Saving Alex: Reflections on Working with Families in Crisis

Joslyn L. Aubin, MA, BCET

In this essay, Joslyn L. Aubin, MA, BCET, explores how an educational therapist can intervene effectively with families in crisis. Aubin describes common characteristics of such families: school refusal, multiple diagnoses, and treatment resistance. While recognizing the difficulty of working with such families, the piece offers suggestions for how educational therapists can respond more effectively to them; committing to follow-up with these families; developing the therapeutic relationship; shoring up realistic self-worth; providing resources; and assembling a treatment team of allied professionals.

Alex's History

Sometimes on sleepless nights, I imagine his intake session.

Sixteen-year-old Alex and his mother sit in my office and tell me about Alex's long history of school challenges. A tall, lanky adolescent with a long face and a rigid gait, Alex seldom makes eye contact. Like many teenagers before him, he is nervous and uncomfortable at this first meeting; this makes him angry, as well, and he blames his mother for his presence here, but also sees her as his only ally in this small office with the strange lady—me. I struggle to engage Alex in conversation, but he glances at his mother every time I ask him a question, as if looking for her to answer; he then contradicts almost every answer she gives, questioning her memory or correcting her interpretation of events or word choice. Alex lives with his mom, who stays at home with him, but sees his father on weekends and twice a week. His parents separated when he was nine. His only other family is an older brother, who is away at college out of state.

Alex is described as having never been typical. He was socially awkward and speech delayed, with production always lagging behind comprehension. Early services included occupational and speech therapies in kindergarten and first grade. Alex was also diagnosed with a sensory-integration disorder because of his hypersensitivity to tags in clothing, certain smells, and bright colors. He loved building with Legos and could hyper-attend for hours at this type of play. In fifth grade there was an incident in which Alex and a friend drew comic books with violent imagery, and Alex got in trouble for trying to sell copies at school. At about that time, Alex had increasing problems with self-esteem. Although clearly intelligent and with a good sense of humor, Alex had difficulty making friends. He was not comfortable expressing emotions, and was described as demonstrating increasingly rigid behavior, with signs of OCD.

Alex always had difficulty with transitions, and the transition to middle school did not go well. Changing classes every 50 minutes was particularly intolerable. He began to have panic attacks which resulted in his mom having to pick him up from school during the day. After a change to a smaller school did not improve the situation, Alex's parents began home schooling him starting in eighth grade. They were distraught. They took him to a psychiatrist, who diagnosed him with Asperger's syndrome. This diagnosis came as a great relief to Alex's parents, as it helped explain many of their son's perplexing behaviors, but in contrast, Alex refused to believe the diagnosis and was not similarly comforted by it. The psychiatrist prescribed the antidepressant Lexapro, but after trying it for three days, Alex had a bad reaction, and refused to try another psychotropic medication after that. Tutoring and desensitization were also recommended, but Alex similarly refused to partake in either.

At the time of this intake, Alex is not taking any medication, nor is he receiving support services from the psychiatrist or any other professional.

Context and Purpose

The young man whose clinical history I've just related, Adam Lanza, never sat in my Hartford office, less than an hour's drive from Sandy Hook Elementary School, where he took 26 lives before ending his own. The details of my imagined intake session are drawn from Andrew Solomon's interview with Adam's father, Peter Lanza, in *The New Yorker,* (Solomon, 2014) and informed by my own experience doing educational therapy intakes with other young men who share features of Adam's history.

Although his is undeniably a story of a family in crisis, there are a lot of reasons Adam didn't receive the help of an educational therapist. Most of our students are referred by school personnel, psychologists, psychiatrists or adolescent psychotherapists, among others. But Adam was not attending a school, nor, to our knowledge, was he receiving treatment from any such clinician. Even had he been referred, getting Adam to come to an intake session would have been very difficult. Indeed, Solomon (2014) reports that Adam's mother did try taking him to a tutor once, but that, "Even ten minutes before we should leave he was getting ready to go, but then had a meltdown and began to cry he couldn't go" (p. 42). His mother was unable to push through this reaction and seems not to have tried again.

