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ABSTRACT

This article explores the myriad challenges facing young, neuroatypical adults struggling through a "failure to launch" – i.e., enduring a pronounced difficulty with establishing themselves academically, socially and professionally after high school graduation. The author recommends integrating traditional psychotherapy with a high level of activity and scaffolding support techniques geared at completing academic and social tasks. The theoretical underpinnings as well as clinical implications of this approach are discussed.

Millennials face greater challenges than previous generations when it comes to achieving independence in adulthood. Establishing oneself professionally has proven to be an uphill battle given precarious economic conditions, stagnating wages, a tighter credit market, and endemic educational debt (Kurz, Geng, & Vine, 2018; Xu, Johnson, Bartholomae, O'Neill, & Gutter, 2015). Additionally, the incidence of depression has risen dramatically – by as much as thirty-three percent since 2013 (Blue Cross Blue Shield, 2018). Last year, over sixty percent of college students said they had experienced "overwhelming anxiety," while over forty percent felt so depressed they had difficulty functioning (American College Health Association, 2018).

Clinicians undoubtedly need to adapt to the needs of a generation beset by these mounting pressures.

Navigating the transition from adolescence to young adulthood (or "adulting," to use the popular vernacular) is particularly challenging for individuals with learning and attentional challenges.

Life-stage transitions require the ability to plan, organize, produce, and adapt – neurocognitive skills that are compromised in this population. Achieving true autonomy and completing the individuation phase also requires confidence and the capacity to take risks. Young adults with a history of learning and attention deficits often lack the emotional skills for "adulting," as they have long relied on a host of outside support from family members and professionals alike. In this paper, I will discuss a developmentally informed treatment approach that directly addresses the neurocognitive deficits and emotional disorders within a psychoanalytic framework. This approach, which integrates psychoanalytical treatment with an emphasis on increased activity, represents a modification and addendum to existing methods and interventions.

Devising an integrated treatment plan to help patients focus on both the internal and external challenges to his/her success is one key aspect that differentiates my work from consulting with a life coach or psychoeducational therapist. While I facilitate task completion with the patient, I concurrently analyze the intrapsychic challenges to their success; while I educate them about their learning and attention difficulties, I attune to their affect surrounding these conditions.

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Working in a sequenced, developmentally informed manner is paramount. I offer my interventions at a pace that feels right to a patient who is striving for balance and independence while providing a safety net during this difficult transition.

Developmental models are a widely accepted means of understanding and treating adolescents (Levy-Warren, 1996). Young adults with neurocognitive challenges tend to organize their experience at the emotional level of latency-age children: they tend to be very rigid and obsessive; they often have high standards and are perfectionistic and unrealistic; and they struggle with severe emotional distress. Helping them reconstitute and regain their sense of competence requires a multifaceted, developmental approach that will be outlined in this paper. With treatment, they are able to mature and present more as adolescents and young adults struggling with identity formation and establishing themselves as autonomous individuals. They are able to develop a mature ego ideal that has realistic expectations of themselves and others and can more easily tolerate ambivalence (Levy-Warren, 2008b).

Marsha Levy-Warren (1996) separates adolescent identity formation into three stages – early, middle, and late – in working with young adults who have not yet achieved autonomy. Every adolescent must pass through each stage on the path to adulthood. For adolescents and young adults with neurocognitive difficulties, separating from their families is more conflicted, as they often require increased family support and may experience difficulty defining themselves in diverse areas of competence that could help this process. As Levy-Warren states, "The pursuit of knowledge and experience outside the life of the family is often an important step in the direction of the maturing of the ego ideal." These young adults typically have significant challenges to succeeding in both academic and professional settings, and therefore separating from their families.

Patients who typically benefit from modifying the traditional psychodynamic approach meet criteria for neurocognitive impairments and psychiatric difficulties. Neurotypical young adults do not need this type of direct intervention, as they can typically manage independently.

Neuroatypical young adults often have well-documented histories of learning disabilities and attention disorders, comorbid with depression and anxiety. Conducting neuropsychological assessments can be extremely helpful in documenting the etiology of these issues. This type of integrated treatment can vary in duration (from months to years) depending on the patient's level of functioning. As the patient progresses, the therapist gradually withdraws their support and scaffolding – while paying close attention to the emotional response to this change in intervention. This is an organic process; patient and therapist collaborate actively to help the patient achieve increased autonomy. As the patient gains independence, fear of success may become a prominent issue in the treatment. Helping the patient manage their dependency wishes, competitive feelings, and ambivalence about meeting their goals is essential to this process.

Though there is voluminous literature on treatment for children with attention and learning difficulties, information regarding treatment methodology for these disorders in adulthood is scarce (Faraone et al., 2000). O'Driscoll (2009) documents the sparse literature available on psychodynamic psychotherapy for adults with learning disabilities; he concludes that therapeutic pessimism may be partially responsible. My approach integrates clinical intervention with neurocognitive remediation. This is an approach that was well-documented with children but has not been adapted for use with adults (McCarthy, Conway, & Szymanski, 2011; Palombo, 2001). Conway (2017) notes that the psychoanalytically informed therapist should regard a child's symptoms (such as inattention and organizational difficulties) within the dynamic context of their development and subjective experience of their symptoms. In this model, integrating behavioral techniques elucidates a view of the ADHD child's "unique psychological world."

