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Thriving in the New Normal: How COVID-19 has Affected Alternative Learners and Their Families and Implementing Effective, Creative Therapeutic Interventions

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ABSTRACT

COVID shelter-in-place directives have increased stress families of kids who are alternative learners—those with ADHD, ASD and LD. Already struggling to manage emotions, to begin and finish home and school tasks and maintain social connections, these kids have lost critical in-person academic, therapeutic and peer support systems. Meanwhile, tension at home has increased as parents, untrained in special education and often dealing with their own attention and learning challenges, have to deal with work, financial and housing responsibilities while tutoring their children without necessary training. Increased anxiety, higher levels of reactivity and persistent disappointment further complicate family relationships. Interventions to help families of kids who are neurodiverse, alternative learners are most effective when they rely on the 5 C's method of successful ADHD parenting. Working together for effective solutions based on meaningful incentives reduces family conflict, improves kids' participation and fosters parent-child cooperation. When therapists apply this model and assist families in using it, they strengthen emotional attunement and shift the family narrative away from problem-saturated thinking toward resilience and thriving.

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Introduction

The combination of changes wrought by COVID-19 and socio-political protests across the world has disrupted life for students, families and school communities everywhere from February to May 2020. Educators across the country scrambled to re-create learning options for students and shift to online classrooms. Students faced significant adjustment and losses of daily routines that kept them on track and organized, extracurricular activities that brought them joy, self-confidence and fitness, and regular social interactions with peers and caring adults. For children and teens¹ who are neurodiverse, alternative learners, those with Attention-Deficit/Hyperactivity Disorder (ADHD) Autism Spectrum Disorders (ASD) and Learning Disabilities (LD),

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¹Throughout this article, the term kids will refer to both children and teens and the terms “child” or “children” may refer to young people from the ages of 5 to 18.

their parents became their teachers, their tutors and advocates, often with a lack of training in special education. Youth who were already struggling to manage emotions, to begin and finish home and school tasks and maintain social connections lost critical in-person academic, therapeutic and peer support systems. Family tensions intensified in the light of food, housing and job insecurity as well as the effects of institutionalized racism and social justice protests. Increased anxiety, higher levels of reactivity and persistent disappointment further complicated family relationships.

Therapeutic interventions are needed to address the complexity of issues facing these families and provide tools to reduce stress, anger and disconnection. The 5 C's of ADHD parenting foster the connection and cooperation that benefits both children and adults alike (Saline, 2018). This integrative, collaborative model offers techniques to improve executive functioning skills, foster positive parent-child attunement, improve problem-solving strategies and reduce conflict for alternative learners and their families. Therapists are better able to serve this population, foster effective, lasting change and help them develop rewarding relationships. This paper is divided into three sections to address the complexity of the issues facing students with ADHD, ASD and LD and their families. Part One reviews the sociocultural context for understanding the frequency and effects of COVID on the general population and those people with mental health issues. Part Two examines the prevalence and traits of neurodiverse, alternative learners and how COVID has affected them. Part Three offers clinical interventions based on the 5 C's approach to improve executive functioning skills, foster family connection and improve productivity.

Part one: the COVID-19 context: how the pandemic has affected the lives of children and families

Starting in March, children, teens their families and educators across the country faced: school closures; social isolation; working from home (both adults and kids); job, housing, food and health uncertainties; pervasive anxiety; unrelenting family time. The economic and educational havoc wreaked by COVID-19 has been unprecedented. In the COVID recession, the number of employed workers in the U.S. labor market fell by 24.7 million from February to April 2020 (Kochhar, 2020). While employment rose from April to May by 4.1 million, job losses remained impressive with unemployment hovering around 13% (Kochhar, 2020). These US unemployment figures have disproportionately affected Black and Latinx men and women, immigrants, young adults and people with less education (Kochhar, 2020). COVID-19 cases, hospitalization rates and deaths have also affected people of color in higher rates than when compared to White peers. Native American or Alaska Natives experienced 2.8x higher cases of the illness, 5.3x higher incidences of

hospitalizations and 1.4x higher rates of death; for Black Americans, the rates are 2.6x higher for cases, 4.7x for hospitalizations and 2.1x for death. For Latinx persons the rates are 2.8x higher for cases, 4.6x for hospitalizations and 1.1x for death (Adhikari et al., 2020; Centers for Disease Control and Prevention (CDC), 2020c). Among children of color, the CDC reported that Latinx kids were hospitalized eight times more often than White counterparts and Black children at five times (Pearson, 2020). People living in poverty, regardless of race or ethnicity, were found to have similar mortality rates (Finch & Hernández Finch, 2020). The World Bank projects at least 71 million people will be forced into extreme poverty by the end of 2020 (The World Bank, 2020).

School closures, in addition to exacerbating food insecurity, also heightened issues of housing instability, access to digital equipment and the Internet. The pandemic forced over 80% of children around the world to stay home (Van Lancker & Parolin, 2020). In the USA, 50 million K-12 public school students had to learn remotely (Common Sense Media, 2020). School closures also meant many children were deprived of breakfast and lunch supplied to them through government programs. Children in both Europe and the US faced hunger. Approximately 6.6% households in Europe and 14% of households in the USA struggle with food insecurity (Van Lancker & Parolin, 2020). In addition, unpredictable housing affects an estimated 2–5% of students in the USA, negatively affecting their lives in multiple ways (Van Lancker & Parolin, 2020). In New York City, for example, homeless and housing instability affect one in ten students (National Center for Homeless Education (NCHE), 2018). Without a stable home, regular meals and consistent access to necessary technology, these students are a high risk for falling behind academically and socially. The rapid shift to online learning highlighted the digital divide among families and issues of differential access to resources. Online learning requires computers, reliable internet and a quiet place to study. Almost 16 million students lacked adequate internet or devices to manage effective remote learning and 9 million students lacked both internet and devices (NCHE, 2018). Students from low income households who do not have access to these necessities are at risk of falling behind (Van Lancker & Parolin, 2020; Weir, 2020a). Precarious housing, loss of government supplied breakfast and lunches in addition to unequal access to digital tools and internet service put poor students at risk in terms of wellbeing and education. Finally, school closures deprived students of counseling and support services where they were previously able to disclose and receive treatment for abuse or violence in their home by school personnel or child welfare agencies (Van Lancker & Parolin, 2020). This lack of access increased student vulnerability and potential exposure to trauma.

