EFFECTIVE PSYCHOTHERAPY TECHNIQUES FOR LEARNING DISORDERED CLIENTS

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INTRODUCTION

The idea that there are people of any age who are not good candidates for psychotherapy is a narrow perspective. What individuals would not benefit from increased insight and self- awareness, or integrating their personal narrative and resolving traumatic events, improving their emotional intelligence and their personal relationships? However, clients who have disorders that interfere with learning are likely to not benefit from the typical Client Centered, CBT, or Psychodynamic approaches. All cognitive based modes of psychotherapy assume that a client does not have any problems with processing new information. Therapists do not have to operate on this assumption because there are methods to modify the sequence, timing, activities, assessments and teaching of material to clients who have problems processing new information.

This paper will explain:

- The relationship of psychotherapy and learning-disorders.
- The impact of learning disorders on Psychotherapy.
- Information about learning disorders.
- How to identify possible learning disorders in clients.
- Treatment planning for clients with learning disorders.
- Therapeutic techniques for clients with learning disorders.

With this information therapists will be able to expand their skills for learning disordered clients. The techniques recommended are additional modifications to standard clinical treatment and standard cognitive therapy approaches. Therapists are encouraged to consider their own strengths and limitations when deciding the best application of the recommended techniques. Working with a caseload of children and ADHD clients has taught me to paying more attention the process of learning during a session. This increased sensitivity has led me to discover the modifications that can shape the learning process.

PSYCHOTHERAPY IS LEARNING

Beck and Ellis founders of Cognitive based therapies relied on the assumption that individuals could use metacognition. (P. Willner 2005). What is metacognition? Metacognition Is a higher order of thinking, a deeper level of knowledge that increases a person's ability to transfer what they learn to a variety of contexts. Metacognition is, put simply, thinking about one's thinking. It is a product of learning. We cannot assume that every individual in counseling can automatically or independently achieve metacognition. Also, we cannot restrict our knowledge and services to people who can independently achieve metacognition.

What is learning?

Learning is hardwired in every human being, even if there were no formal education system individuals would pursue ways to learn. However, when methods for learning are limited by standardized methods then some individuals are excluded from learning. There is more than one way to teach and more than one or two ways to learn. Regardless of the methodology there are common some premises about learning. Learning is:

- a process;
- experiential;
- personally, engaging and interesting;
- multi-sensory and multi-dimensional;
- requires reinforcement (operant conditioning);
- produces measurable, transferable and applicable knowledge.

Learning is generalized process involving smaller, measurable ingredients such as sustained attention, memory/recall, hindsight, insight, processing speed, interpretation of information, processing style- i.e. Multiple Intelligence Theory (http://www.edpsycinteractive.org/topics/summary/basic-principles-

learning.html). By increasing our sensitivity to these processes and the components to learning we can formulate a successful treatment plan for any client regardless of their cognitive abilities.

Introduction to Learning Disorders

Learning disabilities are neurologically-based processing problems. These processing problems can interfere with learning basic skills such as reading, writing and/or math. They can also interfere with higher level skills such as organization, time planning, abstract reasoning, long or short term memory and attention. It is important to realize that learning disabilities can affect an individual's life beyond academics and can impact relationships with family, friends and in the workplace. According to the National Center for Learning disabilities 2.4 Million (5%) of Public School Students were identified with learning disorders (NCLD 2014).

According to Learning Disabilities of America Association the common types of learning disorders include:

- AUDITORY PROCESSING- problems interpreting sounds and meanings of sounds
- DYSLEXIA-problems interpreting letters, words and language correctly
- DYSGRAPHIA- problems processing thoughts and transferring them to written format.
- VISUAL PERCEPTUAL- problems interpreting visual cues or transferring visual information
- LANGUAGE PROCESSING- problems attaching accurate meaning to sounds and words
- NON-VERBAL LEARNING- problems interpreting non-verbal cues, interpreting non-verbal meanings and patterns of information.
- DYSCALCULIA- poor comprehension of math symbols, memorizing and organizing numbers.
- Other disorders that significantly impact learning include but are not considered as learning disabilities include:
    - ADHD- inconsistent regulation of executive functions and impulse control

- Executive Function Deficit- An inefficiency in the cognitive management systems of the brain that affects planning, organization, strategizing, paying attention to and remembering details, and managing time and space.
- Dyspraxia-difficulty in muscle control, which causes problems with movement and coordination, language and speech.
- Memory-problems storing, holding and retrieving information.