Adam's story filled me with questions related to our work with families like his. If Adam did somehow pursue treatment, would we know what we were dealing with? Would we know what to do to help as well as what kinds of referrals to make in such a case? How can we identify students like Adam? How can AET members support each other so that we might make a difference in the lives of young people troubled in some of the ways Adam was? This article is a call to action for myself and others. I am hoping to encourage us to pursue therapeutic

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relationships with families we might otherwise try to duck or refer to someone else because frankly, these families are difficult and exhausting to work with.

Are these kids our kids? Shouldn't we simply refer them to mental health professionals more able to handle their serious emotional issues? Adrian Raine (2013), the first person to do brain imaging on convicted murderers, found that murderers as a group had much poorer functioning in the prefrontal region of the brain. The prefrontal cortex, which educational therapists are all too familiar with due to its role in regulating attention, planning, and organizing, also regulates emotion and helps to inhibit impulsive behavior. Kids with poor executive functioning are our kids. In his book *The Origins of Good and Evil* Paul Bloom (2013) explains that we have a wrong way of thinking about young men like Adam who do bad things. We tend to look for an explanation of when and why they "went bad," but Bloom believes that people don't *go* bad, they start out bad, and then they learn to be good. If Bloom is correct, it implies that at least part of the problem with young men like Adam is that they somehow failed to learn something crucial—morality. Could educational therapy have a role in this type of learning deficiency?

Ever since Sandy Hook, I've thought of the clients I've seen, or whose parents I've talked to, whose cases have elements in common with Adam's, and wondered how we might get better at helping them. Although his is an extreme case, it includes many elements that we see routinely in our work, and as such can shed light on those with a similar profile who themselves would not become violent but suffer greatly nonetheless.

Identifying the Family in Crisis

Families in crisis will not declare themselves as such. How, then, do we recognize them? In my experience, one of the more easily-identified similarities shared by many is that their child is not attending school. This could mean he is being home-schooled out of necessity rather than philosophy, like Adam, or more typically, the child is on "medical leave" from school, or is simply missing more days of school than he is attending. The parent's explanation for this disruption in schooling can take many forms. The child may refuse to go to school. When it's time to go to school, he may have emotional breakdowns, with or without concurrent somatic symptoms, which the parent feels make it impossible for him to go to school. A private school may have suggested or required medical leave due to problematic behavior in school or concern for the child's well-being. Whatever the details, the bottom line is the same. A child not going to school (or being effectively and successfully home-schooled) is a child in crisis, and the longer this situation persists, the more dysfunctional the situation will become.

A related red flag is the difficulty getting the child into my office. Despite their need for help, a comparatively small percentage of first phone calls from families in crisis result in an intake. This also may be for many reasons, but ultimately the underlying cause is that to a family in crisis, making almost any change feels insurmountably difficult. In addition to how overwhelming it can feel to take the steps needed to make an appointment, there is also a deep fear of coming for help. As bad as things are, a certain amount of inertia in dealing with the problem is most likely a result of fear that acting might actually make things worse.

In these cases, the young person rarely has one fixed diagnosis, but has accumulated a laundry list of diagnoses over years. Recently on *This American Life* (Glass, 2014) the mother of an 8-year-old related that he had been diagnosed at various times with ADHD, conduct disorder, oppositional defiant disorder, mood dysregulation disorder, and autism spectrum disorder. A challenge here is knowing how to characterize the child's difficulties. Often the parent "chooses" the diagnosis that is most palatable to them, or the one that feels most right based on their understanding of their child, and that may be the only one they report to the educational therapist.