Increased levels of stress among adults and caregivers posed additional hardships for children and teens during the pandemic. In the first of two

studies on stress from the American Psychological Association (APA) conducted from April to early May, many Americans reported high levels of stress specifically due to COVID-19 and in general around 74% citing the pandemic, government response, disrupted routine or fear of getting the virus (American Psychological Association (APA), 2020a). Parents felt higher levels of stress than those adults without children related to dealing with educational issues, meeting basic needs, obtaining access to health care and missing lifecycle milestones: 71% of parents, in particular, said managing online learning was a primary source of stress (APA, 2020a). In the APA follow up study conducted from mid-May to June, after the deaths of George Floyd, Breanna Taylor and others incited social and political justice protests, most Americans (83%) revealed that the future of the country was a significant source of stress, Black Americans reported discrimination was a major source of stress (55%) and 71% said police race-related violence was caused them significant stress (APA, 2020b). The rate of stress among Americans related to the pandemic rose to 78%, with 66% continuing to feel distressed by the government response (APA, 2020b).

All of this stress increases the risk for anxiety and depression among adults. Without typical social connections or work experiences and increased loneliness, adults may resort to inappropriate coping methods. Higher rates of substance use and the possibility of domestic violence or child abuse are valid concerns, with many parents reporting intensified family conflict including shouting, yelling or stricter discipline with their children or teens (Griffith, 2020; Lee & Ward, 2020). Parental stress and burnout have been found to negatively affect children and contribute to worsening preexisting mental health conditions for caregivers (Finch & Hernández Finch, 2020; Griffith, 2020; Russell, Hutchison, Tambling, Tomkunas, & Horton, 2020). The complete reorganization of the family structure and daily routines resulted in intense psychological distress for the entire family. As Deb Perelman wrote in her opinion piece for the New York Times in July 2020, this combination was overwhelming despite her acknowledgment of her White privilege, “The first few weeks of school and business closures were jaw-clenchingly stressful . . . I managed the remote-learning curriculums of our two children, one in pre-K, one in fifth grade. I compensated by working until about 2 a.m. each night” (Perelman, 2020). Parents with fewer resources than Ms. Perelman faced additional issues of job, food or housing insecurity and/or racial discrimination which added to their stress.

Mental health trends in the general population

Before addressing the issues related to parenting kids with ADHD, LD and ASD during the pandemic, it is important to examine issues of mental health in the general population of children and teens as a foundation for looking at

the context of alternative learners and their families. Unprecedented interruptions to academic, social and extracurricular activities have impacted children of all socioeconomic and ethnic backgrounds to varying extents. In a poll released in early April 2020, Common Sense Media reported that teens felt worried, lonely and determined to stay connected to each other in some way. They worried about how the coronavirus would affect their families including getting ill, and being able to earn money. Almost nine in ten Latinx teens worried about their family's ability to make a living (Common Sense Media, & SurveyMonkey, 2020). Despite 42% feeling lonelier than before, 65% used social media to stay connected to family and friends and many Latinx and Black adolescents worried about keeping up with schoolwork more than White teens (Common Sense Media, & SurveyMonkey, 2020). These concerns reflect an uptick in anxiety and stress felt by children and teens alike and demonstrate the immediate and lingering psychosocial impact of home confinement (Fegert, Vitiello, Plener, & Clemens, 2020; Ghosh, Dubey, Chatterjee, & Dubey, 2020). In fact, one study indicated that post-traumatic stress scores were four times higher for children who had been quarantined compared to those who had not (Wang, Zhang, Zhao, Zhang, & Jiang, 2020). Based on data from prior community and national crises, significant increases in anxiety, depression, trauma and loss, it is reasonable to expect a wide impact on American youth during this pandemic (Weir, 2020a). For young people whose parents or family members are essential workers, the stress is even greater (Ghosh et al., 2020).

Typically, one in five children in the U.S. suffers from a mental, emotional or behavioral disorder with only 20% of them receiving treatment from a specialized provider (Ghosh et al., 2020). Recent studies have found that children, adolescents and adults who have preexisting mental health issues, especially anxiety and mood disorders, are more susceptible to and affected by COVID-related stressors (Fegert et al., 2020; Lee, 2020; Racine et al., 2020). These vulnerabilities have intensified their mental health issues and, in some cases with school closures, blocked their access to assistance. In a recent survey conducted in the UK of school-age participants up to 25 years old, 83% said the pandemic had worsened their conditions and 26% reported being unable to access therapeutic services and support groups. Many found online or phone therapy to be insufficient as well (Lee, 2020). The prolonged effects of quarantine on the psychological well-being of all children and adolescents includes increased incidents of post-traumatic stress symptoms, confusion, anger and grief (Brooks et al., 2020; Guessoum et al., 2020). While adolescents typically wrestle with the transition toward adulthood and that process of maturation can be fraught with intense emotions, for those teens who live with a mental health diagnosis, their sensitivity to the chaotic events around them influences how they are feeling and behaving. Substance abuse and suicidality rates have heightened among adults and adolescents alike (Hanlon, 2020;

Kirzinger, Hamel, Muñana, Kearney, & Brodie, 2020; Panchal et al., 2020). Similarly, caregivers report that they have seen more temper tantrums, arguments and poor cooperation in children (Jefsen, Rohde, Nørremark, & Østergaard, 2020).

Mental health issues have been associated with heightened screen time as well (Gao et al., 2020). “Screen time” refers to how many minutes and hours someone uses a digital screen such as a mobile phone, tablet, television or computer. Typically, people engage in three types of online behavior: hanging out, messing around and geeking out (Ito, 2019). Between attending online school, engaging in remote work and relying on technological devices for socializing and relaxing, COVID confinement heightened the amount of time many children (and adults) spent on screens (Cheng & Wilkinson, 2020). Many parents, despite their desires to monitor access to technology in their families under normal circumstances, permitted their children to have extra access (Orlando, 2020). A mother of 10 year old twins with ADHD summarized the dilemma about relying on screens to occupy her children when she said: “I just had to drop my kids in front of screens to stay sane and do my work.” Long periods of social isolation and stay-at-home directives heightened participation in online gaming by as much as 75% (King, Delfabbro, Billieux, & Potenza, 2020; Shanley, 2020). Gaming has been found to pose risks for some vulnerable children and teens who already struggle with mental health issues. They are more likely to develop unhealthy coping patterns by engaging in this activity, which is exacerbated by prolonged periods of social isolation (King et al., 2020). Moreover, Zoom exhaustion was real: the different quality of attention needed to focus for online school or work depends on simultaneously processing visual and auditory cues that can lead to overstimulation and distracted connection (Hickman, 2020). While a greater allowance of screen time became a necessity for many families during COVID, instead of it being one part of a balanced lifestyle that includes non-screen activities, it became the cornerstone of daily living for many children and families (American Academy of Child & Adolescent Psychiatry (AACAP), 2020).