What impact do learning disorders have on Psychotherapy?

Clients who have a learning disorder or a condition that impairs learning will likely struggle in therapy with restricted self-expression. They will struggle to answer insight oriented questions that therapists are accustomed to asking. They will also struggle to answer these questions because of limited self-awareness. It may not be common for them to consider what they are thinking or how they are feeling because they are distracted or overstimulated by other inputs. They will likely have difficulty determining therapy goals because of the first two difficulties and they are unaware of the possibilities for change beyond their learning disorder. Very often older clients have accepted a constant struggle and decrease the expectations for their lives. Clients will be unable to remember therapeutic content from prior sessions and be unable to transfer therapeutic content to their natural environment. This is not because they are not motivated enough to participate in therapy. They are likely to interpret this as a personal failure added to their list incapable tasks. Clients may incorrectly interpret therapeutic content, for example prioritizing a minor point over a major point; labeling myself is bad and makes me feel bad vs there are types of unhelpful thoughts that always lead to negative feelings, labeling is one of them. Last learning disordered clients may have difficulty establishing rapport with therapists because they often anticipate an interference with relating so they reactively restrict or dominate their interactions. Rapport with these clients' needs to be measured by their willingness to expose

vulnerability. Therapists need to be sensitive to very adaptive avoidance coping strategies from these clients. It can take longer to establish real rapport with these clients depending on how they are coping with their learning disorder. The correlation of learning disorders and psychiatric disorders is significant. Very often the client's response to their learning disorder leads to a psychiatric disorder. The most common overlapping disorders are anxiety, depression and oppositional defiant disorder. Other overlapping disorder include substance abuse, mood disorders, sensory integration, sleep disorders, and elimination disorders. I have found that it is very unproductive to treat these clients for the psychiatric disorder only. It is necessary to identify the relationship between the psychiatric disorder and learning disorder, for example, is anxiety a response to the loss of memory or does the anxiety interrupt the ability to remember? Sometimes clients can answer that question directly and other times certain activities in therapy reveal the relationship between the learning disorder and psychiatric disorder.

How to Identify a Potential Learning Disorder in a Clinical Setting

Psychoeducation Testing performed by a PhD level Psychologist or a master's level Education Specialist is necessary to identify specific details and diagnosis of a learning disorder. However according to the National Center on Learning Disorders "diagnosing a learning disability is a joint effort between the child's pediatrician, parent/caregiver, teacher and school administrator, and counselor" (NCLD 2014). Learning disorders impact every area of a person's life so it is most productive to gather information from all settings to best understand how a learning disorder is impacting the person. Therapists can contribute input by looking for signs of a learning disorder. Here are some common signs of a learning disorder in a psychotherapy setting:

- Parents report of problems related to academic or activities involving learning.
- Teachers report of problems expressing, comprehending, or completing an assignment.
- Behavior problems surrounding school, homework and therapy.

- Significant family history for learning problems.
- Noticeable attention, processing or comprehension problems in therapy sessions.
- Lack of progress or sustaining progress in therapy.
- The client gets frustrated with the therapy process.
- Client cannot remember the prior sessions content.
- Complaints from caregivers that the client is unmotivated and uninterested.

If a Therapist wants to assess for a learning disorder they can do any combination of the following.

- Regularly assess the components of learning- Writing samples, Reasoning games (tic tac toe, Guess who, Heads up), Verbal narratives (Tell me what you did this weekend?)
- Inquire about prior testing and get a copy of testing if available.
- Inquire about interest in learning with specific likes and dislikes
- Inquire about difficulty learning or family history of learning disorders.
- Use some of the following techniques and if they help the client keep using them.

