

Social Therapy with Special-Needs Children and Their Families
Interview with Christine LaCerva
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Christine La Cerva, M.Ed. is the coordinator of Family Development Services at the Social Therapy Group in Manhattan and Brooklyn, New York. She practices social therapy with families and children who come for help with a wide range of emotional and learning difficulties. A pioneer in the multi-family therapy group, La Cerva helps special-needs children shape their lives and mature emotionally and socially. La Cerva's social therapeutic approach draws upon children's capacity to play and perform. She has been successful in helping children diagnosed with Asperger's Syndrome and autism spectrum disorders to develop productive social relations.

La Cerva is co-author of "Therapy After September 11," published in the *Journal of Systemic Therapies*, 21 (3), 2002. She serves as Director of the Therapist Training Program at the East Side Institute for Group and Short Term Psychotherapy www.eastsideinstitute.org where she trains and supervises therapists in the social therapeutic approach. La Cerva received a master's degree in special education at Teachers College, Columbia University, and spent many years working as a classroom teacher with special education students.

Q: Over the years, as a therapist, you've worked with kids who have some kind of developmental, cognitive or emotional issues, or they might have been diagnosed before they came to see you. They might not have. Can you tell me about some of the young people you've seen over the years?

Christine: We've seen children starting at age four through their teenage years – up to eighteen. But I've worked predominantly with younger children, ages four through twelve.

Kids are often diagnosed before they come to see us, most often with either attention deficit disorder (ADD) or attention deficit disorder with hyperactivity (ADHD). These are the more popular diagnostic categories that we started to see about five or six years ago. Most children who go in to see a psychiatrist, if they're having problems sitting in their seat or focusing in any way, are almost immediately diagnosed and prescribed medication.

Q: So by the time they get to you, most of the kids you've seen have been diagnosed?

Christine: Yes, they've been diagnosed.

Some parents will come sooner – as soon as the school recommends some kind of evaluation – because they’re concerned whether to go through with an evaluation. They’re wondering if they should go to their doctor. They don’t want their child on medication. Some people come knowing that the diagnosis is on its way towards them.

In the last five years there’s been an increase in children diagnosed with autism spectrum disorder, which is an umbrella term that includes autism and the newest category, Asperger’s Syndrome.

We’ve had an increase of children ages five through nine who have been diagnosed with Asperger’s. Most therapists will see ADD or ADHD kids, but not the Asperger’s kids. They believe that Asperger’s is an educational issue that needs to be handled by educational specialists to help these children learn. I don’t even like using the language of “Asperger’s,” but that’s part of the territory.

Q: So you’re saying that Asperger’s is typically seen as a learning disorder?

Christine: Yes. It’s not so much viewed as a psychological label as an educational label. Very often, when children are diagnosed with Asperger’s parents ask, “What am I supposed to do? How do I get help with this?” They’re told to put their child in a special-ed classroom, where there’s more support for learning. The only therapeutic help generally recommended, if any, includes cognitive behavioral approaches like reinforced learning that can be used in the classroom and at home.

Q: What about the other autism labels? What are the range of diagnoses and some of the thoughts about appropriate treatment?

Christine: There’s some differentiation among the autism labels. For example, high-functioning autism is a very controversial. Some practitioners don’t even believe it exists. Children labeled high functioning are sometimes referred to behavioral therapists – but *not* to psychotherapists. The prevailing belief is that these children do not have the capacity or the interpersonal skills to function in psychotherapy.

Children with more extreme autism, labeled low-functioning, are sent to educational learning specialists.

Q: So before they come to see you, a social therapist, parents might have been told that therapy was of no use?

Christine: Yes.

Q: But they come anyway?

Christine: They do. Parents hear about us through referrals or our website. Typical comments include, "I heard you work with Asperger's kids. I've been trying to find somebody. Nobody will take my child. What can you do to help?"

Q: What's your response to them?

Christine: We respond to families the same way we respond to everybody. We relate to everyone as having the capacity to develop. We don't pathologize them. We support the human capacity to perform: to be both who you are and *other than* who you are. And we relate to that child and that family as having the capacity to organize what's happening in a more creative and developmental way. We support organizing environments where relationality is key. In essence, social therapy helps all concerned look at the impact they are having on other people. In some cases, that means recognizing that there *are* other people.