How parents and caregivers are coping themselves with the pandemic affects the responses and stability of these vulnerable children and teens in the home. Family togetherness can be an asset or a detriment to the adjustment and adaptation of youth during the pandemic. Higher global reports of domestic violence and physical, emotional and sexualized violence against young people point to a serious threat to the mental health of all children and teens, worsened by reduced access to and supervision from social welfare and child protection services (Ghosh et al., 2020; Jefsen et al., 2020). Therapists should be particularly attuned to these issues and evaluate their at-risk clients regularly which can be difficult due to the lack of privacy if remote sessions are conducted within the home. It is recommended for adults to promote a sense

of security, appropriate reassurance, essential information and stress reduction tools as well as healthy life choices related to sleep, eating and exercise (Guessoum et al., 2020; Jepsen et al., 2020). These recommendations, useful for all young people, are especially important for children and teens living with mental issues whose levels of insecurity, anxiety and/or depression are intensified by pandemic concerns and constraints.

Part two: understanding neurodiverse, alternative learners: facts and trends

For alternative learners, managing ADHD, ASD or a learning disability on a daily basis means coping with cognition, emotion and behaviors that differ from neurotypical youth. Whether at home, in classes or with peers, these kids often struggle to show up and participate in the ways they and the adults in their lives would like to see. While these diagnoses differ, they all experience executive functioning challenges that range from mild to severe. These challenges, with or without co-existing mental health conditions, lead to heightened reactions and problematic adjustments to the effects of COVID-19 on their lives. Understanding the prevalence, nature and traits of ADHD, high functioning ASD and learning disabilities forms the basis for effective work with these clients and their families.

Attention-deficit hyperactivity disorder (ADHD)

ADHD is a chronic condition marked by persistent inattention, hyperactivity, and/or impulsivity that is more frequent and severe than is typically observed in children of the same age and interferes with functioning or development (APA, 2013). It is a neurobiological disorder that affects between 9.4–10.2% of all children and adolescents in the USA, with 7.7% of those ages 4–11 and 13.5% of those ages 12–17. Worldwide instances of ADHD indicate 5–7% of children have the diagnosis (Thomas, Sanders, Doust, Beller, & Glasziou, 2015; Xu, Strathearn, Liu, Yang, & Bao, 2018). Boys are diagnosed 2.5x more often than girls: 13.3%:5.6% mostly with hyperactivity/impulsivity (CHADD, 2019; Rucklidge, 2008). Two out of three children (64%) have at least one co-occurring condition, with the diagnostic rates at 52% for behavioral or conduct issues, 33% for anxiety, 17% for depression and 14% for ASD (CDC, 2020a; Danielson et al., 2018). ADHD is highly inherited: nearly half of all children with the diagnosis have a parent with it and if there is one child in a family with ADHD, there is a 33% chance there will be a second one (Biederman et al., 1995; Larsson, Chang, D’Onofrio, & Lichtenstein, 2014; Starck, Grünwald, & Schlarb, 2016). Approximately 62% of parents of children with ADHD report that their kids are taking medication while 46.7% report

having received behavioral treatment within the past year and 23% sharing that they have had neither one (Danielson et al., 2016).

Socioeconomic status and racial identity appear to affect diagnosis rates: Black children ages 3–17 years are diagnosed with ADHD or a learning disability more often (16.9%) than white children and Latinx children (11.9%); children from families in lower income brackets diagnosed more than those above the federal poverty line (18.7% to 12.7%); children with parents who have a high school education or less diagnosed with ADHD more than those with higher education levels (15.4% to 12.8%) (ADHD editorial board, 2020; Centers for Disease Control and Prevention, 2020a). Consideration of issues of racial bias, structural bias and individual discrimination are essential when assessing children of color for ADHD (along with ASD and LD) and should include evaluating ADHD symptoms in context and addressing racism, trauma, poverty factors as contributing to inattention or hyperactivity (Danielson et al., 2018; Frye, 2020). Approximately 62% of parents of children with ADHD report that they are taking medication while 46.7% report having received behavioral treatment within the past year and 23% sharing that they have had neither one (Danielson et al., 2018). Raising a child with ADHD is expensive: one study found that these families spend approximately five times as much as parents of neurotypical kids (Zhao et al., 2019).

Autism spectrum disorder

Autism spectrum disorder refers to a neurodevelopmental disorder that reflects persistent deficits in social communication and social interaction across a range of settings. It includes difficulties with social-emotional reciprocity and nonverbal communication and may include symptoms of stereotyped (repetitive or ritualistic) behaviors, obsessions with particular topics and atypical interpersonal communication (Applied Behavior Analysis Edu. (2020); Autism Speaks, 2020; Bailey, 2020; Romero et al., 2016). Such deficits can range from mild to severe and some people may be actively more high functioning than others. These children and teens lack an intuitive understanding of several aspects of the social world and frequently experience delays in their social development. Additionally, in 2017–18, children and teens with ASD comprise 10% of all students with disabilities (Schaeffer, 2020). In terms of clinical focus and family interventions, this article refers to children and teens with mild or level one diagnoses, as known as High Functioning Autism (HFA), who have less difficulty integrating into society than those young people with more severe symptoms and may be seen by their peers (and adults) as odd or eccentric (ABA, 2020).

