that particular question the women were asked to clarify their responses: "who was the perpetrator?", "who was the victim?" Seven (7) women out of 10 said that another person was the perpetrator in specific situations. It was noteworthy that 5 women out of 10 reported physical fights as older adolescents and adults in which

they became the perpetrators. As a result of anger, or as the women described it, "rage", they were able to remove themselves from the victim role on particular occasions, and become the perpetrators of physical violence. I feel it necessary to add that when the women described their rageful events, the recipients of their actions were other adults.

During the interviewing sessions when we discussed educational history and classroom trauma, I became acutely aware of how angry the women became when recalling painful and humiliating experiences. However, I was not aware of the depth of their rage until I looked at the responses from the TAQ. Although I wish that I could address this issue of rage as it connects to the women's experiences in the academic and intellectual arena, I am not able to begin that aspect of my research results at this time. Additionally, their trauma histories are inclusive of other types of psychological trauma besides classroom trauma; the complexity and grave importance of the issue demands much more attention than this dissertation can allow.

Conversations: The Reading Circle

The "conversations" I refer to in my dissertation differ from one individual to the next. They are reminiscent of "learning conversations", a reciprocity of dialogue which reaches underneath any given topic of discussion as described by Michelle Gabow (cited from Adelizzi & Goss, 1995).When I asked a question such as "Can you tell me about your experience in elementary school?", I elicited varying responses. Some women told me about their experiences in the "reading circle" before we even touched upon the subject of reading. Some women began by telling me stories of physical and emotional abuse they sustained in the classroom during those years. Almost all of the women covered the same subjects; the time frame differed; the sequence differed. I had to let each of them direct, orchestrate. They spoke many of the same truths, but in different ways and from different perspectives.

The term "reading circle" encompasses the many different arenas which teachers provide for their students to read aloud to a group. They are old methods; they are still used. The "bluebirds" still read fluently and with grace; the "robins" still struggle, hesitating, sometimes driven to silence as a result of their humiliation or fear. The "reading circle" proved to be the common ground for most of the pain, most of the suffering reported by the women in this study. The demand to perform a task which for some women was nearly impossible at a particular developmental period, was emotionally devastating. The humiliation was often so intense that it nearly always triggered panic. When panic consumes a performer or learner, then the fight or flight syndrome presents itself as the sole means of survival; a downshifting occurs in the brain. "Since language exists almost wholly in the new brain, downshifting leaves us speechless, quite literally" (Hart, 1983, p.111). Hence, silence prevailed with many of the women. This kind of silence has often been misinterpreted and referred to in the classroom as non-participatory or uncooperative behavior.

The Unconscious Emotions

The themes of shame and humiliation emerged from the interviewing questions. Both of these themes also came into discussion with many of the women during the diagnostic testing. When we reached a task which precipitated anxiety, the women reflected upon past experiences in the classroom when they were required to perform similar tasks which made them feel ashamed of their inadequacies. They talked of how their teachers yelled when they did not or could not successfully complete a task, answer a question, read out loud to a group. They cried when they spoke of the humiliation they bore; they were angered by the scars which were symbolic of the memories. During the administration of the TAQ the same concerns arose as we talked about peer relationships. The questions from the Classroom Trauma domain of the TAQ re-addressed our other conversations concerning performance, fear of failure, and the witnessing of someone

else's abuse in the classroom environment. All three methods addressed the women's feelings about their self-perceptions as intellectual and worthwhile beings. Throughout the interviewing, testing and the TAQ the women referred to themselves as feeling "stupid"; this was reiterated each time we discussed classroom traumas experienced during different developmental periods.

Children and adults with LD are even more vigilant, more skiddish about performance. "In the conventional classroom, threat to the student stands ever-present through the basic setting of captivity; the power of the instructor to punish, demean, embarrass, reject, or cause loss of of status; and the 'fishbowl' effect of being forced to perform in constant danger of ridicule or public failure" (Hart, 1983, p.112). The "reading circle" created the "fishbowl" effect for many women with LD; everyone could look in and watch, listen and wait. The threat of humiliation lurks behind every corner for many women with LD, waiting to reach out a shadowy finger, reminding them of past inadequacies and shame.

As I looked at the themes of humiliation and shame, our unconscious emotions, I realized how much power is in a classroom. Teachers possess enormous amounts of power; the power to move an individual forward to experience success through positive means, or the power to humble a human being by reminding her of her academic shortcomings. "One feels fear because a situation has been recognized as calling for fear. A student may 'read' tiny signals from a teacher that convey developing hostility, and so feel growing alarm" (Hart, 1983, p.105). In many other types of abusive situations, there may be a single perpetrator, but there often is not a large group of witnesses as there are in a classroom situation. The added factor of a public kind of humiliation changes what we may recognize and identify as humiliation. I asked myself if this perspective added to an individual's feelings of shame, a more private kind of unconscious emotion.

Throughout the interviewing process it never ceased to amaze me how classroom trauma evolved as a repetitive abuse for so many individuals. For many, the humiliation

was a daily drama to be played out. This was not an event that occurred in isolation or that occurred weekly; the tension was ever-present; the threat of humiliation was like a hot breath on the back of their necks. There was not one perpetrator, but many. Throughout their educational histories the classroom traumas experienced occurred as a result of a teacher or a number of professionals/practitioners who were insensitive to the learning differences of a significant number of students. Women reported that some years they were "lucky" and were placed in the care of a teacher who spent time looking for the reasons why an individual was not able to grasp a new concept, keep up with the reading, learn her multiplication tables with her peers. Occasionally a teacher demonstrated a sincere desire to ameliorate difficult situations which caused undue fear and humiliation. Unfortunately, many women reported that these experiences were not as common as the unpleasant classroom situations where teachers demonstrated a more punitive attitude. Hypervigilance became survival for these women. The radar was always on, always scanning, waiting for the next move.

Classroom Trauma

I have defined classroom trauma as a significantly unpleasant (or horrific) external event or stressor which occurs within the confines of an educational environment (e.g., a traditional or nontraditional classroom, a small group or a one-to-one tutorial). This type of trauma, which is a psychological trauma, may leave the student with diminishing self-esteem and in a state of fear, humiliation or learned helplessness to the degree where similar situation(s) will be avoided by the student in the future. The specific and original cause may be a person (such as a teacher, facilitator or peer (s)), although with each repetition, a perpetrator is not necessary to induce fear or humiliation. A situation which is just reminiscent of the original classroom trauma is sufficient to resurrect feelings of fear or humiliation which may impede learning and functioning. This type of trauma may occur repetitively, especially in students with learning disabilities.

Throughout the years I have listened to women's stories of classroom trauma. The settings may vary, but the maltreatment and disrespect experienced by women with LD is the common thread which is found in all of the accounts. Their stories are of humiliations so deep that they speak of personal shame in relation to their self-perceived inabilities to learn and function "normally." Most of these women have not been taught that they process information differently; that they are *not* "stupid." They have not been able to *un*-learn negative attributes which have been assigned to them as human beings trying to function in an academic and intellectual world. It's hard to "keep up" when it's necessary to stop periodically and analyze where breakdowns occur, why lags in learning were experienced; it's difficult to keep pace with peers when there may be a continuous need to get un-lost, to ask someone to repeat directions, to request clarification of a new concept. In this dissertation I devote a chapter to the personal accounts and reflections women have offered about classroom trauma.