Once a diagnosis has been established, it limits what parents and others do with that child. In the case of autism spectrum disorder, parents are told that the child is impaired and cannot socially relate within the range of normal behavior. Autism is related to as a neurobiological disorder, and it might very well be. However, we can still relate to the child and family as having the capacity to transform how they are living their lives.

According to the DSM IV, the autistic child "is not capable of having conversation – which is why they are silent or why they perseverate, or why they have rigidified kinds of behaviors." This diagnosis creates the likelihood that parents of autistic children, unlike parents of so-called regular children, will not have normal conversations with their child.

We're working to help the parents see and relate to their child outside of the confines of those diagnostic categories and the stated limitations of what professionals are telling them their child can and can not do.

People say to infants: "Say goodbye to grandma!" They don't know what a "goodbye" is or a "grandma" is, but you're relating to them as a member of your language and conversational community. But autistic children often are not related to as a member of a shared community, of a language community. They are related to as outsiders, which I believe reinforces the alienation of the child in relationship to others. The child quickly learns that he or she is "special." In my experience, how autistic children are related to is about as important as the disability itself. Ways of being in the world called "autistic" are part of the human experience. It is vitally important that we relate to autistic "ways of being" as something we share as human beings.

Q: So Christine, maybe you can think about a recent family that has come to you for help. Can you take us through the first meetings and then can we talk some about what the therapeutic process looks like. And in particular, can you tell us about any moments that were of surprise to the parents or —

Christine: . . . to the *therapist!*

I have two very different examples that I think are interesting.

In the first example, Jeremy, a six-year-old boy, had been placed in a class for the developmentally delayed. He was not getting much challenging work in school and overall there was not much emphasis on teaching this child or relating to the child as having the capacity to "be a head taller" than himself.

Jeremy's mother brought him to see us. He was pretty difficult, yelling and screaming a lot. For anyone coming to therapy, whether age four or forty, there's nervousness or anxiety about talking to somebody you don't know about the intimate details of your life. And of course a child knows that he or she is being brought there because they're a problem. So we have to deal with that issue immediately.

Q: This is the intake session?

Christine: Yes. During the intake session Jeremy was anxious. He performed himself with a lot of yelling, turning the lights on and off and knocking chairs over in the therapy office. As he began talking to me, his mother told me some of the history. I tried to have him participate with us, but he wouldn't sit down.

He kept coming up to me and saying, "I'm a big boy. I'm a big boy, right? I'm a big boy, right?" He said that for pretty much forty-five minutes. And his mother, as she has been taught to do by cognitive behavioral methods, was trying to get him to stop repeating himself.

I made other comments to him and asked questions such as, "It's really nice to meet you; I wonder if you're nervous?"

Q: And as you'd ask him questions, he said...?

Christine: He kept saying the same thing, which was fine. I didn't have any need for him to answer my questions, but I did want to relate to him as a member of the community I'm in, that is, as part of a community of people who talk to each other and have conversations. His mother identified the presenting problem being that he could not carry on a conversation and would repeat things, *ad infinitum*.

Q: As you're talking to him as part of this conversation and he's saying, "I'm a big boy, I'm a big boy," what was mom doing?

Christine: She began saying, "I can't believe you're not stopping him from repeating himself. It's driving me crazy."

I told her I was glad she was saying that because in social therapy we don't try to stop anybody from doing anything. It wasn't particularly driving me crazy. Many people tell me that I repeat myself. It's just something that people do. Some people do it more than others. Jeremy, of course, was listening as I said this.

Q: And you're speaking to both of them?

Christine: Yes. And I said to him, "I repeat myself. My friends complain about that, too, the way your mother's complaining about you. And it can be annoying to people, but some people think it's funny and it's not really bothering me at the moment."

I continued getting to know him. At the same time, Jeremy's mother and I continued to talk and he was involved in that process. Sometimes Jeremy sat down. I told him that this was my office and he could not turn the lights on and off or throw things on the floor.