In his seminal paper *The Waning of the Oedipus Complex*, Loewald (2000) describes the intrapsychic struggles related to establishing oneself as an independent person. The adolescent needs to metaphorically kill off the parent but struggles to integrate the guilt associated with diminishing this relationship. This is especially difficult for young people who, neurologically, need extra assistance from their parents and other adults in their lives. The harsh, self-critical voice that so many of my

patients hold within them reflects this conflict. Helping them integrate a more compassionate approach and empowering them to develop their own voice are treatment goals that can be accomplished with this integrated approach. In fact, even when the parents are supportive and loving, the child may feel disappointed in their academic difficulties and internalizes the disappointment to feel they are "stupid, "lazy," or both. One of the pivotal goals of the treatment is to unpack the harsh inner voice and resolve those conflicts to facilitate ability to move ahead academically and socially.

Levy-Warren (2008b) further expounds upon the pivotal importance of the Oedipus Complex in adolescence. She argues that recognizing how adolescents experience and work through their oedipal conflicts is a key aspect of adult treatment. Developmentally, oedipal conflicts are reworked during adolescence and require interpretations to that effect. As explained by Levy- Warren, the shift in focus from parents in childhood to the peer group in adolescence is often more strained for adolescents with neurocognitive issues (M. Levy-Warren, personal communication, May 17, 2018). Attention and learning difficulties compound these struggles, preventing teenagers from forming close friendships and/or romantic relationships and hindering their academic performance. These deficits only further interfere with their ability to "adult," e.g. find a career and partner, and live independently. Thus, special attention to these issues is pivotal in the treatment of such young adults.

Failure to launch

One phenomenon associated with young adults presenting with attention and learning disorders is "failure to launch" – young adults who have difficulty separating from home. They are often unable to complete college tasks away from their familiar environment, perhaps because their parents have historically provided the type of support that a college environment cannot.

Beginning a career post-graduation can be similarly challenging, owing in part to their neurocognitive and emotional difficulties.

After extensively studying the population of emerging adults, Arnett (2007) identified three criteria that define the transition from adolescence to adulthood: accepting personal responsibility, independent decision-making, and financial independence. Kins and Beyers (2010) observe that continued co-residence with parents during this stage slows the process by which an individual becomes an independent adult. Young adults who resided at home during college require additional support during this stage. An approach that integrates psychotherapeutic treatment and task-oriented, concrete assistance can be effective in facilitating this challenging transition into independent adulthood for young adults with neurocognitive challenges. My experience with these patients indicates that understanding the neurological underpinnings of their challenges facilitates increased insight into their symptoms, self-acceptance, increased productivity, and decreased psychiatric sequelae.

Understanding the emotional and functional impacts of neurological difficulties on the subjective experience of these young adults is pivotal to their eventual success. The therapist must explain how the attention and learning disorders are contributing to the failure to launch and must explore the psychological impact of these challenges. Young adults may feel ashamed of their dependence on their parents and anger and frustration toward themselves – as such, they often present with compromised self-esteem. Neurocognitively, their poor executive functioning can lead to significant difficulty completing tasks efficiently, such as writing papers, submitting resumes, and managing time. Initially, the sessions may focus more on task completion; however, the emphasis is always on exploring the subjective experience of the patients while providing strategies to compensate for their neurocognitive difficulties. This dual approach is often most helpful for patients who may resist more traditional forms of neurocognitive support (such as tutoring or coaching) but will accept the aid of a therapist with whom they share a unique relationship in which trust and positive regard have been firmly established.

Young adults with attention and learning difficulties often become stuck in the latency period of development; they demonstrate a rigid cognitive style and tend to see things in black and white terms. Part of the therapist's job is to help them see the world and themselves in a more complicated

and nuanced manner. Facilitating this break from a binary (either/or) position in favor of a more open-minded perspective can greatly facilitate emotional, social, and intellectual growth. Demystifying their learning style, facilitating accommodations and support, and helping them gain insight into how their minds and psyches operate is an essential piece of the treatment.

Clinical intervention

Anxiety and organizational, attentional, and learning limitations often prevent these young adults from accomplishing their work and achieving their goals. Completing projects with the therapist – from reading and writing assignments to test preparation – provides the therapist with unique insight into the patient's struggles. In the case of a particular young adult enrolled in an online college course, it took an entire session to write one paragraph. His hands shook as he typed, and he tended to delete his thoughts as soon as he had committed them to the page. Discussing his intense performance anxiety led to recollections of his junior high school and high school years, where he felt like a fraud because he convinced his tutor to do his work for him. We discussed his feelings of shame and inadequacy, and he came to understand that he was a capable young man who worked diligently but was stymied by organizational and attentional deficits that forced him to rely on others to complete his work. He became increasingly independent, and now submits his assignments with minimal support.

Intensive, individuated intervention appears to be a necessary step in enabling independent work. Lending these individuals quiet support and devoted attention as they work is a transitional step. This echoes Winnicott's (1958) concept of being alone in the presence of the other. The child experiences their separate self and ego strengths with the silent support of a caregiver who is not imposing, intrusive, or neglectful. The presence of the therapist can mitigate the intense anxiety aroused by academic tasks.

Attachment theorists discuss the attuned mother who modulates her activity based on cues she receives from her baby (Beebe & Lachmann, 2014). My therapeutic interventions mirror that model: the therapist varies their level of activity and stimulation to create an adequate fit with the patient's needs. Patients who experience paralytic anxiety and attention or learning disorders may benefit from robust activity to improve their productivity. I can work with them, psychoanalytically, as they complete their tasks and the feelings surface. Entering their subjective experience as they directly encounter their neurocognitive challenges helps them self reflect, get in touch with their feelings and conflicts, and become aware of the impact on their interpersonal relationships.

