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Common Factors of a Transtheoretical Model of Autism Spectrum Disorder-Informed Psychotherapy
Facteurs communs du modèle transthéorique d'une psychothérapie fondée sur les connaissances des troubles du spectre autistique

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ABSTRACT

Individuals with autism spectrum disorder-level 1 (ASD-1, formerly Asperger's disorder or Asperger's syndrome) frequently experience relationships as challenging, confusing, or aversive. With the current prevalence of ASD-1 in North America and internationally, there is a pressing need for ASD-informed psychotherapy (ASD-IP). Based in developmental psychology and aligned with the recovery paradigm, this article explores the impact of the common features of ASD-1 on the working alliance as reflective of the individual's relational experience outside of therapy. This article brings together voices from the literature with those of client and therapist, suggesting key elements of ASD-IP and proposing implications for further research, therapist training, and service delivery.

RÉSUMÉ

Pour les personnes atteintes d'un trouble du spectre autistique de niveau 1 (TSA-1, autrefois appelé trouble ou syndrome d'Asperger), les relations sont souvent perçues comme étant difficiles, déroutantes ou désagréables. Considérant la prévalence actuelle des TSA-1 en Amérique du Nord et à l'international, il est de plus en plus urgent de mettre en œuvre une psychothérapie fondée sur la connaissance du TSA. S'inspirant de la psychologie du développement et du paradigme de rétablissement, cet article explore le fait que l'impact des caractéristiques courantes du TSA-1 sur l'alliance de travail puisse être le reflet de l'expérience relationnelle de la personne à l'extérieur du cadre de la thérapie. L'auteur y rassemble les voix issues de la littérature et celles du client et du thérapeute, en suggérant des éléments clés de la psychothérapie fondée sur la connaissance du TSA et en proposant certaines implications pour la recherche à venir, la formation des thérapeutes et la prestation des services.

Traditional psychotherapy is of limited help to people living with autism spectrum disorder-level 1 (ASD-1; previously called Asperger's disorder) because psychotherapy is, in most instances, concerned with stimulating change. Stacey (2006) described therapy as intentionally "bringing about change in individual persons so that they are able to 'go on' more effectively with others in their ordinary, daily interactions" (p. 191). Although the prospect of change may attract neurotypical (i.e., non-ASD) individuals who are living with mental health issues, the experience (and sometimes even the idea) of change is anxiety-provoking to

individuals with ASD-1 (Cheak-Zamora, Teti, & First, 2015). Understanding the common features of ASD will help psychotherapists to intentionally adopt specific ways of being and communicating that make psychotherapy more accessible to individuals with ASD-1. In this article, I offer a common-factors perspective on ASD-informed psychotherapy (ASD-IP) as a working model to guide further research and training that will, in turn, serve to inform the development of an ASD-informed model of psychotherapy.

Individuals with ASD-1 are typically involved in relationships—friendships, intimate, or professional—increasing the likelihood that they will seek psychotherapy more often than individuals at levels 2 or 3 (Helps, 2016). Although many have meaningful careers and live independently or within families of their own, they often experience social interactions as confusing and challenging, described by one adult with ASD-1 as "having a head full of unfinished puzzles" (R. Blackburn, personal communication, October 27, 2006). When they seek help with the resultant relational issues, the outcomes of psychotherapy are often unsatisfactory (Stanford, 2003, p. 22). Koenig and Levine (2011) noted that there is a shortage of literature on adapting psychotherapy to make it accessible to individuals with ASD-1. However, as Wylie (2014), an adult living with ASD-1, testified:

> One way to survive in a predominantly neurotypical world is to act like a neurotypical person, and many autistic adults [sic] do so for decades before we finally understand ourselves; however, pretending to be someone else damages our self-esteem and mental health because we feel unable to honour and express ourselves truthfully. (p. 33)

There is a wide gap between where we are in psychotherapy, and where we need to be, to respond to this problem.

A note on terminology: The release of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association [APA]) in 2013 rendered the terms *Asperger's disorder/syndrome* and *high-functioning autism* (HFA) obsolete. DSM-5 described autism spectrum disorder more precisely than its predecessor, although the change in terminology was met with some resistance from adults who had self-identified as living with Asperger's disorder all their lives (Mayes, Black, & Tierney, 2013). The DSM-5 disassembled the original five diagnoses that composed the autism spectrum, referring instead to autism at levels 1, 2, or 3. People who would have received a DSM-IV diagnosis of Asperger's disorder now receive a DSM-5 diagnosis of ASD-1. Additionally, Baron-Cohen et al. (2009) proposed the term "autism spectrum condition" (ASC) as a less-stigmatizing option, framing ASD within a strengths-based perspective. In this article, I use the term ASD-1 to describe the conditions formerly referred to as Asperger's disorder/syndrome and high functioning autism.