Q: What did he do with that?

Christine: He turned the lights on and off and threw things to see what I was going to do.

I stood up and brought him over to sit, which he did. So now, something had happened; something unusual for him.

Near the end of the session, he said to me, "You don't think I'm a big boy, do you?"

Q: He said that?

Christine: Yes, he said that. After 45 minutes, he stopped repeating. He had something else to say.

I said that he was quite right. I could tell that he was very insightful. I did not think he was a big boy. Then there were bloodcurdling screams and uncontrollable sobbing for thirty minutes (we let the session run over).

Q: What did you and his mother do while that was going on?

Christine: We just waited and worked to be with him. His mom tried to be with him. She wanted to comfort him, and that was okay too. I did not have a need to do that. I thought it was important for him to go through this – to have his response to what we were saying to each other. It's painful to come to experience that you're under-developed. I think the conversation highlighted this for him. I told him that I could help him grow and become a bigger boy, because I could see that it was upsetting to him that he wasn't one.

Q: And he heard you?

Christine: Yes. He didn't say anything, but he was listening. It was clear to me that he had listened to the entire session or I don't think he would have been able to say what he did. The work from that point was with his mom.

Q: Did his mom understand that he had been part of the conversation?

Christine: I don't think she understood that initially because she had been living with this child and had a very different experience with him.

In the next session, when I saw his mother alone, we talked about the assumptions and biases that she and we all have with children who have difficulties.

She said she was shocked at his breaking out of his usual behaviors.

She asked me why I kept asking him questions when I knew he wasn't able to answer me. I explained that my intent was to perform a conversation with him because in the absence of resorting only to trying to stop him from doing what he was doing, he had no learning environment. He wasn't going to be able to learn anything.

I told her that we needed to talk to him conversationally, so he had a shot at *learning what a conversation is*.

She cried and said she realized that she *didn't* have conversations with him. Basically she told him what to do and what not to do, or that she loved him, things like that. But she conducted no conversations with him in any normalized way. She was very taken aback that she had participated in relating to him pathologically, according to the diagnosis he had been given. She learned that her experience of her own child was organized in a very particular way. She was focused on his *limitations*.

Q: Could you say some more about the assumptions we have and the ways we relate to kids who've been diagnosed in this way?

Christine: Okay. You can observe children through your life participation with them. You can decide to see things according to behaviors. And according to a child's current behavior, it may appear that he or she can't do anything else. As social therapists, we work hard not to interpret or become predictive based on a particular set of actions the child is doing.

We use the social therapeutic approach to help adults and children create environments where it's possible to do new things – create new performances. The child experiences herself or himself differently (“Hey, I did something new!”). And adults learn that their children can do all kinds of unexpected things.

Jeremy's mom was very impacted by the first session and decided to go down this road with me. I told her I had no idea whether or not we could help him, but given what the

first session looked like, I thought we had a shot. And I thought we were going to discover all kinds of things.

Q: Why was it important for you to say to her that you had no idea if you could help him or not?

Christine: I didn't know if I could (which didn't mean that I couldn't!). But how we were going to determine whether I could help him was by creating environments where we could discover things about who he is and who he's growing up to become.

Children struggle with making choices about how hard it is for them to go beyond what they know how to do, just like adults do. And sometimes along the way children will decide it's too much work, and will let you know: "I'm not going there. I'm not going to do it."

Q: So when you're saying to Jeremy's mom: "I don't know if I can help him," you think you probably can, but that's still to be determined.

Christine: Yes, I don't know what that will look like.

Q: Because, in part, that depends on whether Jeremy's going to decide to go there with you.

Christine: Right. He's going to have to create that with us. He's going to have to make his choices. It's the same with mom and dad. They're going to have to decide how far they're willing to go in their own development. The place we often reach is that the children are in advance of their parents in being able to do developmental work. And in our family therapy groups, we have to deal with that as a grouping of adults and children.

But one thing I wanted to go back to is that Jeremy had all the classic behavioral characteristics of Asperger's Syndrome as defined by DSM IV in 1994.