Finally, the main way I recognize a family in crisis is the feeling in my gut as I listen to the child's story and take notes during that initial phone call. My immediate reaction will be to run screaming—tell the parent on the phone that I have no room in my schedule, or that I've moved to Alaska. So sorry. Best of luck to you.

Best Practices with Famililies in Crisis

There's a natural urge to blame Adam's parents for what he did. Solomon points out that this is because we want to distance ourselves, to think, "This couldn't happen to my child." I struggle with my own first response of judgment regarding the parenting of these families in crisis. Often, though, as I get to know them, I have more empathy for the choices they make. One mother admitted to me at intake that she did all her son's homework, except his algebra, which she made her husband do. At first, confessions like these seem unfathomable to me until I learn more about the context of each family. This mother could not get her son to do his homework, but he was on his third strike at the private day school he attended, so she did it to keep him in the only place she thought he could possibly make it.

The best tool we have for improving outcomes for kids like Adam, and the place we need to start, is the therapeutic relationship. Well established, it provides a foundation upon which much

can be built. Young adults need a relationship with a respected adult who is not their parent, who can provide feedback the child will believe and respect, and can validate the parent's positions, when they are supportable, as well as counterbalance them, when they are less so. The therapeutic relationship can help a young person gain confidence and develop a sense of self-worth. Adam had become totally isolated from everyone but his mother, with whom in the end he communicated with only via email. He was a young man who had fallen out of relationship with everyone in his life.

Building the therapeutic relationship is more easily said than done, as families in crisis tend to be wary. They correctly fear judgment, false hopes, or just another dead end. Also the family in crisis is most often a family at odds. Two parents may be in deep disagreement about their child, or parent and child may be at each other's throats. I have experienced a handful of intake sessions with young men whose open hostility and contempt for their mothers was deeply disturbing and reminiscent of Solomon's description of Adam's relationship with his mother. Clinically, the error to be made here is to be perceived to have allied with one faction too early. I made this mistake when I worked with Jane, a senior recently diagnosed with ADHD whose mother worried that her daughter would not buy in to the therapeutic relationship. I suggested that I do the intake with Jane alone. I found her to be a lovely young woman who was working hard to maintain a rigorous course schedule and a number of extra-curricular activities while also trying to enjoy the final months of her high school career. I believed, and Jane clearly expressed, that she was benefitting from our sessions and also working to implement the strategies we discussed. Increasingly, though, Jane's mother communicated to me that she felt Jane was manipulating me and that our work together, far from being the help I perceived it to be, was once again wasting her parents' time and money. In a family very much at odds, my solidly-built therapeutic relationship with the daughter jeopardized my relationship with her parent.

It is more typical to make the opposite mistake, of allying too strongly and too quickly with a parent. This is particularly easy to do when a young person is being openly hostile or contemptible to his parent. Mothers tend to be loquacious when talking about their children, and, if allowed, will speed talk for the entire intake while their son and husband sit in stony silence. Should this dynamic develop, I work to direct questions to the young person, to make eye contact with him and draw him out. I try to get a young person on happy terrain, talking about his passions, his favorite book, the team whose cap he's wearing. As I work through my intake questionnaire, asking questions of both him and his parents, I make it clear that I don't see his parents' view of things as "right" and his as "wrong." I make sure to communicate clearly to the child that he is not powerless in this relationship. After explaining what I do, I ask him if it sounds like something he is willing to try. I make clear that this work is a partnership, and invite, rather than demand, him to enter into it.

One of the mistakes to avoid with families in crisis is making a sweeping statement. In the example I discussed above, of the parents who were doing their son's homework so he would not be kicked out of the school they felt was the last, best place for him, I made a sweeping statement: If they were to work with me, they could no longer do his homework. Was this statement the reason I never saw that child in my office again? In hindsight the better approach is to enter the world of the family, no matter how dysfunctional, as an anthropologist at first, studying it, learning its dynamics, becoming a trusted outsider before slowly suggesting needed change.