The section on classroom trauma I created for the TAQ included questions on Teacher-Student Relationships, Means of Discipline in the Classroom and Violence in the Classroom; the format of the questionnaire was consistent. Out of 10 women, 6 women said that their relationships with their teachers were "fearful"; 2 women said they were "fearful and careful"; one woman said they were "fearful yet trusting." Two (2) women stated that their relationships with their teachers were "hostile"; one woman said they were "suspicious." Interestingly enough, during our more informal discussions the women talked often of their fear of teachers, and that just entering the classroom situation as adults precipitated unpleasant memories accompanied by PTSD-like symptoms.

In the category of Means of Discipline, 8 out of 10 women stated that humiliation was regarded as a means of discipline. Humiliation was equated with "being made an example of" publicly, in front of peers and others. Four (4) of the women said that isolation, or being separated from the rest of the class, was a means of punishment often used by teachers. Isolation was equated with "sitting in the hall", "sitting away from peers,

near the teacher", "sitting in a corner" (with or without a "dunce cap"), or being sent away from the class to the principal's office. One woman stated she was verbally abused by a teacher in classroom situations; this was equated to being subjected to name-calling and verbal degradation in front of peers. This category is also inclusive of name-calling by peers. Five women reported being hit by their teachers in the classroom; 4 of those 5 women said that their teachers hit them with objects. All of these reported abuses in the classroom contributed to deep feelings of humiliation and shame in the women.

The women reported their classroom disciplines to have occurred anywhere from 2 times per year, to daily throughout most of their classroom experiences. Four (4) of the women said that their experiences with classroom discipline effected them greatly; one of these women said that "fear damaged my life." Four (4) women stated that they were effected moderately, one person said she was not effected, and one woman said that she felt effected, depending upon the particular incident. This woman had suffered a variety of severe psychological traumas in addition to classroom trauma; her statement was understandable in terms of putting her experienced traumas into personal perspective.

Out of 10 women, 7 women reported that they had witnessed violence in the classroom. It was important for me to remember that cultural differences played a vital role in this category; to me, its role was more obvious than in other categories of the TAQ or in our interviewing sessions. Accounts of more frequent violence in the classroom were reported in the inner city schools with the exception of two women who were educated outside of the U.S. where violence (or violation) in the classroom was a daily occurrence. One woman stated that she witnessed a physical fight in the classroom one time; another woman said that she witnessed physical fights a few times (it remained unclear as to how many times the conflicts were between teacher and student or between student and student). Two (2) women said the violence (inclusive of teachers hitting other students) was frequent. Three (3) women said that the violence they witnessed in the classroom was present on a daily basis.

One woman reported to me during our interviewing session that she watched fighting in her classroom on a daily basis. She said she watched chairs and books fly through the air, students being thrown across desks. I asked her if the teachers had hit the students. She thought for a moment and said, "The teachers were usually scared. They were scared they would be beat up. Nobody learned. School wasn't for learning."

In this particular category, one woman said that violence in the classroom effected her life extremely. Three (3) women said that it effected their lives greatly; one of these 3 women said, "I lost a lot of school because of the fighting, but it made me a lot tougher politically. I am very aware of racial discrimination in the schools." Two (2) women reported that they were effected moderately; four women said they were not effected.

Although the difference appeared clear enough for my purposes, I am sure that the issue of violence in the classroom needs to be scrutinized much more carefully than this dissertation has allowed. The women who attended schools in the West Indies or in small northern European communities came to regard classroom trauma as part of life; it became a cultural norm for them in their lives as children and adolescents. Likewise, women who were educated in *some* (not all) inner city schools came to expect violence in the classroom as part of their school culture; the anger, the discriminatory issues and the violence that ensued as a result became a norm. Settings which provided services in special education (LD/behavior disorders as they may have been termed) seemed to provide fertile ground for violence; anger and frustration built to a level, often daily, where students either planned or inadvertedly became engaged in physical fights. Teachers lost "control" of the situation sometimes because the violence had escalated to heights where they knew they were not capable of intervening effectively, and sometimes because they were genuinely afraid that the fury would be directed at them. When a child is met with sporadic violence in a setting which is usually sedate, she will be "shocked" when violent incidences occur. The shock is an antithesis of what she has always accepted as a norm; her classroom culture has been violated; she has been violated.

Another dimension of classroom trauma: PTSD symptoms

In this dissertation I devote a chapter to the women's personal accounts of their unpleasant physiological responses to traumatic events. The TAQ allowed me to look at the lives of these women from yet another perspective, another dimension. I learned more about who they were before they came to see me, where they came from, who their parents were. From these questions we moved into many other meaningful conversations about experiences at home, in school and in all types of relationships. Our talks correlated with our previous conversations from the initial intake/interview; the connections were comfortable and intriguing. Several women began asking themselves (aloud) if their learning disabilities existed as a result of psychological trauma or because dad or another relative was dyslexic. Some others wondered if their classroom traumas would have existed at all if it wasn't for their reading disabilities, or if the psychological traumas experienced outside the classroom had any connection to the abuse they suffered in the classroom as well.

At this point in my synthesization of the data I had accumulated, I began to notice the major role that PTSD-like symptoms commanded in what appeared to be the cause-and-effect pattern of classroom trauma. With each psychological trauma which was described by the women during their interviewing questions and the TAQ, they connected the intrusion of their physiological symptoms to the specific traumatic event. With each severe classroom trauma reported by the women, a description of emotional and physiological symptoms was provided. As with any type of psychological trauma, classroom trauma has many triggers which may precipitate unpleasant physiological symptoms. For instance, when women with LD begin to think about returning to school, writing a paper, studying for a test or confronting a teacher or professor about almost any issue, they often experience a revisitation of unpleasant physiological symptoms which match the descriptions of those presented in DSM-IV; PTSD.

During our interviewing sessions when we discussed educational histories some women spoke of being "sick" for significant amounts of time and missing school. This of course put them further behind in their work, creating a cycle of fear and anxiety which walked hand in hand with gaps in learning, resulting in even further difficulties. As adults some of these women are plagued by strange illnesses much of which they readily report as being anxiety-driven. They talked of "feeling sick" as children in school, and "feeling sick" when thinking about classroom performance and expectations as adults.

Part II of the TAQ which dealt with current health issues asked the women about major illnesses, accidents or injuries. Five (5) women reported a variety of illnesses as adults ranging from chronic kidney and bladder problems for extended periods of time to anemia, colitis, back pain and an array of broken bones. Three (3) of the 10 women reported self-injurious behaviors.

Additional layers: feeling lost

A significant point in my research occurred as I poured over the TAQ forms. I noticed that most of the women responded negatively to the question: "Was there anyone who recognized you as special?" With most of the women, the immediate response was one of silence. They looked puzzled. The question elicited discomfort for most women because they claimed that they had "never really thought about it." Unfortunately, when they were asked to think about what was being asked, 5 out of 10 women responded "no" to the question. Of the 5 who responded "yes", 3 said that they thought their mothers treated them as being special. One woman said that her father treated her as special; one woman claimed that she remembered a cousin who made her feel important.

During our interviewing sessions the women alluded to feelings of being "lost"; this was a word which was used by several women to describe how they felt in school, and in a very general sense. I interpreted their descriptions of feeling lost with not having enough people to depend on including parents and teachers. Feeling lost is also a feeling

experienced when a child or adult with LD has lost her place, lost her way, became lost in the crowd. It is a struggle to fight through the feeling of being lost so that a feeling of clarity may be experienced. The lost feeling is like a thick gray fog which rolls in for a variety of meteorological reasons. However, once its presence is made known, it becomes exceedingly difficult to "see", to maneuver through the blanket of vapor which blinds an individual, and often causes a feeling of panic. It's difficult to plan and anticipate events when the visibility is poor.