I employ scaffolding techniques with my patients to help them execute tasks they find too difficult to complete independently. These tasks can be academic, (writing papers and test prep) organizational, (returning e-mails) or social (going on social media to make plans). My patients frequently report feelings of shame and guilt, and often worry about disappointing parents and teachers. The therapist can model a tolerant, non-judgmental approach toward the individual's struggles to help them internalize this perspective. Tackling tasks with the therapist in the room can protect the client from the barrage of self-criticism, freeing them to approach the task itself. Showing them that they can indeed accomplish the dreaded, impossible-seeming task can be relieving and energizing. Feelings and conflicts around the tasks are concurrently brought directly into the room and discussed with the therapist. These feelings can vary from shame, guilt, anger, frustration, and ambivalence to satisfaction, euphoria, pride and excitement.

Scaffolding and breaking the task into manageable units effectively addresses the patient's neurocognitive and emotional difficulties. The therapist can help dispel this anxiety by actively demonstrating that the young adult is competent to accomplish the task. This level of activity addresses the often paralytic anxiety accompanied by the tasks and allows the patient to gain confidence and belief in their abilities. Feelings of pride and accomplishment are expressed and mirrored by the therapist, especially as patients graduate to executing the tasks without their aid. As

noted above, any arising feelings of fear, guilt, shame and frustration are discussed and explored in the treatment.

A thirty-two-year-old woman experienced severe difficulty organizing her resume due to the diversity of jobs she had held, paired with significant anxiety about reentering the workforce. She recounted her inability to focus on completing paperwork at home and found herself distracted and depressed. She initially felt like a "bad girl" who could not do her "homework." When I suggested we work on her resume together, a concrete offer of help, she visibly brightened. While listing her disparate jobs on paper she lamented her lack of education and related anxiety and shame at the toll her attentional and psychiatric difficulties had taken on her career. After her resume took shape, she commented on how much easier it had been to work on it and left the office feeling energized. My concrete support, paired with affirmative intervention around understanding her struggles, led directly to her increased confidence. Several months later, she began working with a job consultant and eventually branched out on her own, applying to jobs directly and landing a coveted position as a sales manager.

Offering concrete help also allows the patient to see the legitimacy of their struggle, and that I take their concerns seriously, rather than blaming them or expecting them to just "get over it and do it." When working with people who struggle to organize, plan, or work independently, it is important to be sympathetic, supportive, and concrete – especially because these interventions can bring up feelings of shame and inadequacy harbored as a result of these difficulties. Bright, verbal individuals are typically expected to thrive and often encounter shock, shaming, and disbelief from parents, teachers, friends, and supervisors when their challenges manifest. They are too often told that their learning disabilities are in their mind, and that they just need to buckle down and focus in order to master tasks with which they struggle. Explaining the neurocognitive etiology of their difficulties and unpacking their emotional sequelae helps resolve those painful and internalized experiences.

In addition to their neurocognitive struggles, these individuals may struggle to acknowledge their feelings – both to themselves and often to others. This type of struggle mirrors Killingmo's (2006) description of working with patients who struggle with mentalization and are often removed from their feelings. The paralytic anxiety and emptiness of depression and dread that accompany millennial transitions echo descriptions of his cases. Use of intonation and validation are especially effective in alleviating these feelings. The use of affirmative interventions is crucial in the presence of paralytic anxiety and self-doubt that surface during this life period.

Killingmo's (2006) explication of affirmative messages to the "emotionally isolated" patient serves as an underpinning to the treatment I offer these patients. Helping patients keep their neurocognitive difficulties in mind while not succumbing to the negative affect plays a crucial role in enabling them to become productive and task-oriented.

A young woman with overwhelming anxiety was unable to complete her academic assignments. We began by working on her papers together during sessions in my office. After she graduated from college, we started applying to jobs together. She expressed intense anger and perfectionistic ideas regarding the quality of her work when confronted with difficulty completing the associated tasks. As she began expressing these feelings and we talked through them together, she transitioned to working more independently and eventually began meeting with an employment specialist outside of the office. She then reported frustration when the specialist urged her to express enthusiasm about her job options, and told me she did not feel safe expressing either positive or negative feelings. She explained that she felt expressing her true feelings was dangerous because they could be considered rude and would completely disorganize and overwhelm her. Her ability to hold the painful feelings while continuing to work productively was a key achievement.

The neurocognitive demands of mentalization of affect can pose significant challenges for individuals with processing difficulties. Killingmo (1995) attributes this deficit to poor affective attuning in mother-infant relationships, though it is possible that learning and attention disabilities contribute to a similar presentation. Not understanding what's expected of you, when coupled with issues of effective communication, can create a state of disorganization and

confusion similar to Killingmo's description of the impact of early trauma. Fonagy (2002) posits that affirming the patient's self-state and staying a step ahead of the child can help them mentalize more effectively. Working concretely with patients and offering validation of their feelings grants me proximity to their experience and affords them more independence.