DSM IV says that these children lack empathy, compassion, and a capacity to put themselves in somebody else's shoes. I was very sick one day during our fifth therapy session together. He had a game he liked to play with me called "The Bears." (It really had nothing to do with bears, but that was his name for it.) I said I didn't think I could play "The Bears" today, and that we had to deal with the fact that I wasn't feeling well.

He kept saying, "No, we're going to play 'The Bears,' right? We're going to play 'The Bears,' right? We're going to play 'The Bears,' right?" And I said, "Well, what about the fact that I'm sick?"

It was a very, very difficult conversation and his mother (who was in the session too) said, "This is what I'm talking about. He doesn't *care* that you're sick!"

I said, "Well, I don't know *how* we know that he doesn't care. We know that he's saying he wants to play 'The Bears.' That's all we know." I was very adamant that we should not make interpretations about what we were experiencing with him and make it *mean* something. Because we simply didn't know what it means, and we certainly didn't know that it meant he didn't care.

I asked him if he cared. He said, "No." And then he started crying and saying, "Please play 'The Bears;' please play 'The Bears!'" So I sent mom out, which in this case was a good thing to do because the child often does better. He said to me, "Help me stop crying. I can't stop."

I said, "Okay, great, this is how you do it. You start focusing on something else. You move into another activity, and you can sometimes let go of the crying," which he did. I said, "I'll play 'The Bears' the best I can. How's that?" He said, "Okay."

In the course of "The Bears" game, he played my father and constantly ordered me around and tried to stop me from doing what I was doing – which, of course, is his life experience.

I started crying, which I often did (that's part of my role in "The Bears"). I protested to him that I didn't want to be sent to my room all the time, that I hadn't done anything anyway, so why was he punishing me? And then (this was a *big* move for him) he said, "I heard you're not feeling well. Why don't I fix you a cup of tea? I think you should rest. I think you're jumping up and down too much. Maybe we should call the doctor."

His entire performance became being extremely sensitive to how I, his son in this case, was doing. It was a very, very lovely moment. It was a breakthrough, since what I had been focusing on therapeutically was building my relationship with him. I felt like he had said to me through his activity, "Yes, I'm in therapy with you. I'm going to

recognize that I have an impact on you.” And in some sense, that was the beginning of our therapy.

Q: And his mother’s reaction when you told her? What did she make of it?

Christine: She didn’t know what to make of it. But I think it was the beginning of her being able to see him differently.

In a performance you learn all kinds of things about people. People show you things they can’t show you in the more stilted ways that we get organized to relate to each other. That’s true for everybody, not just Jeremy.

She said she had come to realize that she had essentially written him off. She had no idea that he had the capacity to relate socially. Now he was doing substantially better at home. She was having conversations with him about all kinds of things, so we brought him into group about five weeks later.

Q: Could you tell us more about this group? Who’s in it?

Christine: Adults and kids. We make decisions about who needs to be there each week, depending upon what’s going on therapeutically. Sometimes it’s kids only. Sometimes it’s adults only. Other times, we have dads come in with kids. Sometimes we have everybody there.

Christine: So we brought Jeremy and his mother into the group. There are four other families.

Q: Christine, is a therapy group of this kind unusual in the field of family therapy?

Christine: I think it’s unusual in that it is not a social skills group – teaching children how to play together – which is what is done more traditionally. It’s unusual in that we are not trying to get to the bottom of anything; instead, the activity is focused on creating something together.

I think it’s unusual in that it includes both adults and children, with children leading the process. And the kinds of issues that the kids are facing vary dramatically. There are kids who are quite together, doing fine in school, but who have other emotional issues. And there’s someone like Jeremy who has a lot of difficulty relating to other people (and basically doesn’t).

The day I introduced Jeremy to the group, I had the children come alone. They were totally taken aback. He cried. He had temper tantrums. Nothing he said had anything to do with what we were doing in the group. He talked to himself, out loud. I didn't know to whom he was talking, really – if it was to himself or to anybody. He just talked in a non-relational way, and *very* loudly.