In general, approximately 1 in 54–59 children in the USA has been diagnosed with autism with significant gender differences as boys are likely to be

diagnosed four times more than girls (1 in 34 to 1 in 144) (Autism Speaks, 2020; CDC, 2020b; Pappas, 2020). Studies have shown that 17% of children in the US also have a developmental disorder and the diagnosis rates for ASD in Asia and Europe hover between 1–2% (CDC, 2019). Studies have found racial disparities in diagnostic trends with higher prevalence among White children (15%) relative to both Black (10%) and Latinx (5–14%) kids which could reflect differences in access to care, assessment measure and systemic racism: these children and teens tend to be diagnosed less often and later (Autism Speaks, 2020). ADHD, anxiety, eating disorders and learning disabilities are the most common co-occurring conditions. Although 14% of children with a primary diagnosis of ADHD have a second diagnosis of ASD, 42–58% of young people with a primary diagnosis of ASD have co-occurring ADHD. Anxiety disorders occur in 32% of kids with ASD and eating disorders 90% of the time (Autism Speaks, 2020).

Learning disabilities (LD)

Learning disabilities is an umbrella term encompassing a number of different challenges with learning, most often in reading, writing, math, and problem solving. Learning disabilities are neurological conditions that interfere with an individual's ability to store, process, or produce information and are not the result of lower intelligence, poor parenting or poor educational instruction (Bailey, 2020; National Center for Learning Disabilities (NCLD), 2017a, 2017b). They affect how people learn, receive and process information. A total of 2.3 million (33–35%) of all students in the United States are diagnosed with specific learning disabilities (SLD), most often indicating differences in reading (dyslexia), mathematics (dyscalculia), written expression and auditory or visual processing, with an estimated 80% of students reading or language-based challenges (Learning Disabilities Association of America, 2020; NCES, 2020). Learning disabilities can affect one's ability to read, write, speak, spell, compute math, reason and also affect an individual's attention, memory, coordination, social skills and emotional maturity. A higher percentage of males ages 6 to 21 years who attend public schools, 18%, receive special education services under IDEA than female students at 10% (NCES, 2020). An estimate of 20% of students in the USA (1 in 5 children) and 10% of students worldwide have either learning or attention challenges: 1 in 16 public school students receive services under Individualized Education Programs and 1 in 42–50 kids receive accommodations through 504 plans (NCLD, 2017b; The Understood Team, 2020; University College London, 2013). Specific learning disabilities arise from a variety of factors including genetics, toxin exposure, poverty and adverse childhood experiences (e.g. trauma, abuse, neglect) and are not caused by poor parenting, inadequate instruction or lack of motivation (Boat, 2015;

University College London, 2013). While children from all socioeconomic, religious and racial groups experience specific learning disabilities, racial and structural biases as well as underrepresentation negatively affect children from lower income families, students of color and English language learners (NCLD, 2017b). Students with SLD drop out of school at higher rates than neurotypical peers, around 71% total: in 2015–16, almost 35% of Black, Latinx and Native American students with learning disabilities left high school without a diploma compared to less than 25% of Asian and White students (NCES, 2020). Often the stigma associated with learning disabilities can impede students to ask for the help they need and for teachers to recognize that there is a problem and not “laziness” (The Understood Team, 2020). Undoubtedly, early and accurate identification as well as effective and appropriate interventions and additional training for educators about specific learning disabilities help to facilitate academic progress and achievement for neurodiverse, alternative learners.

Specific learning disabilities co-occur with both ADHD and ASD and are typically related to executive functioning deficits. Executive functions are sophisticated brain functions needed to achieve and accomplish tasks in the service of meeting a goal. There are eleven executive functioning skills that can be synthesized into seven categories: Inhibition, Emotion, Action, Energy, Recall, Focus and Self-Evaluation (Barkley, 2011; Barkley, 2012a; Barkley, 2012b). Executive functioning skill deficits affect children and teens with ADHD, ASD and LD although the range of the impact differs individually (Carter Leno et al., 2018; Rosello-Miranda, Berenguer-Forner, & Miranda-Casas, 2018; Rosenzweig, Krawec, & Montague, 2011). Studies have found that deficits in attention regulation and capability frequently co-exist with learning disabilities and the more severe the executive functioning deficits, the higher the likelihood of a learning disability (Faedda et al., 2019; Mayes & Calhoun, 2006). The presence of autism rises as the severity of learning disabilities increases and 11% of students who receive services under IDEA for specific learning disabilities also have been diagnosed with ASD (O’Brien & Pearson, 2004). Approximately 40% of people with autism have learning disabilities and studies suggest that 80% of kids with high functioning autism meet the criteria for non-verbal learning disability (Dinklage, 2020; Gnanavel, Sharma, Kaushal, & Hussain, 2019; Romero et al., 2016).

Children and teens with ADHD may struggle with and be diagnosed with specific learning disabilities at around 70% and prevalence rates range for reading (dyslexia) occur in 33–45% of kids with ADHD, mathematics (dyscalculia) 20–30% and disorders of written expression (57–65%) (Mayes & Calhoun, 2006; Sexton, Gelhorn, Bell, & Classic, 2012; Yoshimasu et al., 2011). Sadly, many students with ADHD do not receive the services they need and are entitled to. George DuPaul in a large study of over 2500 students with the diagnosis of ADHD concluded:

We found that although the majority of students were currently receiving one or more school services, only a minority received support to manage their behavior, and at least one out of five students did not receive any school support despite experiencing significant educational impairment. (DuPaul, Chronis-Tuscano, Danielson, & Visser, 2018).

Gaps were found to be especially evident for children and adolescents from non-English-speaking and/or lower income families.