Connecting the traumas

The women's discussions from the interviewing questions were laced with talk of other types of psychological traumas. Classroom trauma did not exist in isolation; it sat in the company of verbal abuse, emotional abuse, physical abuse and sexual abuse both in and out of the classroom environment. As mentioned earlier, the most significant trauma in each woman's life varied according to how she took in, absorbed, adapted, coped and accommodated each traumatic event. Each woman with LD meets her traumatic challenges differently; some women have neurological scanning systems which enable them to maintain fastidious vigils. Other women with LD are not as well equipped, do not read life's road signs very well, and are "fooled" by people and situations time and time again. The same traumas seem to repeat themselves throughout life; they are like reruns of T.V. dramas which must be watched over and over. Eventually the script is memorized, but there may exist a wish for a different outcome which develops over time. Why do some women with LD perseverate; why do they relive, revisit the same situations repetitively? There are neurobiological theories which offer answers from one perspective. The theories and possibilities are endless; the guesses are just that; just guesses.

It was significant to note that 8 out of 10 women reported losses and separations as children; 7 of the women lost a parent as a result of death or abandonment. Trauma of this nature can unseat a child cognitively and emotionally so that learning and functioning are at

constant risk. The recovery period for each child varies. Unpleasant physiological symptoms as a result of significant losses in childhood may stay with the girl, the woman, and plague her with each new (and old) situation which is even vaguely reminiscent of the original trauma. I have addressed some of the lasting effects of psychological traumas of this nature in the chapter *The Researcher's Story.*

Part 7 of the TAQ, Family Discipline and Conflict Resolution, asked the women whether they had been physically abused or sexually abused as children. Eight (8) out of 10 women stated that they had endured severe physical abuse as children inclusive of spanking, hitting and hitting with objects. Eight (8) out of 10 women also reported that they had been sexually abused as children; 1 woman reported that most of her sexual abuse occurred in the classroom over a period of 8 or 9 years. Issues of physical and sexual abuse wove their way in and out of our conversations during the interviewing questions as well. Of the 16 women interviewed, 12 reported physical and sexual abuse from childhood and into later adolescence. The women acknowledged that their learning and functioning was impeded as a result of these traumatic events. Many experienced memory loss, feelings of being lost, disoriented, silenced and being scared to death. They described PTSD-like symptoms which occurred and re-occurred throughout their childhoods, adolescence and into adulthood.

The questions which lead to further connections are never-ending. How does a qualitative researcher or an objective scientist prove whether or not a woman with LD experiences repeated classroom trauma as a result of her LD, or because she is trauma-vulnerable? Is she trauma-vulnerable because her LD impedes her ability to read situations and people adequately? Or is she trauma-vulnerable because she is driven to repeat the trauma, revisit it again and again, re-stimulating her brain so that her posttraumatic symptoms return? Does she need to keep banging her head into a wall until she "gets it right?"

As She Grew . . .

She grew to be
tall,
tireless,
clever,
sad.

She became
shamed,
suspicious,
learned,
wise.

She sought
acceptance,
adknowledgement,
and freedom
from the secret.

J.U.Adelizzi'95

Implications of the Study

Educational Implications for Cognition and Development

The greatest implication of this study, standing out as the umbrella under which all of the aspects of my research fall, is the need for an educative component to be provided for teachers and mental health providers in order to meet the needs of individuals with LD/ADD whose learning and functioning has been impacted by their psychological trauma histories. To say that it will be helpful for teachers and other related practitioners to gain an understanding of psychological traumatic exposure in relation to the residual effects of such events, is an understatement. If this can be accomplished without making teachers feel a "blame" or total responsibility for the existence of classroom trauma, then the classroom setting may become a more sensitive and safer place in which to learn.

Aside from teachers, there are still mental health providers who do not fully understand the impact which psychological trauma has upon not only learning, but functioning on a daily basis. For many individuals with LD/ADD the therapy session is yet another risk to take; another arena in which to chance humiliation or feeling *wrong*. This comes from not only their personal trauma histories, but also from expressive language difficulties which many of these people cope with throughout life. They may be regarded in the classroom as "non-participatory", and in the therapy session as "resistant." Often what is occurring is not an unwillingness to share, but a processing difference which does not allow the smooth and spontaneous flow of language to describe what they feel and know.

Educators have far reaching responsibilities in the lives of children, adolescents and adults; it is irresponsible to believe that our mission to facilitate the learning of others ends with the delivery of a planned curriculum for all, and/or with a learning profile which is presented on a piece of paper, administered by professionals who know an individual's behavior only through the reports of teachers and parents. Behaviors which have been labeled as LD, ADD and/or ADHD may appear to match the category as it is described in

an education plan, by DSM-IV, or through a lecture series delivered by well respected theorists. In reality, the observed behaviors require further investigation, and the uncovering of several layers of trauma in order to more fully understand what impediments may be lurking beneath the surface, raising havoc with people's learning and functioning. Learning disorders may occur as a result of familial transmission, head trauma, educational disability or psychological trauma. Any of these causes may co-exist with one another, and probably the combinations are many; there are few purist or absolutist cause and effect relationships. As teachers, practitioners, and clinicians, we need to keep looking, keep digging. We need to be relentless.

When thorough comparisons are made of listed symptomatology of learning disorders, they begin to overlap and mesh too frequently; many symptoms begin to sound reminiscent of post-traumatic stress disorder. As behaviors which are unpleasant, disruptive and disturbing occur in the classroom repeatedly, and often with the same individuals, red flags should go up; something is wrong. This does not mean that a teacher should feel responsible for any one student's emotional baggage which is ultimately sabotaging her efforts in the classroom. Indeed it must be a collaborative effort on the part of several professionals, including the student and the student's family. However, the decision to move the investigation further may rest with the teacher who may be the immediate recipient and interpreter of the student's behavior in the classroom. Often the teacher is the first to witness the "whole" student: the ability to learn, to function cognitively and socio-emotionally. Most importantly, the teacher may be the first to witness the physiological symptoms many individuals experience when they feel threatened and/or humiliated: the avoidance of many tasks which the student may perceive as being risky, an overwhelming sense of panic, a history of being sent to the nurse's office when it's time for math, or time to read aloud in a group. These may seem like insignificant signals to some teachers, and a reason to push the student harder to work in order to break these behaviors which are seen as nonproductive. But when the time is taken to listen

deeply, and watch vigilantly to a student's physiological responses to a variety of situations, then it is clear that this person is suffering in a much different way than was initially suspected. For some children, adolescents, and adults PTSD symptoms are at work. It becomes unimportant as to why, but only important to understand what can be done to ease the feelings of pending doom in these situations so that learning can take place, and daily functioning may become less of an uphill struggle.

The accountability does not end with educators, administrators and educational therapists. All too often psychotherapy treats a list of behaviors which again, are neatly fit into a category, a DSM-IV description. Feelings and behaviors are treated with tried and true therapeutic techniques, depending upon the paradigm. Concerned parents, peers and professionals cannot understand why the individual is better for a while, but then the old problems and behaviors return. What may occur is the temporary and superficial treatment of specific feelings and behaviors, minus the educative component, and lacking an investigation beyond what is submitted as a written learning profile or psychological testing. It's just too easy. It shouldn't be.