HISTORICAL CONTEXT

Historically and currently, behavioural interventions, such as applied behavioural analysis, have been deemed best practice in the treatment and education

of individuals with ASD (Dillenburger, Keenan, Doherty, Byrne, & Gallagher, 2012). Recognizing the capacity for behavioural intervention to demonstrably change behaviour, it cannot claim to enable people with ASD to "become their unique selves" (Meade, 2011, para. 14). Behavioural modification does not intend to be a recovery-oriented pathway to mental health. Its goals are simply to increase desired behaviours and extinguish less-desired ones (www.autismspeaks.org). Although a plethora of literature advocates the use of behavioural techniques to teach people with ASD how to behave in ways that disguise their unique, ASD-influenced personalities, Bambara, Gomez, Koger, Lohrmann-O'Rourke, and Xin (2001) proposed that behaviourally based interventions do not promote the development of social relationships, and may even hinder them. This is a chilling proposition, given that ASD-1 is characterized by obstacles to successful social interaction.

In examining supportive relationships, as defined by academically successful, mentally healthy individuals with ASD, Robledo and Donnellan (2016) noted that no participant in their study attributed their professional success or personal development to behavioural intervention. Swan (2017) asserted that "we are without a humanistic counseling intervention that is adapted for working with children with ASD" (p. 112), and there is no evidence in the literature that this is not equally applicable to adults living with ASD-1. Additionally, in Western cultural contexts, psychopharmacology is often recommended to ameliorate the symptoms of anxiety and depression that frequently co-occur with ASD-1 (Robledo & Donnellan, 2016). When individuals living with ASD-1 seek psychotherapy, I believe we can provide a more recovery-oriented approach than the current standard blend of behavioural modification and medication.

Shifting psychotherapy for individuals with ASD-1 toward a recovery mindset begins by collaborating with the individual in case conceptualization (Sperry, 2005) and treatment planning, referred to in the Mental Health Guidelines as drawing upon their "experiential knowledge" (Mental Health Commission of Canada, 2015, p. 86). It continues by viewing ASD-1 through multiple biopsychosocial and developmental lenses, rather than the monocle of behaviourism. Psychotherapists working with this population recognize that ASD typically co-occurs with various conditions that impact quality of life, of which anxiety is a significant one (Mazurek et al., 2013; McFabe, 2016; Rogers & Ozonoff, 2005; Tavassoli et al., in press). If our work with neurodiverse individuals is to encompass respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society (Canadian Psychological Association [CPA], 2017), a shift in professional perspective with regards to the mental health and well-being of people with ASD-1 is indicated.

The lexicon of developmental psychology helpfully describes multiple, and often subtle, features that are common to individuals living with ASD-1. These common features impact flexible thinking and problem-solving (Gutstein, 2009; Hobson, 1995) and the ability to remember and refer to one's previous emotional experience (Gutstein, 2009; Mazefsky et al., 2013). They also include the capac-

ity to regulate how one interacts with the world through sensory and emotional interfaces (Bitsika, Sharpley, & Mills, 2016; Greenspan & Weider, 1999; Gutstein, 2009; McFabe, 2016), and the dual capacities of gathering information (especially nonverbal) from other people and sharing one's own experience with them (Gutstein, 2009; Holliday-Willey, 2001).

Greenspan and Weider (1999) described disruptions in motor planning and sequencing, and atypical child and family interaction patterns (p. 147). McFabe (2016) proposed additional, common physical and psychological features of ASD (at all levels) that include immune disorders, gastrointestinal disorders, poor sleep patterns, and anxiety. From childhood, individuals with ASD-1 live with a neurological condition that predisposes them to mental and physical health issues, with significant psychological, social, and financial impact on themselves and their families.