The educational effects of COVID-19 on alternative learners

Although reliable figures on how COVID-19 has affected students with disabilities (including those with ADHD, ASD and LD) are not yet available, there seems to be agreement that these students and/or those with mental health issues are least likely to benefit from remote learning (United Nations Sustainable Development Group (UNSDG), 2020). While there are certainly differences among individual students, about 80% of these students rely on school-based services including engagement with special education teachers, counseling services, nutritional programs and assistive technologies that were either no longer available to them when schools closed or did not translate well to online platforms (Masonbrink & Hurley, 2020). Issues of poverty, job, housing or food insecurity as well as systemic racism have deleterious consequences for students and families living with mental health issues and learning disabilities (Asbury, Fox, Deniz, Code, & Toseeb, 2020; Fegert et al., 2020). These families are less likely to advocate effectively and ensure that their children receive the services to which they are entitled such as occupational therapy, speech-language therapy, autism interventions and psychological treatments (Weir, 2020a). Lack of access to necessary digital equipment and internet services disproportionately impacts children from lower socioeconomic groups and, when these youth also deal with ADHD, ASD and LD, the disadvantages in learning intensify. Cut off from mandated educational programs to assist them and relying on well-intentioned but untrained parents for academic assistance, students with coexisting learning challenges and mental health issues are at high risk not only for lagging behind peers but also for experiencing a worsening of mood disorders (Weir, 2020a). What we know about the effect of stress on children with mental health disorders applies to neurodiverse, alternative learners with co-occurring mental health diagnoses only more intensely. Now, on top of coping daily with learning, attention and social interaction differences and their proclivity for anxiety and depression, they are also struggling to manage without the various supports that they have come to rely on. Executive functioning challenges related to weak emotional regulation and working memory for these students may distort their fears and their capacity to process information about COVID-19, producing additional crisis-oriented, harmful stress (Fegert et al., 2020).

Differences based on learning accommodations, socioeconomic status and racial disparities not only reveal the gaps among families of alternative learners but also demonstrate various styles of adapting to COVID and coping with its changes. First, seasonal learning research that compares COVID-related pauses in learning to those of summer breaks has shown that that achievement typically occurs during the summer slide can be applied to COVID school closings (Kuhfeld & Tarasawa, 2020). Such seasonal academic setbacks are greater for families of color and families living below the poverty line (Kuhfeld & Tarasawa, 2020; UNSDG, 2020). A minority of these parents and students may have found COVID confinement a welcome reprise from social pressures and hectic schedules. One father stated: “Not having to go to school and deal with other kids was much less distracting for my son, Deon, who’s 15, with ADHD and ASD. He liked being able to see and talk to kids in the online classes or play video games when he wanted. He could moderate the contact.”

However, many parents of neurodiverse learners point to the lack of school support, appropriate software, engaging teaching methods and social opportunities as further disadvantages for their children and unmanageable burdens for them as caregivers (UNSDG, 2020). One grandmother commented: “My 12 year old grandson who lives with us uses the most horrible language when he’s mad or frustrated that he can’t do his work. The school doesn’t do anything and he’s lost his homework support class. I don’t understand the new math and don’t know what to do to help him. We don’t want him to fail.” With prolonged stay-at-home directives, previous family routines, support networks and valued resources were suddenly disrupted with the onus of monitoring and/or facilitating special education falling onto stressed and anxious parents who lacked appropriate training (Bobo et al., 2020). Stress levels ran high as parents struggled to get kids up for class and motivated to study. A father shared: “The morning routine is brutal, he won’t do what is necessary without me repeating directions over and over. By then I am yelling.” Another mother said: “Remote learning was awful. My daughter’s ADHD got the best of her. She is 13 and defaulted to flight mode in regards to assignment completion or resorted to lying that she was doing them when she wasn’t. She’s lonely and misses her friends.” Loss of meaningful routines, academic accommodations and social interactions: these alternative learners and their caregivers share the very real challenges they face.

General recommendations for reducing stress in these families and particularly for their youth involve lowering parental anxiety and overwhelm through interventions geared toward meeting children’s educational and mental health needs, enhancing resources for home life and reducing family conflict (Bobo et al., 2020). Therapists have to help families in crisis stabilize before working on any other issues related to COVID. Assisting them to access the care they need whether it relates to food, housing, employment or psychological services lowers parental anxiety which benefits both adults and kids

must be a priority (Asbury et al., 2020). Primary interventions include expanding early screening and cultivating awareness in students, families and teachers to identify and manage mental health concerns. In addition, helping parents advocate for their children effectively, equipping teachers with tools to personalize learning, building student awareness about how they learn and how to ask for what assists them and incorporating social-emotional instruction into curriculum will ameliorate the functioning of neurodiverse learners in both school and home environments (NCLD, 2017a, 2017b). Creating effective home routines related to school and chores reduce anxiety for alternative learners, especially those with ASD, and offer opportunities for better family cooperation and less conflict (Ameis, Lai, Mulsant, & Szatmari, 2020; Ghosh et al., 2020). Friendly interactions and calm, clear communication between parents and children foster much-needed connection and attunement. Shifting expectations for academic performance from those based on in-person performance to online realities will lower student anxiety and stress and create more successful learning environments.

In addition to making sure students get the services to which they are entitled, incorporating accommodations, using universal design and integrating personal interests into learning will help neurodiverse, alternative learners stay more engaged and motivated, especially since they lack the cues from peers in classrooms to attend and participate (Weir, 2020b). Finally, these children especially benefit from consistent social interactions as peer relationships can often be challenging for them. It may be hard for them to reach out and communicate effectively within COVID restrictions. Easing social encounters and teaching social skills are essential tools to develop and maintain self-esteem and resilience for alternative learners (Fegert et al., 2020; Ghosh et al., 2020).

Part three: therapeutic interventions to assist neurodiverse, alternative learners and their families during COVID-19

Therapists need an orientation with useful techniques to address the various educational, mental health and interpersonal issues that have arisen for families of alternative learners during COVID-19. The 5 C's approach--*self-Control, Compassion, Collaboration, Consistency and Celebration*--serves as a foundation for therapists to foster some of the recommendations mentioned above: creating routines that reduce anxiety, promoting clear communication and decreasing family conflict, nurturing social skills and reducing overall stress. This model helps families of neurodiverse learners overcome the emotional and educational challenges facing them, while building deeper personal connections and lasting skills. It is an integrative model based on positive psychology, cognitive-behavior therapy, family systems theory, psychodynamic ideology and mindfulness. At its core lies

a combination of strength-based thinking and attentive awareness: identifying traits or behaviors at which a child excels and developing those skills and observing and acknowledging what children and teens are telling people with their words and/or actions (Saline, 2018, p. 9–10). These 5 C's build connection, empathy and cooperation between caregivers and children by blending emotional attunement with effective behavioral changes. This approach serves as the foundation for teaching executive functioning skills and problem-solving tools to children with ADHD, ASD and LD. It assists therapists in their work with students and their families to reduce stress and common problems related to COVID and beyond.