The de-mystification of feelings and behaviors is a frightening thought for many professionals responsible for the care of individuals who are in pain. It's difficult to educate young children as well as adults about their bouts of dissociation, their inability to attend in a classroom, the physiological symptoms they experience when a memory has been triggered. We can watch them, help them to hold vigil, help them to protect themselves, and let them know that as parents, teachers, and caregivers we are there for them. However, most adolescents, and certainly most adults, are capable of effectively learning about themselves. They deserve to be educated as to why they feel the way they do when they have begun to uncover uncomfortable memories or feelings. Awareness of the body-mind connection can only be a healthy component to a much larger plan of action in the care of these individuals. It is not harmful to teach a human being how his or her brain functions, to dispel the uncanny mystique of feelings. It is a good thing, not a bad

thing, to know not only why a panic attack is occurring, but also to understand what actually happens physiologically and neurobiologically during this time of extreme stress. The education of a student or client needs to include as much knowledge as possible in order for them to build a metacognitive profile which embraces a deep understanding and acceptance of self.

The Researcher's Perspective described feelings and behaviors which occurred both in and out of the classroom environment following the psychological traumas of a young woman. In both cases, learning was arrested, development was sidetracked, coping mechanisms were devised by scanning the memory for methods which were familiar. The amygdala was assaulted; kindling was activated, and reactivated, depending upon how often stressful stimuli entered the system, tipping the internal gyroscope. Because of the neurobiological development of the brain, disorientation both physiologically and emotionally was affected each time the amygdala was bruised. When the gyroscope was tipped, when kindling occurred, then bodily coordination became a challenge, memory suffered, and a general feeling of maladjustment and discomfort prevailed in daily life. The ability to judge spatial concepts was affected, thinking in sequential patterns, auditory processing and short term memory skills were impeded. Classroom learning and daily functioning became laborious. Cognition and development were directly impacted by the psychological traumas endured. The neurobiological, residual effects of psychological trauma know no boundaries, no discriminatory rules; everyone has equal rights.

The complication of survival guilt, a secondary component of post-traumatic sequelae, was an additional factor in *The Researcher's Story*. This phenomenon receives little attention and only seems to be acknowledged in individuals who have witnessed war atrocities. Many children and adolescents witness the death of a parent or sibling. They return to school, are acknowledged for their loss, politely overlooked for their inability to complete their work or attend in their classes, and are expected to return to "normal" within

a reasonable amount of time. After all, death is a part of life itself. Unfortunately, it isn't that simple. For many individuals, witnessing the death scene brings a unique set of post-traumatic sequelae to the survivor; guilt. The overwhelming sense of failure and unworthiness that comes with survivor guilt can drive a child or adolescent into behaviors which are the same as other post-traumatic stress disorder behavior, but carry the additional burden of guilt, the need to make up for what was inadequately acted out at the death scene. Traumatic loss of this nature, exacerbated by the feelings of guilt are grossly neglected by professionals who are the facilitators of learning and functioning both in and out of the classroom environment. The long term effects of such trauma histories are under-studied.

Adults witness the deaths of significant others more frequently, and although the cumulative effect of their life experiences aid them in their repertoire of coping abilities and endurance, they are still left with a certain amount of post-traumatic sequelae. The elderly are looked upon as being brave, and are pitied when their gyroscopes become so tipped that their everyday functioning becomes fragile at best. Not often enough are they treated for the residual effects that the psychological trauma of witnessing the death scene has left for them. Because death is a function of life and it did not take place in a concentration camp or on a battlefield, the survivors are often left to pull the pieces of their fragmented selves into an integrated whole without adequate assistance. They don't understand why they feel the way they do, both physiologically and emotionally.

It is the hope of this researcher that educators and other professionals and caregivers in the lives of individuals who suffer from psychological trauma may pause to take a second look at what is diagnosed or interpreted as being an expected set of behaviors. Cognition and development may be impeded at any age, at any level of learning. Post-traumatic sequelae characterizes the lives of many traumatized children, adolescents and adults. Their battlefields do not have to be only located in Southeast Asia. They can exist in the home, in the classroom, or in the minds of the survivors.

The implications of this research strongly suggest that in order for teachers to gain a deeper understanding of psychological trauma, undergraduate and graduate studies in education should include readings and discussions on the subject. Ultimately, teachers can connect what they intuitively know and observe in the classroom to theoretical frameworks which may be provided through structured coursework. Coursework of this nature should not be elective, but should be an existing component of teacher training programs in order to more fully address the emotional connection to learning and functioning.

If teachers need to understand the impact psychological trauma has on learning and functioning, then mental health care providers can also benefit from learning more about the cognitive, neurobiological, and socio-emotional aspects of learning, inclusive of LD/ADD behaviors and issues. In many mental health paradigms, psychological trauma is acknowledged as an existing phenomenon in the lives of many individuals. However, the connections between trauma histories, PTSD symptoms and learning disabilities are simply not complete. They are not understood. There is a "sameness" in the treatment of individuals who present similar kinds of histories or profiles. It is helpful to look beyond and *underneath* the numerical scores presented on inventories which measure depression, anger, attention, trauma, or intelligence. The treatments must be inclusive of *how* that individual is able to express her history, her feelings. How does she learn? How does she live? How has her trauma history, her symptoms, her learning disability affected her ability to learn and function? How will these factors impact the therapeutic outcomes?

The Treatment Model

One of the chief implications of this research is the model of treatment which emerged as a result of diagnostic testing, the one-to-one interactions experienced during the research, and the group support work I completed over a six year period of time with women who are LD/ADD. The importance of healing within the group setting becomes the model of treatment.

If within the group process, the cognitive, social, cultural and emotional components of learning disabilities are discussed directly and indirectly (often through projects and activities) then the women are better able to address the four major target areas of their needs: 1.) acceptance and responsibility for coping with their learning disabilities (locus of control), 2.) expressive and receptive language difficulties, 3.) social deficits; difficulty in perceiving self and others, and 4.) issues of shame and humiliation (which may precipitate low self-esteem and anger/rage). The treatment of these four areas is always contingent upon the degree of psychological traumatic exposure each woman has experienced, both in and out of an educational environment. In order to effectively address each of the four target areas of needs it is necessary to:

1.) compile a complete history of each woman's educational history;
develop a metacognitive profile (through client-educational therapist interview,
diagnostic testing (e.g. WAIS-R, PPVT-R, Rorschach, QNST,
unedited writing sample)
2.) determine through diagnostic testing in conjunction with observation of
perception and response in client- educational therapist interview,
the quality of language possessedby each individual;
the degree of silence in which each woman exists may be adequately
assessed during the interviewing process and in the reviewing of the WAIS-R,
PPVT-R and the writing sample
3.) determine through specific subtests on the WAIS-R
(e.g. Picture Arrangement and supportive assessment for social skills),
and client-educational therapist interviewing, a difficulty in social skills;
further observation is usually necessary in order to assess the degree of difficulty
experienced in self and other perceptions and in the establishment and maintenance
of relationships; Gregorc's Style Delineator is helpful to administer one-to-one,
to be discussed one-to-one, as well as in the group setting

4.) address issues of shame and humiliation which may or may not be elicited in conversation within the client - educational therapist interview; group process may further enhance the emergence and healing of such issues/struggles; self-esteem may be determined through the interviewing process and through the administration of MESI (self-esteem inventory)

In order to gain a deeper understanding of the cognitive, social, cultural and emotional components of LD so that the four target areas of need may be addressed, it is most effective to utilize a cognitive approach, combined with a teaching model inclusive of psycho-educational knowledge of learning theory and LD/ADD. Models which are inclusive of the understanding of relationships with self and others are useful, but must be vigilant of the difficulty some women experience with personal interactions as well as the generation of expressive language, both individually and in group situations. Because of the nature of difficulties in social situations, an effective treatment approach must be inclusive of a feminist view in counseling and therapy, teaching women not only when they have infringed upon the rights and feelings of others, but also when others have assaulted their personal boundaries and fundamental rights.