I said to them that I kind of wanted to let it go and see what he was going to do, and that I thought he was really nervous.

Some of the kids tried to get him to stop talking. They said it was annoying them, and that he was not supportive of the group. I asked them why they were asking him to stop and how they know he *could* stop. I asked them whether we ask people to stop doing things without knowing whether they can. They didn't know him.

Interviewee:

What do you mean by that, Christine, when you consider whether someone has the capacity to stop doing what he or she is doing?

Christine:

Well, people can't do everything. Maybe another child in the group could be quiet. But I knew Jeremy longer than everyone else, and I didn't think he could do that at this time. Another child asked me why I was asking the question. She wanted to know if I was saying that Jeremy couldn't stop talking. I said I didn't know if he could or couldn't, but my experience was that he wasn't stopping.

Then I took a risk. I said that I knew this would be hard for Jeremy to have me say in front of everybody, but that *he wasn't particularly a big boy*, and the group's job was to help him grow. I told the group that I thought we should give him some performance direction on what else he could do.

Q:

And what was he doing while you were telling the group this?

Christine:

Listening. He was muttering, but listening. He did not scream when I said he wasn't a big boy, as he had previously. One of the leaders of the group, who's nine, said perhaps he could lower the volume. I said I thought that was an excellent direction and Jeremy did. He spoke quietly to himself through the entire group. They had a tissue box that they used as a remote control, which meant, "lower the volume!"

In the fifth group, one of the girls said she hated having him there and wanted him to leave. Basically she was saying he repulsed her. This was a girl who, in some sense, was often in his position. She was one of the least developed kids in the group, and people often had difficulty with her. But now he had usurped her place, and he was the more difficult one. She said she hated his guts.

The other kids responded by saying they didn't hate his guts, but didn't know what to do, either. I said I didn't care whether they liked each other or not. But I did care about their figuring out how they were going to work together because he wasn't going anywhere.

Q: You made that clear?

Christine: I made it very clear that he wasn't going anywhere. Then Jeremy stopped talking to himself. He said, "I get it. I like everybody in here. She hates me [to the girl] and you [Christine] don't care. (*Laughter.*)

I said well, that's close. You're going to have to figure out how to work together whether you like each other or not.

Q: And what did they all do with that?

Christine: They started to figure out how they were going to work together. The boys, in particular, became very supportive of him and worked to include him. In fact, one boy suggested that we play "The Bears," knowing that it was Jeremy's favorite game.

Q: How did they know about "The Bears?"

Christine: One of the ways we introduced Jeremy to the group was that Jeremy and I played "The Bears" together, and we worked on how to include the group in the game. This process was extremely difficult for him. "The Bears" was very scripted, on his part. It went a certain way at a certain time, with almost no variation, except the day I was sick. He cried a lot when the children became involved in "The Bears" because they did different things with the game. I worked very closely with him, as did my co-therapists, to teach him that when you give something to other people – as he had given "The Bears" to the group – that they do different things with it. And that helps you grow.

He has continued to cry through "The Bears," but we continue to play it now and then and he's doing much better. In fact he's now talking to us, and sometimes as part of a very intense, emotional dialogue. And keep in mind that most often, children like Jeremy are related to as if they cannot do that, it's not possible. At times he will start perseverating: "I have something to say! I have something to say! I have something to say!" And sometimes the kids will say, "Hey, you need to wait because so and so is talking. You need to support the other person." And then when the other person's finished, they'll turn to him and say, "Okay, what is it?" And he'll say, "I just want to tell you all that you have a really nice place here, and I like everybody."

So he's learning how to respond emotionally and how to express his caring and respect for people. We're just crazy about him. And we're crazy about this experience that he's having.

Q: It's very beautiful what you're saying. I'm wondering what the repercussions of his development have been in his world.

Christine: Mom has made a decision to change his school and put him in a more challenging environment. Of course, this has been a challenging task for her. A lot of school administrators and teachers, when they meet him and view him through the eyes of people trained in these diagnostic categories, don't want to take him because they feel that he will not be able to function.