The 5 C's of ADHD evolved from qualitative research conducted for “What your ADHD child wishes you knew: Working together to empower kids for success in school and life” (Saline, 2018) and over 30 years of clinical experience working with neurodiverse learners and their families. Typical challenges for these parents include:

- **Dysregulation:** It's natural to get upset when a child is screaming, kicking or hitting. But adult agitation only adds fuel to their fire. Mature adult brains have the capacity to calm intense emotions in ways that developing brains have not yet mastered. For children and teens with ADHD, whose pre-frontal lobes finish maturing at 25 or later, they need extra assistance from caregivers to learn how to do this.
- **Misunderstanding their experience as a young person who is an alternative learner:** In the midst of busy lives where there's so much to do and not enough hours in the day, parents struggle to remember that kids are trying to do the best they can each day while struggling with significant executive functioning challenges. Alternative learners do not wake up each day thinking about how they can complicate their own lives and those of their parents. Lacking empathy for their struggles exacerbates tension and conflict.
- **Imposing solutions to daily problems without kids' participation:** Young people with ADHD, ASD and LD, even young children, have their own ideas about what is not working and what could be better. Whether at school--a place where they often face social, academic or emotional challenges--or at home, they constantly hear from adults and peers about how they have missed the mark and what they should do differently, even if these ideas do not make sense to their uniquely wired brains.
- **Creating plans or threatening consequences that are unlikely to be executed.** Neurodiverse learners, despite their protests, thrive on routines and predictability. When parents struggle to stick with a behavioral plan or improvise a spontaneous punishment, it is confusing. Do the adults

mean what they say or not? Are limits to be taken seriously? Like most children, these kids look for ways to entice parents to change their minds. If they learn that pressure in the form of pestering or inappropriate behaviors gets them the desired result, then they will continue this behavior.

- **Too much focus on outcomes and overlooking process and efforts along the way.** Many parents, understandably, want to see immediate changes in their child's behaviors when they give feedback or start a behavioral plan. They are hoping to assist their kids in achieving steps toward being a responsible, productive adult. Often these goals overshadow the child's efforts to make progress on tasks or behavioral changes. Too much feedback focused on how they could do things better can backfire into kids simply giving up. While it's important to keep the end in sight, neurodiverse learners, many of whom naturally struggle with initiating tasks and perseverance, can easily lose motivation and momentum.

The 5 C's model offers a roadmap for therapists to address these challenges and teach parents innovative, effective strategies for making different choices.

- (1) **Self-Control:** Adults start by managing their emotions before attempting to deal with their child. Notice the physiological signs of activation and slow things down using predetermined options such as breathing techniques, drinking water or removing themselves briefly from the situation by stepping outside or using the bathroom. This pause in the action to re-center assists them in thinking clearly and making cogent choices. When the adult has re-grouped, then they can work with the child to do the same. Monica, mother of Terrell, age 8 explains: "I lost it with him yesterday. After three reminders to put on his shoes, I yelled. I wish I had more patience" (Saline, 2018, p. 7).
- (2) **Compassion.** Meet kids where they are, not where parents, caregivers or educators expect them to be or think they should be. The first step in having empathy for others is to create self-compassion. If parents can start to accept who they are, foibles and all, it will be easier to accept their child and what is going on with them. Developmental shifts in social, academic and emotional realms will occur eventually; alternative learners frequently need more time than their parents may desire. Oliver age 9 says: "School is okay but homework, especially homework with my mom, is the worst thing. She just doesn't understand what it's like for me" (Saline, 2018, p. xv).
- (3) **Collaboration:** When parents or caregivers include the opinions of kids with ADHD to address problem areas, there's more buy-in and,

ultimately, cooperation. Collaboration means working together with neurodiverse learners (and other important adults) to find solutions to daily challenges instead of imposing rules on them and using incentives, not punishment to motivate them. This collaboration offers a “we” attitude instead of a “you” attitude: kids will see caring adults more as allies instead of opponents. This reduces family stress. By feeling seen, heard and valued, children and adults will participate more readily because they are part of the process. Of course, during crisis moments regarding health or safety, adults make the decisions and that’s made clear from the beginning. Otherwise, teach and help parents to take the time to listen to kids’ perspectives and incorporate what matters to them into any solution. Jackson, age 14, states: “It doesn’t work when my parents take things away because I will keep on asking for it or do other things that annoy them. Now that I’m in high school, I wish they would trust me more so we could talk about stuff.” (Saline, 2018, p. 24).

- (4) **Consistency:** No parent can follow through all of the time. The goal is aiming for clear messages and similar consequences for the same behavior as often as possible, staying steady. Consistent parenting means that adults do not threaten or give children and teens consequences that cannot be enforced, remembered or supported. Many alternative learners already struggle with trial-and-error learning and benefit from having clear plans that are not renegotiated in the heat of a moment. This can be very tough for parents, many of whom struggle with executive functioning deficits similar to those of their children. Scott, father of Darren, age 15, reveals: “We can’t always stick with a plan. Sometimes we forget or something happens or we just feel tired. I know we give mixed messages but we are trying our best” (Saline, 2018, p. 8). Consistency also involves supporting “efforting”: the process of trying, stumbling and trying again, a cornerstone of growth mind-sets. Efforting fosters growth mind-sets which are essential cultivating self-esteem and confidence.
- (5) **Celebration:** When adults notice efforting, progress as well as outcomes, they cultivate self-esteem and confidence in alternative learners. Paying attention to the process and the progress made along the way helps validate how kids are trying to do what is asked of them and encourages them to keep going. Of course, acknowledging positive outcomes matter too. Despite whatever their words or actions display to the contrary, neurodiverse learners need parental support and validation to counteract the numerous negative messages they receive daily. Research has found that a 3:1 ratio of positive comments to negative ones makes a big difference in promoting behavioral changes and can-do attitudes (Fredrickson, 2009,

p. 32). Martina, age 17, summarizes Celebration in her family: “My mom taught me to think positively. If you can ask yourself ‘What can I do to make this situation a little better?,’ then you can turn around a crappy situation. When we do this together, she helps me find something good which I really appreciate.”