If the Therapist suspects a learning disorder that has not yet been identified they can provide feedback to the client or parents from the assessments and refer client for Psychoeducational testing. Unless a therapist has a population with a lot of children struggling in school and with behavior it is not necessary to assess every client for a learning disorder. Rather stay sensitive to the progress of treatment if there seems to be any interference in learning then start to assess for it. Unfortunately, there are very negative public perspectives about people with learning disorders so carefully inquire and assess and incorporate the issues into the treatment plan and goals.

The effective techniques for learning disordered clients are driven by clinical judgement and intuition. Increasing therapists' awareness to the process of learning in therapy can preserve the therapeutic relationship and secure the achievement of the goals. One area of sensitivity therapists can increase is

toward the cognitive tasks they are asking the clients to participate in. Common cognitive tasks therapists use are:

- Organization of time and information (i.e. Tell me what happened?)
- Mindfulness/Relaxation/visual imagery
- Verbal expression of abstract concepts (i.e. What did that feel like? What was that experience like?)
- Written expression for journaling, homework assignments
- Recalling past events, and their emotions and cognitions
- Visual spatial expression and comprehension through explanation of relational interactions, or understanding of analogies.
- Metacognition
- Processing primarily with language and listening for 60 minutes.
- Advanced verbal comprehension using uncommon vocabulary.
- Nonverbal processing of facial expressions, voice, tone and interaction with toys
- Following sequences of abstract information (i.e. ABCs of CBT)

Each Therapist has unique style of therapy that most likely repeatedly uses of few of the cognitive tasks thus they can learn to modify the few tasks to accommodate learning disordered clients. If a client has psychoeducational testing the therapist can use information from the results to determine what modifications may be necessary. Below is a sample of psychoeducational testing results and recommendations which indicates that client is intelligent and has definite cognitive strengths. This client was diagnosed with ADHD and Non-Verbal Learning Disorder. Based on the results the client's cognitive strengths are comprehension, overall processing speed and visual processing. The client's weaknesses include working memory (work mem), and auditory processing. Therefore, a therapist would serve this client well to use advanced concepts and advanced vocabulary. Ask the client to share

their knowledge and gain insight from diagrams and infographics. On the contrary, this client would not enjoy or benefit from therapy that consisted of an hour of talking with concepts presented by listening only and in a sequence with each concept building upon the previous one.

COMP-KNOWLEDGE (*Gc*)	**114 (105-122)**	**High Average**	**82**
Oral Vocabulary	121 (110-132)	Superior	92
General Information	106 (95-116)	Average	65
FLUID REASONING (*Gf*)	**111 (101-120)**	**High Average**	**76**
Number Series	104 (95-114)	Average	62
Concept Formation	113 (101-126)	High Average	81
S-TERM WORK MEM (*Gwm*)	**82 (73-92)**	**Low Average**	**12**
Verbal Attention	87 (75-99)	Low Average	19
Numbers Reversed	83 (72-94)	Low Average	13
COG PROCESS SPEED (*Gs*)	**116 (107-125)**	**High Average**	**86**
Letter-Pattern Matching	107 (92-123)	Average	68
Pair Cancellation	121 (113-129)	Superior	92
AUDITORY PROCESS (*Ga*)	**87 (80-94)**	**Low Average**	**19**
Phonological Processing	87 (77-97)	Low Average	19
Nonword Repetition	89 (80-98)	Low Average	23
L-TERM RETRIEVAL (*Glr*)	**98 (91-106)**	**Average**	**46**
Story Recall	95 (86-103)	Average	36
Visual-Auditory Learning	101 (93-110)	Average	54
VISUAL PROCESSING (*Gv*)	**114 (102-126)**	**High Average**	**82**
Visualization	103 (93-114)	Average	59
Picture Recognition	120 (102-137)	High Average	90

Sample of Recommendations page;

Break big chunks of information into smaller pieces
Use checklists for tasks with multiple steps. For example, create a checklist for actions to take during a break from class. It might include: listen to messages, check and answer e-mails, review calendar, and review notes from class.
Develop routines to reduce forgetfulness and disorganization. For example, one routine might be to place your cell phone and keys in the same place every time, as soon as you walk in the door.
Practice working memory skills by utilizing strategies to remember lists of information. Strategies may include creating a song or rhyme. Visualization of information to recall can also be helpful.
Reduce multitasking. Complete one task and then move on to the next to increase efficiency and effectiveness.