Recently, a twenty-five-year-old woman (who I have treated in group and individual settings since adolescence) came to session determined to respond to e-mails concerning recommendation letters for graduate school applications. She commented, "Why is it so hard for me to return these e-mails? Why can I only do them with you in the room?" We discussed these two questions as we worked on her replies. She associated to memories of being pulled out of class for testing in elementary school with no explanation, and the confusion and embarrassment surrounding educational support services. She also associated to her parents decreeing she should wait to hire a GRE tutor until after she took a practice exam. She continued, noting that when she tries to respond to e-mails or do "adulting" tasks, she often feels like she's walking on a wobbly tightrope. In contrast, with me she feels safe and relaxed. She linked her anxiety to her parents' and her school's refusal to keep her informed about her learning needs. Eventually she evoked positive feelings about graduate school and her use of the test-prep tutor.

Students with learning and attention disorders are often unable to transfer knowledge learned in the classroom to homework assignments and tests. These situations evoke painful memories of frustrated parents and teachers questioning, "How could you not know that?" and, "You must know this! I just told you." These interactions have a tendency to cause children to internalize blame for their learning difficulties and lead them to avoid intervention. As these young adults grow comfortable accepting help, they rework their past experiences and understand that the adults who misunderstood their issues and were not patient and supportive were the real problem. Even when children with attention and learning disorders receive the utmost support and love from parents and teachers, experiences of academic failure, dysregulation, poor organization and slowed processing speed may cause children to internalize feelings of shame, lowered efficacy, and poor self-esteem.

Patients often struggle with the stigmas and infantilization associated with receiving additional help from a specialist or family members – these support systems can also trigger painful past experiences. These additional relationships with coaches, tutors, and therapists can feel interpersonally overwhelming. The therapist can work from a unique position of strength if she has developed a trusting and supportive relationship with the student – who will then be open to accepting suggestions and intervention more readily. An emotionally fragile college student with debilitating anxiety was only able to complete her papers with me, or sometimes in my office.

Progressively, she was able to write papers in the waiting room with periodic check-ins. By graduation she was able to work effectively with other people and had internalized efficacy away from my office. One way to effectively ease patients from my support is by exploring their concerns about accepting help from other people. They are often highly suspicious and mistrustful as a result of past experiences, and partially due to high levels of anxiety and depression.

Providing the client with tools they can employ outside of session is both meaningful and complex. As with all therapeutic suggestions and interventions, (e.g. medication, cognitive behavior techniques of hypnosis, etc.) the treatment's impact needs to be recognized, discussed, and understood. Transferentially, the patient may feel infantilized or annoyed at the therapist's perceived intrusiveness but concurrently grateful for their support with tasks. They may feel frustrated that the therapist isn't helpful enough or angry if they feel pressured by the therapist. Countertransferentially, this approach may lead to concerns about the patient's level of dependence and regression, and frustration if the patient does not follow up effectively. These feelings provide a multilayered prism for the therapist and patient to explore feelings of mutual dependency, frustration, and anxiety related to the patient's challenges. These subjective experiences in the treatment resonate with the patient's experiences in school and with family members while directly tapping into their inner world and how they experience themselves.

Issues of identity and how they value themselves (and how others value them) surface and can be addressed in session.

In working with a college student with learning, attention issues and anxiety. Part of work together is checking in with him to ensure that he has done his assignments, taken college tests, and so on. Despite his intelligence, he is currently on academic probation and will be asked to leave the school if he fails any more classes. I have taken an active role in this. He receives accommodations and support and has a homework helper. Despite this, he is still falling short. He reveals to me that he is in danger of failing a class and he had been omitting this information from our sessions. Countertransferentially, I experienced significant anxiety and frustration, both about his precarious academic standing and the wrath of his mother. I am able to inquire about what went awry and brainstorm with him how to solve the problem. He then writes an e-mail to his professor pleading with her to allow him to retake an exam and the plan succeeds. We discuss how his feelings of shame caused him to avoid discussing this with me or his professor, and that through our conversation, he was able to understand that when these things happen, he would be so ashamed that he could not look at the teacher or confront the reality of the situation with any focus. He now realizes that his issues are due to his ADD and that he doesn't have to pout in the corner.

Maintaining a high level of activity during treatment requires a heightened level of self- awareness on the part of the therapist. The countertransferential pull can be extremely powerful in these cases; the therapist must beware of becoming overly involved with the patient's actual tasks and strive to maintain an analytic stance. Checking in with the patient and remaining open to modifying the original plan is crucial to maintaining boundaries and preventing the therapist from hijacking the session. A young adult came into session and expressed a desire to invite her friends and colleagues to a birthday celebration. I enthusiastically supported this idea and actively encouraged her to text people to invite them to the party. During her next session she was deflated and hesitant to speak; she had gotten a limited response and wanted to cancel the event but felt I would pressure her to further invite people and host the party. She clarified that, when she expressed the idea about the party, she'd regarded it more as a fantasy. I apologized for pressuring her; she said, "I know you were only encouraging me because you knew the party would make me happy." I acknowledged that impulse and we discussed an alternative plan for her to socialize on that date. We discussed the balance between me supporting her and pressuring her, how easily intruded upon she feels, and the impact of her social anxiety and sensitivity to intrusion on her ability to form and sustain relationships.