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In such cases, the educational therapist absolutely needs to prioritize shoring up self worth. Solomon (2014) writes, "The more Adam hated himself, the more he hated everyone else" (p. 44). Lack of confidence is the cause of many maladaptive coping skills and can throw a monkey wrench into the work. The mother of one of my students cautioned me at the beginning of my work with him that if her son sensed someone didn't like him, it was all over. He then did everything he could to *be* unlikeable, in what seemed a clear attempt at self-sabotage. Recognizing this dynamic helped me to have compassion for this young person who most likely was completely unaware of how he was shooting himself in the foot, and to ultimately change the dynamic, at least in our relationship. I have learned that as much as a child needs the unconditional love of a parent, the client needs the unconditional regard of the educational therapist to thrive.

Here is where the work is our saving grace. Real self-worth doesn't come from empty compliments; the child must have a growing sense of true competence. He must be able to do things he could not do previously. It doesn't hurt, of course, to hold a mirror up to actual skills and talents as we see them, and to be specific about these, but we must also quickly build skills the child needs for academic success. My student Mary desperately needed to improve her math skills, but was unable to work on them with me. Her deep shame at her inadequacy in math led her to derail our work at the sheer sign of a number, until I was able to get her practicing math facts on freerice.com, where she had the satisfaction that her practice was earning rice for poor children. This ego protection enabled her to do the work, build confidence in her skills, and ultimately feel safe enough to do more advanced math work together. This balance of skill building and ego protection is the routine work of educational

therapy, but tends to be more emotionally fraught with the child in crisis.

Families in crisis are likely to be treatment resistant. One of the most striking aspects of Adam's history is how little professional support he received despite the very serious nature of his academic and mental health challenges. How can we get these families to enter into the therapeutic relationship? We only get one shot at this—the first phone call. Here we not only have to convince the parent that we can help, but provide her with tools necessary to convince her child as well. I usually start these calls with a simple, "Why don't you tell me about your child?" I listen carefully, take notes, and ask questions. Often a parent will then ask me what I can do for her child. This is the place where my intervention with the parent actually begins, and if done well, this will communicate to the parent my level of expertise and hopefully inspire confidence. I am careful at this point to make clear what I can not and/or am not qualified to do for the family, which serves to set important boundaries right from the beginning. Before the phone call ends, I will also discuss, if necessary, strategies she might take to increase the child's willingness to come in for an intake. Next comes the hard part. If a family is truly in crisis, our instinct will be to run away. We need to push ourselves to follow up, though, to keep trying with these families because we have confidence in the work of educational therapy.

During and after that first phone call, it is imperative to build an alliance in an atmosphere of non-judgment. Sometimes this requires meeting with only some members of the family. If the adolescent's relationship with her parents is fractured, I might meet with the adolescent alone at intake. This lets the child feel she is forming the relationship on her own terms, and presenting herself to you, rather than being presented by a parent. If a child refuses to come, I might suggest to the parents that they meet with me alone. Over the course of his treatment, Randy's mother had several sessions alone with me on days when Randy refused to come. A lot of benefit came from these days when we put our heads together as members of Randy's team. Parents need emotional support, help making decisions, and information. Working with them, even without the child present, can help them learn better parenting skills, connect them to resources, and allow time to share vital information from the school or other members of the team. I also try to immediately point the parent to resources they might find helpful. During intake, I gave the mother who was doing her son's homework a copy of the book *Stop Negotiating with your Teen: Strategies for Parenting Your Angry, Manipulative, Moody or Depressed Adolescent* (Edgette, 2002). She called me later to say that she read it all in one day and it gave her the courage to change her family's situation. A list of short, accessible resources for parents and adolescents is an important part of our toolkit.