How can a therapist use psychoeducation testing for treatment planning?

In summary, the testing results offer a picture the clients cognitive strengths and weaknesses. While the recommendations are written towards Educators, Therapists can apply the same concepts to the therapy setting by matching counseling interventions with the client's cognitive strengths and modify interventions for the client's cognitive weaknesses.

Consider this case scenario, A boy named Carl is 9 years old. He has been diagnosed ADHD, dyslexia and dysgraphia learning disabilities. He comes to counseling because of his behavior outbursts which interferes with every area of life. He has trouble with handwriting, expressing himself, self-management in the classroom, defiant and deceptive behavior. He is very impulsive, inattentive and hyperactive. He has family history of learning and psychiatric disorders to include OCD and Personality disorders. His father has sole custody, mother has supervised visitation. His father brings him to therapy with the complaint that his emotions and behavior are unmanageable everywhere he goes.

Here is a modified treatment plan for Carl

1. Identify his Multiple Intelligence, which is bodily-kinesthetic

2. Build rapport with structured flexibility (low stimulating room, limited selection of activities to choose from)
3. Set up sequence of activities in the beginning with a reward choice at the end of the sequence.
4. Plan multiple activities with common theme for sustained attention.
5. Use a timer for each activity to govern time.
6. Use movement with self-expression (i.e. ball toss) and guided self-expression (i.e. thumb ball)
7. Use unrestricted drawing but no writing or sand tray.

Consider another case scenario for an adult client named Lynn. Lynn is an over-functioning, anxious, dependent on alcohol, 55-year-old. She has a career in education but lost a prominent position because of impulsivity and poor judgement. She made minimal progress in therapy for 4 years and restarted when she was told by her Doctor that she needs to quit drinking. She recently completed an intensive outpatient substance abuse treatment program

Here is a modified treatment plan for Lynn;

1. Assess and diagnosed for ADHD from DSM 5, refer to an ADHD specialist for medication evaluation.
2. Set up phases of treatment. Phase 1 INCREASE SELF AWARENESS
3. 15 min of session use repetitive self -assessment sequence to internalize insight- what are you grateful for? What are your hang ups/hindrances? What do you need?, What are your plans
4. 15 min of Psychoeducation- target hang ups or needs- i.e. cognitive distortions
5. 15 min of Psychodynamic or EMDR i.e. family of origin maladaptive coping patterns.
6. 10 min summarize session and write in her journal what she wants to remember.

THERAPETUTIC TECHNIQUES FOR LEARNING DISORDERS

Finally, the techniques that Therapists can use for clients with learning disorders are listed and explained as they might appear during each session task. First, it is necessary to list what therapists need to avoid when working with learning disordered clients. Do not:

1. Focus only skill building which does not lead to internalization or generalization.
2. Wing it because the clients cannot decipher hidden meanings.
3. Assume the client will come with a plan or preference for therapy session.
4. Continue doing the same thing without any results.
5. Blame the client's motivation, commitment or capacity for therapy.
6. Let the client's or caregiver's complaints guide the course of therapy.

List of effective techniques:

1. STRUCTURE SESSIONS AND ESTABLISH A SESSION ROUTINE
2. BREAKDOWN CONCEPTS INTO SMALL CHUNKS
3. REVIEW, REPEAT, REPROCESS
4. PLAN IMMEDIATE AND SHORT TERM REINFORCEMENTS FOR MOTIVATION
5. USE PROMPTS TO HELP SELF EXPRESSION AND AWARENESS
6. USE EDUCATIONAL TECHNIQUES I.E. SCAFFOLDING, CHUNKING, ANALOGIES
7. USE MULTISENSORY APPROACH
8. PRODUCE A THERAPY PRODUCT (BOOK, DRAWING)
9. REGULARLY USE TOOLS FOR OUTCOME MEASUREMENT (PRE-AND POST SESSIONS) *

The same techniques can be applied to adult and child populations with some delivery modifications. For example, techniques used with adults can be more discrete and with children the plan is more concrete. To further explain the techniques, I have broken down a therapy session into seven common tasks and listed techniques appropriate for each task.