Many of these patients work concurrently with tutors, organizational coaches, and psychopharmacologists; in this crowded field, the therapist must function as the quarterback – someone who holds the system together and helps the patient navigate the many moving parts of their life. By staying involved in the patient's day-to-date activities, the therapist can directly help them organize and manage tasks – skills that are compromised by the patient's executive functioning challenges. This means helping the patient concretely in the office, following up with the other service providers they're working with, and providing daily phone calls or text check- ins. Here, the therapist functions as an auxiliary ego that is eventually internalized by the patient (Hoffman, 2013). This is particularly important for individuals with executive functioning issues, as they may lack the organizational skills required to coordinate, plan and manage details.

Helping them in this way also offers them an emotional "glue" and helps them transition to taking over these tasks independently.

Levy-Warren discusses the clinical dilemmas presented by patients who come with a team, and the importance of the therapist taking an active role in managing the treatment. She characterizes these experiences as a "fast-moving thicket," and postulates that the therapist's job is to slow down the experience while helping the adolescent connect with the therapist in a genuine manner (Levy-Warren, 2008a). Because young adults with neurocognitive challenges often require multiple services (tutoring, medication, accommodations, etc.), helping them manage and coordinate the many professionals involved paves the way to a more meaningful connection with the therapist.

Working together on concrete tasks allows for exploration of intense feelings and a better understanding of how past experiences inform their approach to completing these tasks.

The therapist takes over an integrative function that is essential in helping the patient manage coordinating the diverse support services they need. If there is no integration, the multitude of services risks further fragmentation and disorganization for the patient.

A young woman with severe anxiety, depression, and learning disorders received daily assistance from her parents with laundry, schoolwork, appointment-making, and medication. They often erupted into intense conflict when she resented their support, yet she still felt dependent on them. Her intense anxiety and hyper-vigilance meant she could not work with anybody else or allow anybody into her home. Over the course of treatment, she began working with a tutor, a personal assistant, and a cleaning person. Her team was comprised of referrals I made and worked closely with. I prevented splitting and disorganization by explicitly referring to the professionals she worked with and letting her know about our conversations. She was able to improve her relationship with her parents and increase her functional independence.

We often discuss the task-oriented difficulties that arise from both neurocognitive and psychiatric difficulties in my group for young adults. I recently suggested that the group use our session to apply for jobs together as a way of facilitating a common goal. Working simultaneously on their laptops, they advised one another on traversing this daunting task. When we debriefed, each patient commented on how much easier it was to fill out applications and identify possible jobs in this setting. Though memories of being called "lazy" or "stupid" surfaced, (as did feelings of anger, frustration, and inadequacy) completing a concrete task in the presence of a group leader provided a cathartic experience and a space to express the frustrations associated with organizational difficulties.

Exploring patients' dreams, fantasies, interests in movies and video games, and use of the internet are other ways of accessing their internal worlds. We discuss these activities in individual and group sessions, as this population is very connected to media (in all formats) – these habits provide a useful window into their psychic experiences. My patients will often show me YouTube clips, read back texts and e-mails, and describe movie or book plots as a vehicle for me to enter their world. Being conversant with their experiences helps build rapport, facilitates trust, and provides a bridge to help them establish more "real world" connections – as opposed to virtual ones. A young adult who self-describes as being obsessed with World of Warcraft, an online multiplayer video game, came into session and said, "I wish I could transfer my level of commitment and excitement about the game to my other goals." We explored the pull of the game, what makes it so exciting for him, and how to take some of those qualities and apply them to other areas of his life. He identified that he feels confident while playing, enjoys the social aspects and the task-based challenges, and relishes the consistent structure of the game.

In addition to discussing video games, books, and movies, the group frequently explores negotiating work-related issues with supervisors as an ongoing matter of concern. In my observations, individuals with learning and/or attention disorders often exhibit difficulty understanding hierarchical and organizational systems due to their neurological impairments. Histories of social and academic failures produce sensitivity to perceived criticism and incite concerns that they are disappointing their bosses. Thus, they often struggle to advocate for their needs in a workplace setting.

A young woman with a Nonverbal Learning Disorder, anxiety, and depression was frustrated by her boss's inability to set a regular schedule for her. The group encouraged her to confront the boss; she did so, despite severe trepidation. She internalized her peers' suggestions because they resonated with her struggles and gave her the confidence necessary to advocate for her needs.

Understanding diagnoses

Psychoeducation (or demystification), a process popularized by Mel Levine, often marks the beginning of treatment. Levine (2002) explains the necessity of demystifying the learning disability and explaining how the brain works while highlighting strategies that can be used to improve a person's skills.

Understanding the patient's learning style helps them make sense of their challenges so they can begin to advocate for themselves. The therapist's ability to understand and communicate the patient's neurocognitive difficulties affords the patient access to this crucial information. As the patient resonates with the therapist and acquires insight into the etiology of their challenges, they begin to embrace strategies that will improve their skills. In addition, the patient begins to understand the disparity in function with their peers that they have perceived over the course of their development. This perceived disparity can lead to painful feelings of self-blame, shame, low self-esteem, anxiety and depression. As I demystify their neurocognitive challenges, we also unpack the experience of knowing something is "wrong" feeling "stupid," "lazy," or "unmotivated." The following sections discuss specific diagnoses.

Attention deficit disorder (ADD)

Individuals with Attention Deficit Disorder (ADD) present with severe distractibility, poor focus, short attention span, and impulsivity (Conway, 2017). They often demonstrate significant executive functioning issues, such as poor organizational skills, compromised time management, impaired planning abilities, and lack of stamina.