The contextual background for this model of treatment for LD women considers the individual experience of each woman. She brings her personal culture to the group setting which has been developed by her family, her community, and the educational system which was responsible for the quality of her learning experiences. The permeating aura throughout her history which she brings to the group setting is that of psychological traumatic exposure. Each woman's individual trauma history may consist solely of classroom trauma, but for most of these women other psychological stresses or traumas have impeded their learning and development. Will we ever know if the atrocities to which they were exposed were responsible for their academic struggles, or if their neurological deficits were already present, before they began to experience threat and violation in the

classroom? Which came first? Did they occur together? These are all issues which emerge within the group process, and need to be further investigated by the researcher.

Acknowledging the Silence

What has emerged from this study as a result of an overview on women with LD/ADD as a culture, and their sometimes subsequent silence, is the need for an integrated model of treatment, as mentioned above. Beyond that, lie implications in education and within a larger socio-cultural context. A silent or silenced woman is not to be viewed as non-participatory. A silent child is not necessarily a personally nor academically successful child. Silence is not an indicator of "good" behavior. Conversely, silence is not an indication of "knowing less" nor "being less."

Although for a variety of reason(s) women with LD/ADD lose their voices, feel unheard, and sometimes choose not to be heard, a universal truth remains; as healing as the expression of feelings and thoughts may be, it is often not safe to share them. Choices are made by many women to be heard, to shed the silence which has held them captive for so long. However, for some women the development of their expressive language has directly influenced their silence; this factor keeps them from confidently speaking out. But there are other factors as well involved in their language development. The personal cultures in which they were raised have a great deal to do with their self-perceptions, their perceptions of others and of a society which never seems to "match" what it is they feel they have to offer. Personal culture also dictates how and when a woman should speak out, sometimes making the existence of learning disabilities appear as tertiary in importance.

The suppression of thoughts and ideas has been allowed by many LD women because they have been made to feel unworthy by the culture of schools, their expectations, and the continued punitive treatment of them during most of their early years of education. They feel that what they have to say is not significant, not important, and probably

"wrong" in context or conceptually. The result of this may leave them immobilized, not able to take action, not wanting to take the risk of crying out or speaking out. Their self-perceptions are impaired, and their faith in what it is they have to offer intellectually feels consistently invalidated. Therefore, they are left susceptible to further psychological traumatic exposures, both in and out of the classroom environment. They seem to wait, sometimes in quiet anticipation and resignation, sometimes in a frenzied and agitated state of fear.

As adults they have carried these experiences with them, feeling their constant burden throughout their daily lives. By the time they have searched for assistance in this process, they are weighed down by the shackles of defeat and low self-esteem. Their language development has suffered terribly. They do not speak out because they are afraid they will sound "wrong", "dumb", or "not good enough." If they wish to express their feelings and ideas in writing, often they are deterred in this effort because they have not been able to gain adequate skills, or have not received appropriate academic assistance which guides them through the process of total literacy. We need, as a society, to listen more deeply to their silence, to search for the reasons for it so that we may find ways to mentor them away from their exiles.

The seeds of silence may be genetic. They may be the unfortunate gifts of heredity. Many women with LD/ADD are able to move beyond that point if they have had adequate support systems in their lives. However, many are not that fortunate. The seeds of silence take root, and grow with each new stage of development, suppressing thoughts and ideas, and often crippling expressive language and the achievement of total literacy.

As educators, clinicians and parents there is a great deal to be offered in remediation and in the prevention of the silence of women with LD/ADD, and on a broader scale, on behalf of all learners, young and old, male and female, cross-culturally. An integrated treatment model may set the stage for successful intervention for language arrestation, or a metaphorical silence which may affect learners on all levels. If the professionals involved

in the lives of all learners are willing to consistently and integratively address the cognitive, neurobiological, socio-emotional, and cultural components of each individual, then the difficulties which arise in any or all of these areas may be impeded from evolving into the *Sounds of Silence.*

> *And in the naked light I saw*
> *ten thousand people, maybe more,*
> *People talking, without speaking,*
> *people hearing without listening.*
> *People writing songs that voices never share*
> *and that no one dare disturb,*
> *The Sound of Silence.*
> *(Paul Simon, The Sound of Silence)*

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Appendix A-1
Jane Utley Adelizzi

CONSENT FORM

This is a study of ***The Impact of Psychological Traumatic Exposure on Learning and Functioning InWomen Who Are Learning Disabled (LD)***

You have been selected to participate in this study because you are a woman who has experienced academic difficulties or challenges, and may have been diagnosed with a learning disability. I am a Certified Educational Therapist through the Association of Educational Therapists, and am qualified to administer and interpret diagnostic testing for learning disabilities.

Your participation will take from 1 to 5 hours, depending upon the amount of diagnostic testing you have already completed. You may discuss and reflect upon your former classroom experiences, how you feel about yourself as a learner, and how and if you feel that psychological trauma has impacted your learning. By discussing these interrelated topics you will be helping the researcher investigate and better understand the impact of psychological trauma on learning in women who are LD. As a result of this research you will make it easier for other women who are LD to share their experiences as well. It is possible that recommendations or proposals may be developed as a result of this information in order to improve educational programs and therapeutic treatment for women who are LD.

There are no hidden or experimental treatments and no risks or discomforts that the interviewer is aware of beyond the possibility that some of the questions may arouse strong opinions or remind you of past unpleasant experiences both in and out of the classroom environment. If at any time you require emotional support/therapy, with your permission I will make the appropriate referrals in order to meet your individual needs and circumstances. However, as the interviewer/researcher, I cannot assume the financial responsibility for outside therapeutic intervention. Your participation is entirely voluntary. You are free to discontinue at any time. If you wish to have any or all material excluded, just inform the interviewer of such. If you have questions now or at any other time, please feel free to ask the interviewer.

This research is being done as part of the requirements for Ph.D. work in educational studies at Lesley College in Cambridge, MA. All information provided will be confidential. That is, no response you provide will be associated with your name (or in any way associated with your position in your organization or academic environment without your permission).

The interview will be tape recorded, but your confidentiality will be protected in the following ways. No identifying information will appear on the transcript of the tape. All names, places, etc. will be deleted during transcription. Access to this interview will be strictly limited to this researcher and the Lesley College faculty associated with this project. Short excerpts from this interview may be used in academic presentations or in a few cases published reports of this research, but these will be disguised to insure unrecognizability. If any direct quotation from this interview is to be used in an article, academic presentation or report, it also will be disguised.

I have read and/or listened to and understood the statements listed above and I agree to participate in this study.