Therapy task 1: Check in

When a client arrives and the therapist breaks the ice and sets up the session time. If a client has a learning disorder consider the following modifications to improve the completion of this task.

Sequencing warm up routines. Using the prompts that assist with insight orientation, for example, the 3Cs is Complaint/Confess/Compliment. Therapist asks the client share a complaint (something they are unhappy about) a confession (something they are sad or regretful about) and a compliment (something they are proud of or grateful for. Another example is to ask client to share something from each of these categories, what are you grateful for? What do you feel like is hindering you? what are you aware of that you need? What plans do you need to make based on what you just shared? Another example is writing sprints. Writing sprints are brief insight oriented questions that the therapist gives the client before the session begins. Then the therapist can review with the client at check in. Here is a sample writing sprint:

Answer the following on a scale of 1-10 (10 is the highest rating)
How many times have you gotten angry since your last session?
Who were you angry with?
What were you angry about?
How negative were your actions when you were angry?
How hard did you try to do something different when you were angry?

- Use a timer to govern time. It is easier to sustain attention when the time is predetermined and is being externally monitored. For each activity during the session set a simple handheld timer for the predetermined amount of time and then set it aside. When the timer goes off, honor it and praise the attention and effort then move on to the next activity.
- Use an interval schedule such as, work and play then work and break. Working in intervals builds up stamina and endurance for the less desired activities. Over time the intervals can be longer because the client has made progress. Initially the intervals could be as brief as 5 min each.
- Structure the session with a PPP. A PPP stands for Plan/Prepare/Prioritize. A PPP has four columns and as many rows as the number of tasks needed to complete. The columns are set up left to right: Order, Task, Length of time, Completed check. This technique can be introduced when deciding how to focus the session, what to talk about and what to work on. Giving the client as much choice as possible will bypass many oppositional behaviors.

<u>Therapy Task 2: Rapport Building</u>

Connecting with the client and with their story is important at the beginning of each session. It is difficult for clients to share vulnerabilities but these techniques can be productive.

- Share control by offering choice of activities, the amount of time spent on a task and/or the order of activities. Using the PPP is an easy way to lay out the choices. Over time a therapist can negotiate with the client to lead them to more challenging and vulnerable activities.
- Work up to the hardest activity and start with the easiest. When planning activities keep them within a theme. For example, for a narrative therapy approach start with a mad lib then a comic strip story about a fictional character then a comic strip personal story about the client.
- Keep length of a session to a successful length of time. The successful length of time can be measured by how long the client can give good effort level and stay engaged with therapist.

Also, therapists need to be careful that the session is not dominated by redirections. It is counterproductive to hold an hour session if it is filled with 20-30 minutes of redirections. Rather than blame the client for not being able to attend a full session only plan activities for the successful amount of time and praise the client for their participation. Over time the length of the session will be able to increase.

- Incorporate contemplative practices such as brain breaks, relaxation exercises, and yoga. It can help a client to participate in these activities with the therapist participates with them. There are several video resources on you tube of brain breaks, breathing exercises and brief yoga for kids. I often use the 4-7-8 breathing video by Go Zen.
- Protect therapy time from activities that will be negative for the client. For example, with child clients do not allow parents to take up significant time giving reports or complaining about their child. Instead give parents surveys or writing sprints to complete while you are meeting with the child. Or in your treatment planning set up to meet with the parents separately to discuss progress and goals. This will help the client stay focused and positive about therapy.

<u>Therapy Task 3: Goal Setting</u>

- Quantify the abstract self-reflection questions. For example, instead of asking a client how they feel ask them to rate various levels of energy out of 100%, physical energy and mental energy. If they are visual consider graphing their responses over several sessions to increase their insight and identify goals. Also, ask the client to quantify their needs with numbers 0-10, for example how sad do you currently feel 1-10 (10 is the worst), how sad is reasonable to feel in these circumstances, 1-10? How sad do you want to feel by the end of the session, 1-10? Another way to quantify self-reflection is to use comparisons such as more and less. What do you want to feel more and feel less? What do you want to think about more and think about less?