Hallowell and Ratey (1995) emphasized the importance of educating the patient about their disability in the treatment of ADHD. Self-awareness is paramount to academic success for an individual with attention and learning difficulties. Nadeau (1995) discusses the various executive functions that adults with ADD lack, and how these deficits impact life-management skills. She advocates for a therapeutic model involving direct facilitation of time management, activity planning, and tasked-based skills. Various studies recommend coaching the patient using action-oriented processes to help plan, organize, and monitor behavior (Ratey, Hallowell, & Miller, 1997).

Adding a psychoanalytic component (as Conway (2017) advocates) links these useful interventions with understanding of their deficits within a psychological framework and facilitates awareness and insight by entering their world and helping them recognize their feelings, conflicts, hopes, and dreams.

Adults with attentional and learning difficulties often present with time management issues. They forget assignments and tests, and struggle with scheduling and punctuality. These manifestations are often viewed as oppositional and borne of poor work ethic by patients, their families, friends, and bosses. Even within the framework of a supportive family and school, the patient's inner experience is marked by frustration, self-blame and feelings of inadequacy. Explaining the etiology of these behaviors helps patients cultivate compassion for themselves and creates a space to devise solutions to these problems.

When combined with a learning specialist, tech-based utilities like online calendars and phone alarms are helpful compensatory techniques. I begin by directly addressing the patient's issues in

session, creating a calendar with them. I ask for their help in creating a schedule and plan for the week. I then keep in touch with them throughout the week, navigating potential roadblocks and keeping them on track with their tasks. Being on the front line allows me to directly experience the day-to-day challenges of the patient, affording me the opportunity to fine tune interventions and provide a sounding board if they become discouraged or frustrated. As I negotiate these concrete tanks, I also pay attention to the transferential/countertransferential implications of this type of support. We discuss how the patient feels about the support, and I fine tune my interventions in tandem with these experiences. Some patients readily appreciate the support, while others are more

ambivalent and can even feel resentful or pressured. All these experiences and feelings are discussed and understood in light of the patient's internal world and family patterns.

I tell these patients they need a secretary to help them track their appointments, papers, clerical tasks, and other projects. They benefit from specific and concrete techniques that enable them to succeed with quotidian tasks. A bright, verbal lawyer complained of difficulty completing forms at work. He explained that he starts his day by writing ideas in his notebook and can often spend hours "scribbling" rather than performing at his job. I suggested implementing a one-hour timeframe to write ideas before putting his notebook away and starting his day.

Offering concrete help also shows the patient that their struggle is real, and that I take their concerns seriously. When working with people who struggle to organize, plan, or work independently, it is important to show them sympathy and support while being concretely helpful. People with attention and organizational difficulties struggle with devoting time to work – and so the act of organizing papers and sitting at a workspace must be analyzed and treated. Noisy coffee shops are often ideal for individuals with ADD who require external stimulation to help them focus.

A bright college student diagnosed with ADD could not complete his coursework due to avoidance and anxiety. He characterized himself as lazy and unmotivated. He began utilizing our sessions to work on school assignments, allowing us both to further understand his learning style. He began by checking over his work with me, running every line he wrote by me. He was wholly unsure of his skills and responses. With support and encouragement, he began working independently in the waiting room and soon required fewer check-ins. He then transitioned to working at home, where he began to recognize the triggers to his anxiety. He instituted breaks whenever he felt overloaded, and then returned to his work. He also began "talking out" his plans with his mother, solidifying them in his mind before undertaking tasks. During sessions, we discussed how his history of academic difficulties distorted his sense of self. He began identifying as a self-directed entrepreneur and internalized that he was an energetic and focused young man.

Language-based learning disorders

Adults with language-based learning disorders present with poor speech fluency, compromised verbal comprehension and word-retrieval skills, and difficulty with reading and writing. They benefit from receiving directions in writing, breaking down complex tasks (particularly when asked to read or write), visual maps to organize information, and rehearsing ideas to facilitate fluency.

After several years of intense treatment, a young man who had not been able to attend college began taking courses online. Initially, he could only work with the therapist on written work for college. An updated neuropsychological assessment revealed that in addition to his already diagnosed Attention Deficit Disorder, he had severe dyslexia that had never been diagnosed. He had compensated for his dyslexia throughout this life with his Very Superior verbal skills and reliance on tutors. We discussed his diagnosis, the impact on his functioning, and ways to compensate for this disability. Feelings of being "stupid," "lazy." and a "fraud" all surfaced and were discussed in treatment. As he began to understand his learning issues and feel better about himself, he transitioned to working in the waiting room, and eventually to working productively with a tutor. Through active collaboration with the tutor and the therapist, he was able to work independently and efficiently. He expressed significant pride in his achievement and was able to take control of his work. Upon the therapist's suggestion, he was able to use several technological adaptations for individuals with dyslexia (such as audiobooks) to facilitate assignment completion.

Patients with language-based learning disorders often find themselves at a disadvantage in social situations because they cannot fully participate in the rapid banter of their peers. Individual and group therapy allows them the opportunity to practice their conversational skills in a relaxed setting and gain confidence in their ability to express themselves – leaving them with new

techniques to help strengthen friendships outside of the group. A shy, dyslexic young adult complained he felt tongue tied in social situations and had difficulty initiating and sustaining friendships. In group, he developed a repertoire of questions and comments that he could use during social encounters. He also expressed ambivalence about social interactions, fear of rejection and criticism and a desire to avoid vulnerability. These subjective experiences were explored in light of past bullying by peers, criticism by his mother, and experiences of academic and social failure.