Name ____ Date ______________

Appendix A-2
Jane Utley Adelizzi

Informed Consent

The Impact of Psychological Trauma on Learning and Functioning in Women with Learning Disabilities (LD/ADD): Classroom Trauma

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TRAUMATIC ANTECEDENTS QUESTIONNAIRE
(Herman & van der Kolk, 1990)
with Modifications for Classroom Trauma by Jane Utley Adelizzi, 4-95

I, ________________________________, being of full age and legal capacity, agree to participate in this investigation of the impact of psychological trauma on learning and functioning. I understand that a portion of this study involves my answering this questionnaire about my life experiences, inclusive of unpleasant classroom experiences. This questionnaire will probably not take more than an hour to complete with the researcher. I understand that, if I wish, the results of this study will be made available to my referring therapist or physician or to other professionals who are involved in my education and emotional well being.

I understand that participation in this study is entirely voluntary, and that I may choose not to participate, or to stop at any time. I understand that all published reports will be anonymous and that I will in no way be personally identified as having participated in this study.

The Federal Department of Health and Human Services requires by regulation research subjects to be informed of what coverage, if any, is afforded for compensation for physical injury resulting from participation in research projects. Giving answers to questionnaires is most unlikely to result in injury. Neither Jane Utley Adelizzi nor Lesley College will pay for the treatment of injury resulting from participation in this research project.

I have fully explained to the subject the nature of the procedures described and the risks involved in their performance.

____
Date *Signature of Researcher*

____
Date *Signature of Subject*

Appendix B
Jane Utley Adelizzi

DEFINITIONS

Attention Deficit Disorder is a complex neurobehavioral disorder. Although researchers have not been able to determine the specific portion of the central nervous system that is malfunctioning, most agree that ADD involves the neurochemical abnormality of neurotransmitters in the brain. The necessary amounts of neurological chemicals which act as triggers, transmitters and receptors for normal neurotransmitter functioning are not present in the brain of an ADD child. Thus, the ADD child is not fully aware of his/her problem or fully prepared to master life's developmental tasks. Not being able to see the physical disability internal to the ADD child produces much misunderstanding about the behavior of the ADD child for many adults.
-from *ACA Independent Reading*: *Attention Deficit Disorder (1993)*

ADD/ADHD

DSM-III-R Diagnostic Criteria for
Attention-deficit Hyperactivity Disorder:

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age.

A. A disturbance of at least six months during which at least eight of the following are present:

1. often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
2. has difficulty remaining seated when required to do so
3. is easily distracted by extraneous stimuli
4. has difficulty awaiting turn in games or group situations
5. often blurts out answers to questions before they have been completed
6. has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fail to finish chores
7. has difficulty sustaining attention in tasks or play activities
8. often shifts from one uncompleted activity to another

9. has difficulty playing quietly
10. often talks excessively
11. often interrupts or intrudes on others, e.g., butts into other children's games
12. often does not seem to listen to what is being said to him or her
13. often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)
14. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking) e.g., runs into street without looking

Note: the above items are listed in descending order of discrimination power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavioral Disorders

B. Onset before the age of seven

C. Does not meet the criteria for a Pervasive Developmental Disorder

The DSM-III-R also contains the residual category of Undifferentiated Attention-deficit Disorder (UADD) for personas who may have earlier had ADD. The predominant feature of UADD is the persistence of developmentally inappropriate and marked inattention that is not a symptom of another disorder, such as Mental Retardation or Attention-deficit Hyperactivity Disorder, or of a disorganized and chaotic environment. Some of the disturbances that in DSM-III would have been categorized as Attention Deficit Disorder without Hyperactivity would be included in this category.

According to Ned Hallowell, a psychiatrist and author of a book on ADD, said in a talk to a support group for learning disabled women (**WILL**: Women Involved In Lifelong Learning) in 1992, "*ADD is like being super-charged all the time. You get one idea and you have to act on it, and then, what do you know, but you've got another idea before you've finished up with the first one, and so you go for that one, but of course a third idea intercepts the second, and you just have to follow that one, and pretty soon people are calling you disorganized and impulsive and all sorts of impolite words that miss the point completely. Plus which, you're spilling over all the time. You're drumming your fingers, tapping your feet, humming a song, whistling, looking here, looking there, scratching, stretching, doodling and people think you're not paying attention or that you're not interested, but all you're doing is spilling over so that you can pay attention. I can pay a lot better attention when I'm in a crowded noisy room than when I'm still and surrounded by*

silence. God save me from reading rooms. Have you ever been into the one in Widener Library? The only thing that saves it is that so many of the people who use it have ADD that there's a constant, soothing bustle."

Classroom trauma is a significantly unpleasant (or horrific) external event or stressor which occurs within the confines of an educational environment (e.g., a traditional or nontraditional classroom, a small group or a one-to-one tutorial). This type of trauma, which is a psychological trauma, may leave the student with diminishing self-esteem and in a state of fear, humiliation or learned helplessness to the degree where similar situation(s) will be avoided by the student in the future. The specific and original cause may be a persona (such as a teacher, facilitator or peer(s)), although with each repetition, a perpetrator is not necessary to induce fear or humiliation. A situation which is just reminiscent of the original classroom trauma is sufficient to resurrect feelings of fear or humiliation which may impede learning and functioning. This type of trauma may occur repetitively, especially in students with learning disabilities.

Learning Disabilities
Specific Developmental Disorder (Axis II)
Academic Skills Disorder

315.10 Developmental Arithmetic Disorder

The essential feature of this disorder is marked impairment in the development of arithmetic skills that is not explainable by Mental Retardation, inadequate schooling, or hearing or visual defects. The diagnosis is made only if this impairment significantly interferes with academic achievement or with activities of daily living that require arithmetic skills.

There are a number of different types of skills that be impaired in Developmental Arithmetic Disorder. These include: "linguistic" skills (such as understanding or naming mathematical terms, understanding or naming mathematical operations or concepts, and coding written problems into mathematical symbols); "perceptual" skills (such as recognizing or reading numerical symbols or arithmetic signs, and clustering objects into groups); "attention" skills (such as copying figures correctly, remembering to add in "carried" numbers, and observing operational signs); and "mathematical" skills (such as

following sequences of mathematical steps, counting objects, and learning multiplication tables).

315.80 Developmental Expressive Writing Disorder

The essential feature of this disorder is marked impairment in the development of expressive writing skills that is not explainable by Mental Retardation or inadequate schooling and that is not due to a visual or hearing defect or a neurological disorder. The diagnosis is made only if this impairment significantly interferes with academic achievement or with activities of daily living that require expressive writing skills. The impairment in the ability to compose written texts may be marked by spelling errors, grammatical or punctuation errors within sentences, or poor paragraph organization.

315.00 Developmental Reading Disorder

The essential feature of this disorder is marked impairment in the development of word recognition skills and reading comprehension that is not explainable by Mental Retardation or inadequate schooling and that is not due to a visual or hearing defect or a neurological disorder. The disorder is made only if this impairment significantly interferes with academic achievement or with activities of daily living that require reading skills.

Oral reading is characterized by omissions, distortions, and substitutions of words and by slow, halting reading. Reading comprehension is also affected. This order has been referred to as "dyslexia."

315.31 Developmental Expressive Language Disorder

The essential feature of this disorder is marked impairment in the development of expressive language that is not explainable by Mental Retardation or inadequate schooling and that is not due to a Pervasive Developmental Disorder, hearing impairment, or a neurological disorder. The diagnosis is made only if this impairment significantly interferes with academic achievement or with activities of daily living that require the expression of verbal (or sign) language.