- Use consistent measurements to measure progress so the client and begin to internally evaluate their progress. There are many effective therapeutic measurements available. I like to use the online assessments from the DSM 5, The Connor Davidson Resiliency Scale, and Scott Miller's Outcome Rating Scale. Evaluating the session and progress toward goals is not just for good documentation or insurance justification. For learning disordered clients' regular evaluation helps them develop their own set of self-evaluation skills that can guide their behaviors.
- Use repetitive prompts instead of changing the wording of questions every session. For example, when goal setting use the same sequence for the client to fill in the blanks. When I realized… I decided I want to…. First I will....Then I will… When I have ... I will... For some learning disordered clients' it is easier for them to remember with repetitive patterns.
- Use a reward menu to find out what motivates the client to work. Rewards are in important and natural part of life and should not be overlooked. There are many rewards that are free and meaningful. For example, when an adult client meets a goal or completes a phase of therapy they may feel rewarded by taking a week or two off from therapy and use that time for recreation. A child client is rewarded by free time, play time or good report to parents. Learning disordered clients can give more effort when they have a reward to work for. There are many reward menu samples available on the internet.
- Use treatment phases as a measurable and tangible way to move through complex treatment. Clients' can sustain more motivation by moving through phases instead of unending, problem focused treatment. Typical phases of treatment include assessment, increasing insight, changing core beliefs, practicing new core beliefs, maintaining new beliefs and termination. The Therapist can plan the number of sessions needed for each phase and can reward client when a phase is completed.

<u>Therapy Task 4: Intervention</u>

Therapeutic interventions are the most significant part of the session, it is what people pay for. Clients need to be ready to receive the interventions to maximize its impact. For learning disordered clients' interventions need to be broken down in smaller chunks for processing. In addition to delivery of the intervention needs to support the client's cognitive strengths and not trigger their weaknesses. Therapists are not working to resolve the learning disorder but they are capable of facilitating change with a learning disorder present. Some helpful ways to breakdown interventions are:

- Supported narratives can be used for CBT, narrative and psychodynamic modes of therapy. For example, a child is working through divorce adjustment and the therapist creates a story template with fill in blanks. The client can verbalize or write the answers in. Each page has a different title and can be used with parents to complete. At each session, the story is reviewed from the beginning and another page is started. The intervention is in the direction of the story, the questions to be answered and gathering of facts and expression of feelings.
- Make abstract concepts three dimensional by using Info graphics and diagrams. Instead of asking the client to recall a concept from memory they will have more success recalling with visualization and action. Over time the Therapist can ask the client to duplicate the concept with fewer and fewer prompts and ultimately teach the concept to someone else.
- Use Analogies to help clients make connections with new material and familiar experiences. Present analogies that have been tested and thought through because clients will most likely remember the first explanation of new information and it is difficult to correct after the first time. For example, working with an ADHD client who is working on self-control and is very interested in video games. The Therapist's analogy intervention could be: "A remote control has buttons that tell the games how to response. In a similar way, we can activate buttons internally to tell our thoughts and feelings how to respond to different situations. Let's name the buttons on your personal remote control so you can practice using them. What kind of

buttons do you need? What buttons would you use the most often? Close your eyes and visualize using this remote to control your thoughts and feelings."