Nonverbal learning disorder

Clients with nonverbal learning challenges present with difficulty completing visual-spatial tasks and can benefit from using words to mediate information. For instance, instead of reading a map, they may benefit from writing directions in a step-by-step format. Organizing time and managing sequenced tasks can be particularly challenging. Again, compiling a to-do list with structured time blocks is a strong first step. Understanding that these patients require more time to complete tasks is essential; helping them estimate the amount of time needed is invaluable. I direct my

patients to double or triple how long they think it will take to complete a task, as they chronically underestimate these figures.

A bright, verbal college student with paralytic anxiety about completing homework assignments presented with a significant nonverbal disability – e.g., a discrepancy between her language and visual-spatial skills (Palombo, 2006). Students who fit this profile typically excel with verbal subjects such as English and history but have significant difficulty when tasked with mathematical and visual concepts in science. This patient complained of forgetfulness, poor organization, and difficulty completing her work. We discussed the impact of her compromised visual sequencing and organization skills on her time-management abilities and planning skills, and her ability to keep track of her assignments, books, and papers. Working in tandem with an organizational coach, she began keeping notes in a planner and thereafter discovered efficient study strategies. Her confidence improved, dispelling much of her anxiety about school. We concurrently discussed her ambivalence about independence and separation and the fear that, if she was successful, she would no longer be taken care of by her parents.

As mentioned above, individuals with nonverbal learning disorders have difficulty making sense of visual information; understanding graphs, maps, and pictorial representations is especially challenging. These individuals often suffer through social interactions due to misinterpretation of social cues, facial expressions, and body language. Visual stimuli are also confusing and distracting to these individuals. Recent research further indicates that dyslexia is a disorder of the visual field in which visual stimuli are processed incorrectly (Yeatman, 2016).

These difficulties often lead sufferers to look away in order to think and cause them to misinterpret facial expressions. Additionally, elements of shame and inadequacy that surface during social interactions often inspire eye contact avoidance. The therapist can exaggerate facial expressions and dramatize nonverbal cues to assist accurate interpretation of these essential nuances. In group therapy, patients are encouraged to attend to facial and nonverbal clues, such as people looking away, yawning, or appearing preoccupied. Eye contact is discussed and facilitated, because many of these patients are not comfortable with and don't rely on visual cues to initiate or maintain interactions. I model eye contact and facial gestures and encourage group members to give me and each other feedback about their physical presentation in the group. Eye contact is an important skill in achieving academic and professional success, particularly when interviewing or maintaining good relationships with your boss and colleagues.

A patient in the group recently brought up an upcoming internship interview and asked his peers for help with strategies. The group members all discussed importance of eye contact, active listening techniques – including nodding to help the other person feel heard and making statements that show that you understand the conversation. They came up with relevant questions and discussed possible answers. This useful exercise also prompted the group members to reflect on their inner experiences

of interviewing for jobs or making themselves socially vulnerable in other ways. Past experiences of failure surfaced, as well as times when they were successful.

After the group session ended, the patient asked me to role play an interview with him. Actively seeking out support in this way was very meaningful for this patient, who typically resisted support and was very defensive about his difficulties. I role-played with him and commended him for his ability to take risks and be vulnerable with me and the group.

Parental involvement

Are parents involved in the treatment of these young adults? This is a complicated decision, considering these patients are technically young adults who function more like teenagers. Most of them live at home and are financially dependent on their parents, who are typically involved in helping them with day-to-day functioning. Parental involvement can thus range from weekly guidance sessions to a very hands-off approach, depending on the comfort level of those involved. During the initial stages of treatment, there are often frequent sessions with the family during which I employ many of the principles I have previously outlined – demystification, education about the neurocognitive and psychiatric deficits, and brainstorming methods for shifting the responsibility for the patient's day-to-day functioning away from the parents and onto the therapist or other providers. As the young adult becomes more independent, I reduce the frequency of contact with parents, and eventually may only meet with them as a family. I am transparent with my patients regarding my meetings with their parents and invite them to join if they feel comfortable doing so.

I often encourage parents to seek their own therapy or support group to reckon with their feelings and anxiety about their children, and any guilt with regard to perceived contributions to their child's issues. These interventions greatly reduce tension and conflict within the family.

Separation and individuation are far more complicated process for families with children presenting with neurocognitive challenges; these children require real support – meaning parents must take a more active role. It is important to differentiate the parental response from the reality of the child's difficulties if a parent is having a tough time separating these factors. Coordinating the need for specific parental support is a complex dance. The parents of individuals with attention and learning issues require a great deal of help and support, as parenting these individuals is complicated and brings up a host of intense feelings including anger, frustration, guilt and shame. Being mindful of these issues and encouraging parents to seek their own support is essential to the treatment of these young adults.

Psychiatric sequelae

Lowered self-esteem is a byproduct of learning and behavioral difficulties. Most of the adults I treat are convinced that their neurocognitive and psychiatric obstacles stem from a lack of intelligence, discipline, motivation, and effort. They recall the disappointment in their parents' and teachers' voices when they came home with poor grades or a negative behavior report. Even when they receive significant support at home and in school, the academic and social changes they face lead to depression and anxiety, as they often blame themselves for these difficulties.

Clarifying learning challenges over time can shift the self-image in a positive direction.