With the 5 C’s as the foundation, therapists can effectively support families of alternative learners to teach essential executive functioning skills. Parents seek guidance about managing a variety of issues, including home-learning, screen overuse, back-talk, and social isolation. Tyler, father of Desiree, age 14, says: “You make it up as you go along and, even though it’s the best you’ve got, you still feel like you’re failing.” They need encouragement from caring adults that they’re *not* failing and crave tools to help their families stay connected and reduce conflict. Creating collaborative, effective daily routines contributes to improved planning, prioritization and organization as well as initiation and personal responsibility. With this predictability in their lives, anxiety goes down as kids feel like they have some control over their lives and gauge their actions and hopes accordingly. Using incentives that matter to children and adolescents, including screen time, boosts their participation, productivity and cooperation. Fostering a balanced life based on a doable, collaborative schedule that both parents and kids can follow is one of the most effective strategies for families of neurodiverse learners during COVID. Here are suggestions for how to do this in session and home visits:

Begin by helping adults start with focusing on compassion—for themselves and their children. Remind them that everybody is doing the best they can to get by in an unprecedented time. Alternative learners, who naturally struggle with impulse control and managing emotions, are likely to act out more than usual by refusing to cooperate or arguing with everyone about trivial issues. Talk with parents about expecting and preparing for these challenges and how to adjust expectations accordingly instead of being surprised each time recurring behaviors happen again. Coach parents in how to hold a weekly or twice weekly family meeting to discuss key issues instead of bringing them up randomly and regularly throughout the week. This predictable time to discuss, evaluate and adjust any plan decreases family tensions because children and adults know there will be a specific time to address issues and agreements. Renegotiations for neurodiverse youth and their parents are rarely successful in a moment of emotional intensity and dysregulation.

Next, assist families in working out a daily or weekly plan that includes time for learning, chores, activities, adult own work-from-home responsibilities and personal breaks from each other. Instead of using punishments or threats to force kids to cooperate, focus on using earning privileges. The have-to’s must proceed the want-to’s in any schedule because incentives motivate kids with ADHD, ASD and LD if they remain novel and meaningful. Talk with

parents about what they want for each day, what they need to accomplish professionally or personally and what will help them stay as calm as possible. Remember, if the adults are dysregulated, then the kids will be too. Next consider what children and teens have to get done for school and chores: the have-to list, what assists them in working on those tasks and how many breaks they need for movement, screens, snacks, etc. Think about times for waking up, when to study and going to bed. Once the adults have clarified their ideas, open a discussion with the young people about their ideas.

Depending on their ages, explore with kids their opinions and desires about how to spend their time, initially alone if appropriate, and then with their parents/caregivers. The goal is collaborating together on negotiating a structure that makes sense for everyone. Incorporate some aspect of the youths' ideas into the agreement so they buy-into the process and the plan. To identify meaningful incentives, start by making two lists of their "want-to's": one with smaller items such as playing with the dog, hearing a story, yoga or movement or getting a snack. Then make another one with bigger items such as screen time: surfing the net, gaming or social media; doing a favorite activity with a parent or caregiver such as cooking, art projects, playing catch or making music; or even watching a tv show or movie. Link these incentives to the items on the have-to list.

Using these incentives, work with families to set up study periods using these incentives. Ask the student how long they think they can concentrate before needing a break. Depending on their level of interest and the challenge of the work, this period can last 5 to 20 minutes for elementary school kids, depending on their interest and the level of challenge in the work. For high school students, it varies between 15 and 45 minutes. Then ask the parent for their estimates based on observations. Together, decide on the length of their study periods and how many they will need per hour and per day.

Evaluate which subjects require hard, easy or medium efforts and discuss an order and strategy for approaching the work that makes sense to their brains and stamina. Agree to set up alerts and alarms to bookend their study and break periods. Choose smaller incentives for shorter breaks between study periods with a clear list of acceptable activities such as movement, bathroom, snacks, petting the dog, etc. Then identify bigger ones for larger benchmarks, expecting that after an hour most students will need a longer break. This is the opportunity for those "want-to's" like Youtube, social media, gaming, reading, listening to music or exercise. This framework builds initiation, organization, planning and prioritizing skills.

In order to foster sustained attention, focus and goal-directed persistence, it helps when parents work alongside these alternative learners. *Family work time* establishes that everybody is engaged in doing something important. Parents can do their own tasks while being near enough to children and adolescents to redirect or assist them when necessary. This sends a message

that everyone is taking this plan seriously and it is time to settle down. Homework, however, needs to belong to the students. When parents correct their children's work, teachers cannot receive an accurate understanding of learning strengths and weaknesses. Encourage parents to resist the temptation to get involved in the homework and instead create a plan with the school to monitor and assist their students.

Trevor, age 16, has a diagnosis of ADHD and dyslexia. He receives daily learning support services through his IEP. He has a history of lying to his parents about assignments and not turning them. Negotiating a new agreement for this academic year, he said that he wants to be finished with all school by 3 pm: "I can't focus anymore. I'm tired and I want it to be over." The collaborative agreement with his parents included a phone meeting at 2 pm to review what was finished and what needed to be completed using screen sharing and going over the Google school documents. If he cooperates with this plan, he can see his friends with social distance, ride his bike or play frisbee. If he does not cooperate, he will immediately do a special home chore with his mother and lose social time. He was motivated to do peer-related activities enough to follow the program. Since neurodiverse learners benefit from visual cues, this plan was written down and posted in the kitchen and his bedroom. With this agreement, family stress and anxiety diminished.

This is a time when everybody needs to chip in and chores are part of working together. Assist families in how to come together for the collective well-being. As with educational goals, keep chores for kids simple and manageable. If they weren't doing them before, this isn't the time to add something new. Instead, link the completion of their chores to some of the incentives they desire. Include self-care tasks such as grooming, wearing clean clothes, adequate sleep and cleaning their room. Decide in advance how many reminders youngsters will need and in what form. Again, visual cues are most helpful so incorporate these items into the daily plan that is posted. Parents should be prepared to supervise children and adolescents or keep them company: it is often difficult for them to complete chores alone, just as it can be to engage with home studying. *Family chore time* indicates that everybody is contributing simultaneously and makes it easier for parental supervision simultaneously.