Therapy Task 5: Teaching

Teaching new concepts to a client is often necessary to be able to use interventions. The psychoeducational component in a therapy session can be modified for learning disordered clients with these methods:

- Use a multisensory approach that involves at least two of the five senses. Consider the client's cognitive strengths to determine with senses are the best to utilize. For example, there are many verbal and visual teaching aids like Unhelpful Thinking Style Chart from PsychologyTools.com. Another example is using a ball to toss back and forth or put together a puzzle as you describe or discuss a topic with the client. Interactive videos are good multisensory aids to teach new concepts. Make sure to preview videos all the way through before introducing to a client because it is likely they will focus on an unimportant part of the video. Watch Well Cast video channel on you tube has some good videos for adolescent clients. Last there are APPS that are interactive and helpful for teaching and interventions. The EMDR APP has several options to use different sounds and sights the client can have a lot of control over the options.
- Use a group dynamic to create enough sensory stimulation for teaching new concepts. Often a pair of siblings or a parent willing to participate will increase the sensory input to optimize teaching. Group therapy is also effective with a small number of learning disordered clients because the therapist will have to plan accommodations for each client's learning disorder.

- Use drama therapy techniques are great to facilitate the experiential part of learning a therapy session. Some techniques include role reversal, empty chair, the client or therapist as the director of a script.
- Use novelty to keep clients interested and curious about therapy sessions. It is best to change the activity or techniques at the first small sign of disinterest. In addition, when giving choices, keep them limited so that the client will keep having new choices available.

Therapy Task 6: Application

Towards the end of the teaching or intervention the client needs to apply new knowledge. The purpose of application is not being right or accurate but to practice using the knowledge for a greater understanding. For learning disordered clients assigning "practicing" homework is usually unproductive until they have repeatedly used the knowledge in therapy. Therefore, it is best to make time for application in the session. The following are some methods that can help facilitate application.

- Use multiple modes of treatment, for example if the session was one on one bring in the parent for the application portion. Depending on the client's confidence level the parent can participate or observe. Using technology such as voice recording or making a video are useful for application. It is best to change the modality when applying new information.
- Assign the client interactive homework that can be easily measured and is not like school work. For example, ask the client to explain a new idea to someone else and get their feedback on it. When the client returns ask them to share the feedback they received. For some clients who are extroverted this is a pleasant homework task to do. The more engaged a client is in session the more likely they will complete a homework task.
- Create a therapy product like a book, drawing, or video the client can review or show to others.

Therapy Task 7: Reinforcement

Reinforcing therapeutic content in a session can be done throughout the session if the client has been in therapy for a while. It is important that therapists intentionally engage the client in review and reinforcement because of the learning disorder. Here are some helpful reinforcement techniques:

- Review a product that is being created in therapy. When reviewing start from the beginning every time and pay attention to the client getting it accurate (unlike the application stage). Another way to review is to play hangman using a keyword to a concept then play fill in the blank- therapist starts a sentence and the client finishes it. Another good technique is to use two white boards for the therapist and the client to duplicate a previously concept on the boards. The therapist can start as the lead and gradually take instruction from the client.

- Assign a home monitor sheet that can simply and clearly measure the desired behaviors or tasks. Offering a reward for returning the home monitor sheets to the next session may increase the client's awareness and reinforcement of the goals. Frequently use measurement tools, such as the Connor-Davidson resiliency scale to reinforce the progression of therapy. The client will internalize more self-monitoring when the therapist repeatedly uses the same measurement tool.

- Teach parents/spouses/family the same content by asking them to attend the session and either participate or observe. Make sure a secure rapport has been established with client first. There will be more opportunity for reinforcement if another person knows the information.

- Set specific goals and rewards for the client to demonstrate knowledge and skills. Initially the Therapist should control goals and rewards until the client and parents learn how to set good goals and follow through with rewards. For example, set up a quiz session for the client to review everything they have learning in phase of treatment. Even though Therapists do not

give tests or quizzes a client with a competitive nature will gladly compete to show their knowledge.

Summary and Conclusion

Psychotherapy is built upon the presumption that individuals can learn and achieve metacognition. While this is possible for most of the general population there are individuals who have learning disorders and these individuals can benefit from psychotherapy. In addition, these clients should not be excluded by a limited delivery of the profession. However, to provide effective therapy to learning disordered clients' therapist need to be able to identify interferences in the learning process, utilize psychoeducation results to assist with treatment plan and develop individualize treatment plans for clients with learning disorders. Modifications can be easily considered in each task of a therapy session. Modified techniques are considered effective when they allow the client to stay engaged in the session and make measurable progress toward their therapy goals.

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