His parents finally found a place for Jeremy to go. He also has joined a karate class, which people thought he couldn't do and, I must say I didn't think he would be able to handle. He came back and told me the karate master was mad at him. I said that he had to decide if he wanted to perform being a big boy in that class or not.

All week I was concerned that I had asked him to do something he couldn't do, and that my request was unfair. But it turns out he changed his performance in the karate class and is doing great. So I'm learning that I have my own biases operating, and he's teaching me about them. And he's teaching the group! The other children have learned how to be more inclusive, how to work together, how to work with everybody's differences. They've learned how to deal with their reactions and biases and how to play together cooperatively.

I think the children have learned how to do the social therapy group. They talk group talk, they say things like: "You have to support the group!" and "What does the group want to do?" Someone will say, "I want to do this, does the group want to do that?" They are very aware that what they are doing is building the group. They talk about group leadership – "Who's leading today?" – or commenting, "That's a leadership thing to say." They make good use of their therapist. They ask for help. They have broken out of categorized ways of relating to each other and themselves.

With the parents it's more difficult. As adults, we're just more consolidated into what I call our lack-of-relatedness, our rigidified thinking, and our categorical thinking. It's often very exposing for parents to be in the group because things will come up that are hard to look at. I think in this culture, and probably in others, one of the worst things that you can do is talk about how you're not very good at being a mother or father. I think there are tremendous social constraints on parents being able to talk openly about their struggles as parents.

Q: And they're talking about their struggles as parents in front of the kids?

Christine: We're saying it all in front of the kids.

Recently I said to a mother who has some emotional difficulties (in front of the child) that I thought a way that he was in advance of her is that she kept expecting that he (the child) should take care of her. I said that making an emotional demand on him to take care of her when she was having a hard time was a misuse of their relationship. Moreover, he came to the group to get help, but she didn't do that. She went to him for help.

She just reported today (a number of weeks after this conversation) that she was having a very hard time and that her son had said to her, "Do you remember in therapy when Christine said that I don't need to take care of you? What would it look like if we did that right now?" This is a nine-year-old! Mom responded, "Why don't you go out and play, and I'll pick up the phone and call somebody."

Q: And they talked about it in the next group?

Christine: Yes. She said that he made that move with her and that she was able to respond. And that's talked about in front of the kids – in fact not just in *front of them*, but also *with* them. And

more often than not the kids rise to the occasion of being supportive of their parents.

Q: What makes your work seem to be so vital and important is that you're reaching these kids that no one else has been able to reach, and helping them grow and relate to others.

Christine: Yes. They develop, and develop quickly. It's even quicker than I thought possible.

Q: How are parents are responding to this approach?

Christine: Parents and teachers are interested because they see the changes. Sometimes they write it off as magical. I used to think it was magical myself! Now I have a better understanding of how it's effective.

Q: Are your adult groups as creative as this? I mean, presumably you're not playing "The Bears" with adult groups.

Christine: Yes. They are creative. We're all practicing social therapy.

I think adults have their version of "The Bears" game. We all have ways that we talk about ourselves and our histories that are extremely rigidified and limited. We've learned to tell stories and live our lives in ways that are categorical and alienated. In that sense, I think any adult in a social therapy group talking about his or her life is doing "The Bears" game. And the growth process involves letting other people impact on that story, creating different ways of telling stories, even understanding differently what a story is.

I want to share something about working with older people. We have an eighteen-year-old girl who came to us last year, who was diagnosed with Asperger's. She grew up with the diagnosis.

She was doing very well while she was in a social context in high school. But then she stopped going to school and was basically in bed sleeping the entire day for a year. Her parents didn't know what to do or how to continue. So she came to therapy with us.

Q: How did she find you?

Christine: Their doctor referred her to us. A lot of doctors refer to us. And one of our therapists, who I am supervising, was working with her.

The young woman had all of the characteristics of this diagnostic category. She had also been diagnosed with obsessive-compulsive disorder, which is another part of this whole syndrome. She was very categorical – she liked to talk about certain things only in certain ways. She had very limited, scripted ways of talking.

In many ways we all do these things. But for her, it's just a little bit different. She would ask the therapist, "What's your favorite this? What's your worst this? What do you like best? What do you like least?" etc.