Managing screen time during COVID is a common source of tension in families with and without neurodiverse, alternative learners. Kids with ADHD, ASD and LD often struggle mightily to get off their screens. Gaming and social media can be their lifelines for connections with friends but screen time has to be treated as a privilege, not an entitlement. Facilitate a process where families create collaborative plans about when, where and how screen time occurs. Help them plan for a certain amount of daily automatic screen time with added bonus time. Here's how this works: If a parent wants their daughter to have two hours of daily time on her devices outside of school work, start by

giving them a baseline of ninety minutes. Their daughter can then earn bonus time based on completing school work and chores or the lack of yelling, cursing, etc. Any desired behavior can be part of this plan. If she argues or becomes violent when it is time to get off the devices as planned, then she won't earn the privileged bonus time. If parents are working from home, encourage them to use the automatic screen time to their advantage. Schedule it for times that will help them with work or a needed break from supervision. Parents can also attach bonus time to completion of chores, lack of yelling or cursing, etc. Expect to adjust this plan along the way and make those changes during the family meeting, not in the heated moment. Of course, the inappropriate use of screens such as sexting, online bullying and visiting inappropriate sites indicates lack of readiness for screen privileges and necessitates a different agreement.

Given the uncertainty, loss and stress in the lives of young people as a result of COVID-19, increased anxiety for alternative learners (for those with previous diagnoses or not) requires therapeutic attention. Anxiety comes from wanting safety and security instead of being unsure. While anxiety is adaptive and helps prepare people for threats, whether they are real or imagined, it propels people into responding to them. Sometimes these responses are appropriate in cases of actual danger but sometimes they are distorted when the threat is perceived but not imminent or rational. Therapists need to assist kids and their parents with tools to examine and respond to anxiety and in healthy ways, rather than depending on reassurance or minimizing concern to allay insecurity. When COVID –19 concerns about health, socializing, school, food, job or housing security may arise daily, this is the time to take a step back and examine how someone's anxiety operates by focusing on the way it works – the process and not the content. For neurodiverse learners who frequently struggle with the executive functioning skills of working memory and emotional control, separating themselves from their worries can be confusing and complicated.

Dealing successfully with anxiety relies on the three R's: Reflect, Recognize and Reset. Instead of minimizing feelings or trying to get rid of them by saying things like "Don't worry, you'll be fine", acknowledging how children, teens and parents are feeling and offering them tools to tolerate the discomfort of their emotions is an important focus of therapeutic work. Assist parents in using language with their kids such as: "Of course you're disappointed and angry that graduation may be cancelled. It's terribly sad." Or, "Of course you're missing your friends and hanging out. It's lonely not seeing them in person." Statements such as this show that parents are listening compassionately and acknowledging what their kids are saying or showing them about their worries. By validating these concerns and the child's reaction to them, adults manifest compassion and set the stage for a collaborative response. Together, families can brainstorm the next appropriate step which may or may

not “solve” the problem but explores an effective coping strategy. This process helps children and teens reset in a moment when they’re lost or overwhelmed or frustrated.

Nurturing resilience is another crucial piece to dealing successfully with anxiety in alternative learners (Ameis et al., 2020). Anxiety is very skilled at causing amnesia about memories of past successes – times when children or teens faced a fear and overcame the obstacle. To build confidence in the ability to tackle and survive tough times, kids need reminders of their previous achievements. Assist families in recalling obstacles they have overcome in the past and what tools helped them do this. Write these down so they can refer to these strategies in different moments. This approach dovetails with Consistency and Celebration. When their efforts to lower the volume on their anxiety and to respond differently to it are noticed and encouraged, they strengthen growth mind-sets and learn to bounce back. Neurodiverse learners especially need this resilience to build self-confidence in their daily lives. As Jade, age 12 with ADHD and dyscalculia, tells herself: “Hopefully this works. If not, I’m going to have to find a new way to get it done. It’s hard sometimes, but there’s always a way to pick yourself up” (Saline, 2018, p. 164).

Conclusion

Whatever routines therapists and families create during this unusual time, offering positive feedback to neurodiverse, alternative learners is essential for encouraging their efforts and acknowledging their accomplishments. Of course, any programs will need tweaking at some point not only because of student boredom with monotony but also because the COVID situation is constantly shifting. This does not mean that the plans are not working but is a natural part of working with the 5 C’s approach. Instead of arguments and frustration dominating parent-child relationships, an inability for children and teens who are alternative learners to earn rewards or cooperate indicates that the tasks need to be altered to better suit their capabilities and adjust for their limitations during COVID and beyond. Work with their desire to avoid conflict, talk about how to reduce arguing and see their struggles as reflections of being overwhelmed to access resources in a given situation. Living with learning and mental health challenges, neurodiverse youth are struggling to get by: they may not be able to articulate how they feel. Parents, stressed by coping with socioeconomic, health and educational challenges beyond their control, need support, education and interventions to reduce their anxiety and improve family cooperation. Using the 5 C’s approach as the basis for interventions to improve executive functioning skills and desired behaviors in these students also fosters greater cooperation and less conflict in the families of neurodiverse, alternative learners through

negotiated collaboration. There is more balance, empathy and connection. As one parent reflects: “The biggest challenge for me has been keeping my kids safe and physically and mentally okay. Everybody has different needs and it’s hard to balance all of that. We are all doing what we can to keep our heads above water at the same time.”

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Notes on contributor

Sharon Saline, Psy.D. has focused her work on ADHD, anxiety, learning differences and mental health challenges and their impact on school and family dynamics for over 30 years. Her unique perspective, a sibling of a child who wrestled with untreated ADHD, combined with decades of academic excellence and clinical experience, assists her in guiding families as they navigate from the confusing maze of diagnoses and conflict to successful interventions and connections. Dr. Saline funnels this expertise into her book, *What Your ADHD Child Wishes You Knew: Working Together to Empower Kids for Success in School and Life*. Heralded as an invaluable resource, her book is the recipient of two awards: Best Book Awards winner by American Book Fest and the Gold Medal from Moms’ Choice Awards. She recently published *The ADHD Solution Deck*.

As an international lecturer and workshop facilitator, Dr. Saline combines psychology with her love of theater to animatedly present on a variety of topics from understanding ADHD, executive functioning and anxiety in children and teens to working with different kinds of learners and raising digital citizens. Dr. Saline is a regular contributor to *ADDitudemag.com* and *PsychologyToday.com*, a featured expert on MASS Appeal on WWLP-TV and a part-time lecturer at the Smith College School for Social Work in Northampton, MA.

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