I once compared a patient's learning disability to an invisible wheelchair. She responded immediately, saying there was nothing wrong with her, and she should be able to do her work independently. I connected this statement with her blaming herself for her academic and social difficulties in school. She described an inner voice named "The Tyrant" who was critical of her academic difficulties and need for extra help. By unpacking the source of her struggles, (e.g., explaining the impact of her learning disability on her ability to complete her work) we were able to quiet the self-critical voice and understand her learning style in a more complex and sympathetic way.

Many individuals with learning and attention difficulties are convinced they are stupid. They harbor painful, self-critical assessments of their skills owing to their past academic and social failures. When children underperform in elementary school, they are often greeted with criticism from their teachers, peers, and parents. Even when feedback is not overtly negative, children compare themselves with their peers, highlighting areas of deficiency and deciding they are "stupid." It is an essential part of the therapist's work to alleviate this self-criticism and provide alternative explanations to their history of academic failures.

Once the neurocognitive issues are recognized and the patient is receiving academic intervention, they can tackle feelings of shame, inadequacy, and vulnerability. Bright individuals have learned how to compensate for their learning and attention disorders. When they are no longer able to compensate, their academic challenges become extremely painful and can induce psychiatric symptoms.

A bright student failed a course in his first year of medical school. Comprehensive neuropsychological testing revealed significant dyslexia she had been compensating for using her superlative auditory memory. With accommodations and support, she was able to do well in school. Therapy was recommended to help address her low self-esteem and depression.

The myth of laziness is a particularly potent example of self-blame when presented with neurocognitive impairment. Understanding why people procrastinate without judgment is extremely important; helping reframe procrastination and laziness as an anxious or avoidant approach to learning or attention challenges is the first step to building self-confidence and reducing the intense self-criticism that goes along with the false notion that one is just lazy. Challenging those beliefs and developing a more accurate picture of the true neurocognitive challenges is crucial. Entering the subjective world of the patients and offering empathically attended interventions lays the groundwork for self-acceptance.

Individuals with learning and attention challenges often feel like frauds. Repeatedly guessing when presented with challenges and "winging it" on tasks engenders feelings of a false self (Winnicott, 1960). These patients are painfully aware of their deficits, and believe they are tricking those around them by hiding or covering up their difficulties. Reliance on tutors and academic support can convince the young adult that they are cheating – even getting extended time on tests can feel like gaming the system. These feelings need to be explored and debunked.

Understanding that learning and/or attention challenges are real and deserving of support and accommodations can help resolve these feelings of fraudulence.

Because the therapist is conversant with both the neurocognitive and psychiatric challenges these young adults demonstrate, they can introduce the role of "reality" in an integrated manner. Kohut (1977) employs a similar approach to help patients reflect on their experiences and disprove their beliefs about the world and others in it. By challenging unconscious beliefs about learning and attention disorders, patients can become more self-reflective and can employ these insights to better adjust to specific obstacles. Integrating these self-statements allows them to move forward and achieve independence.

Many of my patients poignantly recall the angry and frustrated responses to their struggles with learning and comprehension. They tell of parents, teachers, and tutors asking, "How could you not know this? I already explained it to you ten times!" This type of treatment leads a child with learning disabilities to blame themselves for their difficulties, internalizing a self-image of someone who is "stupid, lazy, or both" (Kelly & Ramundo, 2006). Growing to understand their learning challenges and brainstorming compensatory strategies with me leads them to realize that the angry adults in their lives were acting inappropriately – they can then begin to let go of some of these painful, internalized experiences. These experiences also stem from their own awareness that their peers are performing tasks more efficiently and effectively than they are. We discuss these experiences of frustration and help them feel empathy for themselves.

A young adult who was unemployed and adamant about not attending college recently discussed an episode where his mother had inadvertently locked him out on the patio. He had become enraged, said he would break the door down and called her "stupid." He reported that he knows

he gets very angry when the people he relies on are "stupid." I asked him if he felt stupid and he said that he felt both stupid and more intelligent than everybody. He began to discuss his experiences of academic failure in a highly competitive private school that led to him leaving that school and entering a more supportive educational environment. Understanding the neurological underpinnings of his lack of success and consequent feelings of frustration led to a productive discussion of how to cope with these feelings and negotiate frustration more effectively.

Peer interaction and support are incredibly effective for these young adults frozen in adolescence – a time when the peer group becomes critical to development (Levy-Warren, 2008a). Group therapy that focuses on helping them achieve their goals while receiving feedback from peers can help them navigate the transition into adulthood. Understanding their developmental trajectories helps these young adults re-stabilize and facilitates increased independence and competence.

Providing the patients with concrete life skills within the framework of an empathic, psychoanalytic treatment helps them internalize the skills and improve their confidence and competence. As their ability to navigate the tasks improves, the therapist diminishes the level of active support in collaboration with the patient. Entering their psychic world with a profound understanding of the complex neurocognitive and psychiatric issues facilitates productivity and self-esteem.

In conclusion, young adults with learning and attention difficulties require a developmentally informed, integrated approach that provides clinical intervention and practical coaching/scaffolding. The therapist must take an active stance within a psychoanalytic framework, allowing these young adults to progress in their development to independent adulthood.

Understanding the subjective experience of their learning and attention difficulties, giving attention to the relationship with the therapist, and facilitating empathy for themselves are key components of this approach. The active stance enables patients to internalize a heightened understanding of their neurocognitive deficits and integrate insight and self-awareness, enabling them to compensate for their difficulties while facilitating their self-efficacy.

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