So I told the therapist to participate in that conversation, because I thought that was how to build a relationship with her. And they did that. After about a month or two into the therapy, the therapist made a move and said, "I don't really have a favorite color. I like a lot of different things and I'm mixed about some things. Some things I like: I like a blue dress. But I don't like a blue plate."

The young woman got very, very upset. "No, no, no!!! It *must* be one way or the other." (This is how a lot of these kids tend to relate.) The therapist stood her ground. The young woman said to her, "I'm going to help you figure out what your favorite color is." The therapist said, "That sounds great. Teach me how you do that. How do you do favorite, not favorite, most like, least like? I don't live my life that way. You do. So teach me about that."

What ensued was a very interesting deconstruction of how that young woman thinks about and organizes her life. And off of that five-to-six-week dialogue, they began to have different kinds of conversations about all kinds of things. They talked about being conflicted – about wanting to do something and *not* wanting to, all at the same time. And from there they went to talking about boys, music, and all kinds of things that were much less categorical.

Q: And for the young woman, that was a whole new way of approaching something?

Christine: Yes. Because what would typically happen is that she would have a major temper tantrum if you tried to go outside of how she did things. And so people had stopped trying, because it was so upsetting to her.

I think her parents didn't know how to handle the behavior so they just backed off. A lot of kids with a diagnosis of

Asperger's will behave this way. The frustration level is so high with many of these children – they want to relate and are unable to, and they create havoc.

Q: What was it that led your therapist to say to the client, “Teach me?”

Christine: I think the social therapist has to build with what she’s got, while at the same time relate to the person as a head taller than herself. You have to do all of that at the same time.

You want to have her teach it to you as a way of engaging her in a more philosophical conversation that will show the therapist how this young woman understands, as well as to build a relationship. The therapist is investigating why she’s come to think this way and why this is so terribly important to her. The therapist allows her to have the experience – that’s very important. At the same time the therapist is relating to her as having the capacity to perform a conversation other than the ones she knows how to.

Q: What happened off of this?

Christine: What happened was very interesting. As she began to develop – and this is often the case – her family decided to take her out of therapy.

She was having fewer tantrums and talking with them about what she thought. So they decided to put her in a day treatment program, which we fully supported. She wanted to go somewhere and be able to live her life. And I think the therapy helped them all decide to do that. So she’s now in school full time.

The family came to see that she could do something other than what she was doing. She can get out of bed. She can learn. She’s expressing her feelings and thoughts in a way that is less hostile, and she has a greater range of ways of relating. And her growth, I think, motivated her family and encouraged them to find something else for her to do other than being alone in the home all day. So the therapy was very brief – two-and-a-half to three months. That was it. And I was just thrilled with it.

Q: I wanted to go back to what you said about the assumption that many professionals have that these kids only have a capacity for some kind of behavioral, cognitive therapy. You had said that Asperger’s is seen as a *learning* disorder. By contrast, I hear in everything you’ve talked about today that

the social therapeutic approach relates to the kids' *total* development: cognitive, linguistic, social and emotional. They're learning how to learn; they're philosophizing. And their emotional development is integral to their overall growth.

Christine:

Yes. We're doing a unity of learning and development.

It's certainly true that we are teaching them social skills. There's no doubt about that. However, how we're going about that I think is very different. We're putting the demand on them that they're going to have to create environments where, with the appropriate help, they can create new ways of performing. They have performances they're doing – some of which are working and, by their own account, some of which are not working. Many of them will say, "I don't have any friends." But we are collectively creating environments – all of us together, children and adults – where they can develop emotionally and socially. And there's no separation for any of it.

It's not a technique. It looks different, depending on who the child is and who the parent is. I think everybody's learning how children and adults can talk together. Usually conversations are segregated: you talk to adults *or* you talk to children. For years, we've been struggling for ways to talk to each other given that some of us are eight and some of us are forty-eight.

Q:

You talk about "The Bears" with seriousness and respect. And at the same time, you convey it's a child's game. You don't denigrate it as a child's game. You're not doing silly talk about the child's game. It's a serious consideration of the game.