The linguistic features of Developmental Expressive Language Disorder are varied and depend on the severity of the disorder and the age of the child. Nonlinguistic functioning, however, is usually within normal limits. among the expressive language limitations that may be present are: limited size of vocabulary, difficulty acquiring new words, vocabulary errors (such as substitutions, circumlocutions, overgeneralizations of jargon), shortened sentences, simplified grammatical structures, limited varieties of grammatical structures (such as verb forms), limited varieties of sentence types (such as

imperatives, questions, etc.), omissions of critical parts of sentences, unusual word order, tangential responses, and slow rate of language development progressing slowly).

315.31 Developmental Receptive Language Disorder

The essential feature of this disorder is marked impairment in the development of language comprehension that is not explainable by Mental Retardation or inadequate schooling and that is not due to a Pervasive Developmental Disorder, hearing impairment, or neurological disorder. The diagnosis is made only if this impairment significantly interferes with academic achievement or with activities of daily living that require comprehension of verbal (or sign) language.

The comprehension deficit varies depending on the severity of the disorder and the age of the child. In mild cases there may be only difficulties in understanding particular types of words (such as spatial terms) or statements (for example, complex "if-then" sentences). In more severe cases, there may be multiple disabilities, including an inability to understand basic vocabulary or simple sentences, and deficits in various areas of auditory processing (e.g., discrimination of sounds, association of sounds and symbols, storage, recall, and sequencing).
from ***DSM-III-R***

"***Learning disabilities*** is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities, or of social skills. These disorders are intrinsic to the individual and presumed to be due to central nervous system dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g., sensory impairment, mental retardation, social and emotional disturbance), with socioenvironmental influences (e.g., cultural factors) and especially with attention deficit disorder, all of which may cause learning problems, a learning disability is not the direct result of those conditions or influences."
from ***The Interagency Committee, 1988***

Public Law 94-142, the Education for All Handicapped Children Act, defines *learning disability* as "a disorder in one or more of the basic psychological processes involved in understanding and using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, and do mathematical calculations."

A second part of the federal definition appears in the regulations used to interpret Public Law 94-142. It states that a specific learning disability exists if the students does

not achieve at the proper age and ability levels in one or more of several specific areas when provided with appropriate learning experience, and the student has a severe discrepancy between achievement and intellectual ability in one or more of these six areas:

1. oral comprehension
2. listening comprehension
3. written expression
4. basic reading skill
5. mathematics calculation
6. mathematics reasoning

from *Succeeding Against The Odds* by Sally Smith

"***Learning disabilities*** in adulthood affect each individual uniquely. For some, difficulties lie in only one specific functional area; for them, problems are more global in nature, including social and emotional problems. For many, certain functional areas of adult life are limited compared to other areas. Adults with learning disabilities are of average or above average intelligence, but intelligence often times has not relation to the degree of disability. Learning disabilities persist throughout the lifespan, with some areas improving and others worsening. specific details associated with learning disabilities are real and persistent and may pose significant difficulties in vocation and career. Nevertheless, such deficits do not necessarily preclude achievement, and in some cases, may have a positive relationship with achievement. In almost all cases, learning disabilities necessitate alternative approaches to achieve vocational success."
from Reiff, H.B., Gerber, P.J., & Ginsberg, R. (1993). *Definitions of learning disabilities from adults with learning disabilities: The insiders' perspectives. Learning Disability Quarterly,* 16, p.114-125.

"Those who find it especially difficult to couple their auditory and visual analytic systems, or to attain some kind of access to the principles that underlie human activity that has attained enormous importance, end up at a distinct disadvantage in a realm of human activity that has attained enormous importance. Recently we have come to call these people "***dyslexic.***" Dyslexics would not be recognized in an illiterate society or in a society where reading occurs with ideographs, but if a person at risk for dyslexia is born into a literate society that happens to use an alphabetic system, he must somehow overcome his limitations ***if he wishes to participate fully in his culture.***"
from Howard Gardner, *The Unschooled Mind*, Basic Books, 1991, p.37

Educational Therapy

"An educational therapist works in the educational domain with individuals who exhibit learning disabilities and learning problems. An educational therapist is skilled in: 1) formal and informal educational assessment; 2) synthesis of information from other specialists; 3) development and implementation of appropriate remedial programs for school-related learning and behavior problems; 4) strategies for addressing social and emotional aspects of learning problems; 5) formation of supportive relationships with the individual and with those involved in his educational development; 6) facilitation of communication between the individual, the family, the school, and involved professionals."

from *Psychoeducational Perspectives;* a compilation by Dorothy Ungerleider

"***Post-Traumatic Stress disorder (PTSD)*** is the aftermath of a traumatic even that has passed. If the symptoms of distress continue unabated or return within six months, the victim is in the acute/protest phase of PTSD. If the symptoms stop and reappear after six months, the victim is in the chronic/numbing phase of PTSD."

- from Raymond B. Flannery. Post-Traumatic Stress Disorder; 1993, p.8

Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror

B. The traumatic event is persistently reexperienced in one or more of the following ways:

(1) distressing recollections of the event (e.g., images, thoughts, perceptions)

(2) recurrent distressing dreams of the event

(3) acting or feeling as if the traumatic event were recurring (hallucinations, flashbacks)

(4) intense psychological distress at exposure to internal or external cues

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

-from *DSM-IV*, 309.81

"***Psychological trauma*** is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning."

-from Judith Herman. *Trauma and Recovery;* 1992, p.33

"***Psychological trauma*** is the state of severe fright that we experience when we are confronted with a sudden, unexpected, potentially life-threatening event over which we have no control, and to which we are unable to respond effectively not matter how hard we try. Witnessing such an event can produce the same severe fright."

-from Raymond B. Flannery, Jr. *Post-Traumatic Stress Disorder*, p.7

Appendix C-1

Intake/Interviewing Questions

Intake:

1. Where were you born?
2. Is English your primary language? at home? at school?
3. Can you tell me about your experience in elementary school?
4. Can you tell me about your experience in high school?
5. When were you diagnosed with a learning disability? by whom?

Interview I

1. How would you define a psychological trauma?
2. How would you define a classroom trauma?
3. Has your learning disability affected your adult life?

Appendix C-2

Interview II

1. The Reading Circle:
    - A. How did you feel when you were called upon to read aloud?
    - B. Can you describe the feeling(s)?
    - C. Can you describe any physical symptoms that you experienced?
2. How did you feel when you were yelled at or laughed at?
    - A. Can you describe the feeling(s)?
    - B. Can you describe any physical symptoms that you experienced?
3. How difficult is it to keep the SECRET as an adult?
4. Has your LD made you stronger as an adult in any way?