Families in crisis who have not already done so need to be helped to put together a team of allied professionals that will include the educational therapist but also at the very minimum one mental health professional. Success with adolescents who are this needy is rarely the work of one professional, but instead requires a team whose members are largely in agreement about the family's issues and needs. Randy's mother would regularly walk between my office and her son's psychiatrist's office. She assembled a team for her son that at various times involved, in addition to the psychiatrist and myself, a therapist, a neuropsychologist, a school refusal treatment center, and a special education lawyer. Her son is thriving today.

Although certainly not unique to families in crisis, the issue of medication resistance in Adam's case cannot be ignored. Teenagers are infamous for their noncompliance in taking psychotropic medication, and unfortunately many of their parents have learned most of what they know about these medications from news sources which are less than reliable. I have met with many families like the Lanzas who tried one medication, had a negative experience, and then gave up altogether. It is imperative to help these families understand that there are many good medications out there, but that finding the right one might be a process. A medication consult with a trusted psychiatrist is the next step.

Conclusion

It's too late to save Adam, of course, but this work is saving work. Ultimately, when I am doing the "real" work, it isn't about getting a grade point average up or adding 100 more points to a teen's SAT. It's about helping Randy have the strength and courage to get out of bed on any given day and go to school. It's about helping Bruce see himself as bright and a thinker, when school has made him believe otherwise. It's about forging a connection with young people in crisis that can give them the skills, resilience and confidence to become productive members of society instead of retreating into misery, hatred and violence.

On my morning walks through the neighborhood where I live and work, I pass a memorial playground dedicated to Ana Grace, one of the little girls Adam killed. I look at her picture and try to fathom her parents' pain, try to imagine who she might have become, what the world lost in her. Make no mistake–I am angry as hell at Adam and his parents. But twenty-seven young people died that day, and by failing Adam ultimately we failed everyone touched by this tragedy. It's not enough to build shiny playgrounds. We have to identify, reach out to and support the gawky, unpretty adolescent boys who can never fit into any school, whose parents' love for them is complicated by how challenging they are to raise, whose illness, pain and misery drive them to hurt themselves and others. These children, whom Andrew Solomon describes as having fallen "far from the tree," also deserve to be saved.

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One Step Further: Executive Functioning and Thinking

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"An educational therapist's toolbox may include the development of intellectual thinking through specific steps designed to engage and develop the internal dialogue needed for effective executive functioning."

Introduction

While commonly thought of as the ability to organize, execute and self-reflect, executive functioning has both internal and external manifestations. Externally, a student's ability to listen and act and do is the measurable means by which executive functioning is often spoken about. Another albeit less observable quality is the internal dialogue and process of organizing information, creating useful categories, connections, and applying constructs to learning. This process of ideation can be taught and discussed with a student. In *Instrumental Enrichment: An Intervention Program for Cognitive Modifiability*, Reuben Feuerstein (1980) describes the process of teaching students who were described as delayed in analyzing and thinking. He describes this process as mediated learning whereby an educator can actively and explicitly teach a student how to effectively organize, reflect upon, and make choices in their thinking, and as a result, change their behavior.

When examining the literature regarding memory systems, research emphasizes many important cognitive interactions which educational therapists often refer to as metacognition or the ability to think about one's actions. Although the brain has regions of known functioning, in higher level activities these regions become interdependent and are not unitary (Carter, 1998). One can begin to understand the importance of the clinician or educational therapist in mediating the internal process of learning. For the educational therapist, attention, focused discussion and exploration of the manner in which a student takes in, uses, processes, retrieves and integrates information becomes as important as external systems of organization. In my training as a therapist, this is the process of becoming self-aware and responsible for oneself. In the practice of educational therapy, I will refer to this concept of developing an active self-awareness about learning as an internal dialogue which develops through mediation by the educational therapist. Again, while this is a process often referred to as metacognition, use of "internal dialogue" is intentionally meant to describe the goal of treatment: a sustainable and transferable skill developed by and with an educational therapist. Students' executive functioning becomes both an external and internal experience which can be described, established and acted upon.