Christine:

Yes. And in the process we are hopefully busting through the children's and the adults' assumptions about what children can understand, who adults are and how they respond, and what children are capable of.

I used to be shocked by the kinds of things children said because they seemed so advanced. But then I had to take a look at how I saw children, and that I romanticized or idealized children in a certain kind of way that doesn't relate to them as workers.

Children work to create their development. They're insightful; they're ridiculous; they have a lot to offer; they have nothing to offer. They're like everybody else. So there's

no special treatment in therapy because you're five. As there's no special treatment because you're a mom or a dad. We're working together and you give what you can give, and you give the best you can give. That's the demand.

So the group will often say, "You can do better than that. That's not good enough. You're not going to get away with saying that you're bored. You're going to have to respond to what people in the group are saying." Now these are often *children* saying these things. Or a parent will say: "I can't believe that she (the child) just said that!" And I'll say, "Why not? Why would you not believe she said that? I think you don't know who she is." We're constantly engaging and challenging the expectations and assumptions about how people see who children are. And how they see themselves.

Q: It's almost a cliché the extent to which parents and kids are in a logjam. A child might say to the parent, "You don't understand me. You can't hear me. You don't know who I am." And for their part, adults can get exasperated. That dynamic seems to be a critical part of what is going on in these conversations among kids and adults.

Christine: Yes. I think we're working very hard to create an environment where the adults in the room can see their child and other children in very different and new ways. Not see them simply as *their* child, but see who that child is in the world; see who that child is socially and relationally. See who that child is becoming.

And the same goes for the kids. They're seeing not just *my* mom. The group is saying, "This is your mother, a woman in the world. Do you want to get to know her or do you just want her to do what you want her to do? This is who your dad is. He's not always nice to your mom. That doesn't mean that you get to be not nice to your dad."

So parents and kids are learning who each other is in the world. This supports the inherent socialness of who we are. It helps everyone break out of more traditional, confining roles of family life – and of life in general.

Parents will often say, "I feel like I've gotten to know my child." And children will say, "It's okay. This is my mom and dad. And neither one is perfect. They're not even necessarily very good at being parents. But they're here and we're all developing together. We're working. We're not being cute. We're not being mommy. We're not taking care

of each other. Everybody's working together." I think that's unusual.

Q: What is your response to, how do you react to, the success of what you're creating here?

Christine: I think that looks a million different ways. I'm beginning to train other people and that's very helpful to me because I'm seeing more clearly what we're doing.

For one thing, the work is very emotional. I've seen several children for a number of years. One child I've seen for five years, and a few weeks ago I realized, "Hey, she's going to make it. She's going to be okay!" It was an extraordinary moment. And that's what motivates me.

I want more people to know about these successes. I want more people to challenge the existing methodologies of helping and begin to question what help is, what kinds of social arrangements we need to construct in order to do it with some degree of success. Can we create performatory environments where human beings can develop and not just settle for eradicating negative behavior in and of itself? I believe it can be done, and I want more people to learn how to do it. I saw a new family yesterday. I used to somewhat dread seeing families. But now, I feel excited that we're going to give this to somebody else.

I've worked with young people for a very long time, since I was a young person myself. When I was eighteen I taught in the South Bronx for a couple of years. I've worked with kids who are deaf, learning disabled, gifted, and severely emotionally disturbed. And I think our work in social therapy is a way to help people, young and old, build environments where we can continuously discover how to be both who we are and other than who we are.

And given what's happening with young people today and the epidemic of autism in particular, I think it's vital for us to continue to develop this work. It's in the beginning stages, but small as it is, the work is very significant. And people are seeing that. Teachers are seeing that. The kids are better. The families are happier. People are living more growthful lives.

I'm very dedicated to continuing to create social therapy, and happy to be doing it with more and more people, including therapists from other disciplines who are coming here to train and learn how to do this work with families.

These therapists are, in turn, bringing their own sets of skills and creativity to the work, which is also very exciting.

Q: Thank you for sharing this with us.

Christine: Thank you.

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