Appendix D

TRAUMATIC ANTECEDENTS QUESTIONNAIRE
(Herman & van der Kolk)

with Modifications for Classroom Trauma by
Jane Utley Adelizzi

Code Name (Pseudonym) ______________________ Date _______

PART ONE: DEMOGRAPHICS

1. sex
2. age
3. marital status
4. present religious identification
5. role of religion in current life
6. religion of upbringing
7. role of religion in upbringing
8. ethnic/racial background
9. education
10. occupation
11. current employment
12. estimate current household income
13. number of people in household
    a. relationship to subject
14. number of children (including those not currently living with subject)
15. people subject relies on for practical help
16. people subject relies on for emotional support

PART TWO: CURRENT HEALTH

17. health; self rating
18. number of days sick in last year
19. cigarettes
20. alcohol consumption per week
    a. days drinking per week
    b. drinks in 24 hour period
    c. type of drink
    d. was there a time in your life when you had a drinking problem
        1. time, and circumstances
21. prescription medications
    a. length of time used
    b. was there a time when you thought taking these medications was causing a problem for you
        1. dates, and circumstances

22. have you ever taken illegal drugs on a regular basis
    a. which ones
    b. was there a time when you thought taking these medications was causing a problem for you
        1. quantity, dates and circumstances
23. major illnesses, current
24. major accidents or injuries (including self-inflicted injuries and suicide attempts)
    a. SIB: frequency
    b. SIB: age at onset
25. hospitalizations (medical and/or psychiatric)
    a. how many times
    b. at what ages
26. pregnancies (number and outcome)

PART THREE: FAMILY OF ORIGIN DEMOGRAPHICS

27. birthplace
28. where spent most of childhood (till age 16)
29. number of moves before age 16
30. persons in childhood household
31. birth order
32. father's occupation
33. mother's occupation
34. father's education
35. mother's education
36. who in family was affectionate to you
37. was affection:
    a. reliable and consistent
    b. unreliable and inconsistent
    c. other
38. was there anyone who recognized you as a special person
39. if yes, what happened to that relationship
40. was there anyone you felt safe with growing up
41. if yes, what happened to that relationship

PART FOUR: CHILDHOOD CARETAKERS AND SEPARATIONS

42. primary caretaker before age 16
43. ever separated from that person for more than a few weeks
44. if yes, # of episodes
45. if yes, describe each episode
46. any deaths in immediate family prior to age 16
    a. relationship of family member to subject
    b. subject's age at time of death
47. serious illnesses/hospitalizations in family before age 16
48. absences of other family members prior to age 16
49. age first lived away from home
50. circumstances for leaving home
51. ever attempt to run away from home
52. if yes, # of episodes

PART FIVE: PEER RELATIONSHIPS AND CHILDHOOD STRENGTHS

53. description of friendships in childhood
54. description of friendships in adolescence
55. description of peer group in childhood
56. description of peer group in adolescence
57. relationships with siblings
58. was there something you were good at as a child
    (e.g., sports, hobby, schoolwork, creative activity)

PART FIVE A: CLASSROOM TRAUMA: *Experiences in Learning*

Jane Utley Adelizzi, 1994

CT1. relationships with teachers in elementary school (K-5):
1. trusting
2. careful
3. hostile
4. suspicious

CT2. relationships with teachers in middle school (6-8):
1. trusting
2. careful
3. hostile
4. suspicious

CT3. relationships with teachers in high school (9-12):
1. trusting
2. careful
3. hostile
4. suspicious

CT4. the usual means of discipline in elementary school (K-5):
1. scolding
2. threatening
3. yelling
4. verbal abuse (e.g., name calling)
5. humiliation (make an example of)
6. isolation (e.g., sitting in a corner, in hallway)
7. hitting
8. hitting with an object

CT5. the usual means of discipline in middle school (6-8):
1. scolding
2. threatening
3. yelling
4. verbal abuse (e.g., name calling)
5. humiliation (make an example of)

6. isolation (e.g., sitting in a corner, in hallway)
7. hitting
8. hitting with an object

CT6. the usual means of discipline in high school (9-12):
1. scolding
2. threatening
3. yelling
4. verbal abuse (e.g., name calling)
5. humiliation (make an example of)
6. isolation (e.g., sitting in a corner, in hallway)
7. hitting
8. hitting with an object

CT7. estimated frequency of punishment __________/month

CT8. how upsetting was this to subject at the time:
1. not at all
2. not very
3. somewhat
4. very
5. extremely

CT9. subject's estimate of incident's effect on life:
1. great
2. moderate
3. little
4. none202

CT8. ever witness violence in the classroom
0. no
1. yes

CT9. if yes: how often did this happen:
1. once
2. a few times
3. frequently

CT9: how upsetting was this to subject at the time:
1. not at all
2. not very
3. somewhat
4. very
5. extremely

CT10. subject's estimate of incident's effect on life:
1. great
2. moderate
3. little
4. none

PART SIX: FAMILY ALCOHOLISM

59. family customs regarding alcohol
60. ever suspect any family member had drinking problem
    a. who
61. if yes, describe relationship, onset, duration, severity, current status
62. describe the type of drinker (e.g., daily, weekend, binge)
63. did you ever seek help from anyone because of family member's drinking problem
64. if yes, were efforts to get help successful

PART SEVEN: FAMILY DISCIPLINE AND CONFLICT RESOLUTION

65. who made rules and enforced them at home
66. description of family rules
67. did you consider the rules usually fair
68. usual means of disciplining children
69. estimated frequency of punishment
70. usual way parents solved their disagreements
71. ever witness violence in family
72. if yes, how often did this happen
73. if yes, for each incident specify:
    a. the perpetrator
    b. the victim
    c. subject's age at time of occurrence
    d. description of incident
    e. how upsetting was it at the time
74. was there a gun in the house
75. if yes, what it ever used against anyone
76. anyone in household ever receive medical attention as a result of violence at home
77. ever seek help to limit violence at home
78. if yes, were efforts to get help successful
79. since age 16 ever involved in physical fight that included hitting, punching or use of a weapon
80. if yes, how many times has this happened
81. if yes, for each incident specify:
    a. perpetrator
    b. victim
    c. subject's age at time of occurrence
    d. description of incident

PART EIGHT: EARLY SEXUAL EXPERIENCES

82. source of most sexual information (e.g., mother, siblings)
83. parental attitudes toward children's sexual curiosity
84. able to ask questions or discuss sex with any family member
85. if yes, person you could talk to
86. before age16 any ever try or succeed in having any kind of sexual contact with you
87. if yes, for each incident describe:

a. subject's age
b. age and relationship of perpetrator
c. duration
d. frequency
e. type of sexual contact
f. use of force or means of coercion
g. was the sexual contact a secret

88. sometimes when people think about their sexual experiences they forget to include experiences that may have happened with family members
    a. before you were 16, did you have any sexual experiences that involved people related to you
89. if yes, for each incident describe:
    a. subject's age
    b. age and relationship of perpetrator
    c. duration
    d. frequency
    e. type of sexual contact
    f. use of force or means of coercion
    g. was the sexual contact a secret
90. if answer to #88 and #89 is yes, before age 16 ever tell anyone or try to get help because of unwanted sexual experience
91. if answer to #90 is yes, were efforts to get help successful
92. after age 16 anyone ever pressure or force you into unwanted sexual contact
93. if answer to #92 is yes, for each incident describe the following:
    a. subject's age
    b. age and relationship of perpetrator
    c. duration
    d. frequency
    e. type of sexual contact
    f. use of force or means of coercion
    g. was the sexual contact a secret
94. if answer to #93 is yes, after age 16 ever tell anyone or try to get help
95. if answer to #94 is yes, were efforts to get help successful

PART NINE: REVIEW AND SUMMARY

96. of all traumatic experiences discussed, which has had most serious or lasting effects on life
    1. death of someone close
    2. physical illness of someone close
    3. mental illness of someone close
    4. alcohol problem in someone close
    5. physical abuse by someone close
    6. sexual abuse by someone close
    7. physical assault by acquaintance or stranger
    8. sexual assault by acquaintance or stranger
    9. other
97. effect on life: select most stressful incident
98. what has been most helpful in overcoming the traumatic effects of these events
99. what advice would you give to others on the basis of your experiences
100. what advice would you give to psychiatrists and other mental health professionals