Common Features of ASD

DSM-5 organizes the diagnostic criteria for ASD according to the degree of support needed by an individual for optimal quality of life. The diagnostic process is assessment and observation-based, and is conducted ecologically (Dishion & Stormshak, 2007), involving multiple individuals who know the client in different contexts. Diagnosis is easier in children than in adults because input is available from people, usually parents, who recall the individual's early development. Abilities and obstacles are assessed in two domains: (a) social communication/social interaction and (b) restricted or repetitive patterns of behaviour, interests, or activities. In the presence of challenges (developmental gaps) in both areas, individuals are diagnosed with ASD and are assigned a diagnostic level: 1, 2, or 3. Those at level 3 need the most support for self-actualization, and at level 1, the least (APA, 2013). Diagnosis is made when the impact on both domains has affected functioning in at least one context (home, school, work) since childhood (APA, 2013).

There are currently many adults living without a diagnosis but with the common features of ASD-1, because their social and communication challenges were neither recognized nor investigated in childhood. The life-altering experience of late diagnosis of ASD was described succinctly by Wylie (2014, p. 19): "I always knew that I was different but did not understand the underlying cause. I always struggled to maintain relationships and jobs, and for decades I was unaware of the severe social stress and anxiety I was experiencing." For Wylie, diagnosis "made sense of the fact that so many people had described me as being strange, eccentric, interesting, ungrounded, un-coordinated, selfish, and so forth" (p. 20).

The atypical social communication and interaction that characterize ASD-1 manifest in a variety of ways. Psychotherapists may observe that these individuals often speak at length about their unique interests without intuiting or understanding when (or why) to change the topic or invite input, causing difficulty

in social interactions (Stanford, 2003). Alongside the communication issues, the repetitive behaviours and restricted interests that are characteristic of ASD also impact the ability to form and sustain mutually satisfying relationships. Differences cause difficulty at all life stages, and are often highlighted in adolescence, when peer acceptance is critical (White et al., 2013). Equally, they may additionally complicate life for adults and their loved ones at transitional stages within the family life cycle (Gerson, 1995), or at times of personal stress or organizational change, when flexible thinking and adaptability are advantageous coping mechanisms.

ASD and mental health

The DSM-5 (APA, 2013) description of generalized anxiety disorder is disarmingly familiar to professionals and laypeople alike. Martin (2003) presented an overview of epidemiological data suggesting that anxiety is the most prevalent psychiatric disorder in adults in Western, industrialized cultures. In neurotypical children and adolescents, Muris et al. (2017) also designated anxiety disorders as the most prevalent psychiatric problem currently. In Western cultural contexts, it is the rare individual whose life will not be affected by anxiety, directly or indirectly.

Anxiety is particularly prevalent in people with ASD-1 (Kerns et al., 2014; van Steensel, Bogels, & Dirksen, 2012). This has been attributed to such individuals living with an increased likelihood of reacting with aversion to emotional experiences (which inherently feature unpredictability), along with a reduced ability to identify and understand their own emotions (Maisel et al., 2016). McFabe (2016) asserted that there is a higher incidence of anxiety and depression in individuals with ASD than in the general population, profoundly impacting their own and their loved ones' quality of life. Wood and Gadow (2010) noted that children with ASD regularly have co-occurring anxiety, proposing that it is the anxiety rather than the ASD per se that impairs functioning. Carley (2008), an adult who lives with ASD-1, described the anxiety he experienced during social interactions: "We know there's that banana peel looming; we just don't know when we'll slip on it, or how bad the fall will be" (p. 155). Further insight was provided by Holliday-Willey (2001), also an adult living with ASD-1, who observed that in social discourse people regularly use metaphors that defy interpretation: "I know this fear well. It turns the word into a wobbly place, a place that moves faster than the eye, a place that hides behind many masks" (p. 41).

The literature supports the lived experience of these individuals. In exploring anxiety in children with and without ASD, van Steensel et al. (2012) highlighted that, although the frequency, prevalence, and severity of anxiety disorders were similar between the groups, the incidence of specific phobias was significantly higher in the ASD group. Wood and Gadow (2010) explored the nature and function of anxiety in individuals with ASD, proposing that it may be an outcome of social rejection, a moderator of ASD symptoms, or a proxy for core ASD features.

Practice-based experience suggests to me that it demonstrates a self-perpetuating interplay between the three. Ironically, although clinicians regularly suggest that individuals with anxiety intentionally re-establish social connections, Panayiotou and Karekla (2013) observed that the pathology of anxiety negatively biases the individual's perception of, and ability to sustain, helpful social networks (p. 292). If this is true for neurotypical individuals with anxiety, it is profoundly true for people with ASD and anxiety whose neurological profile predisposes them to withdraw in response to stress.

Developmentally, attachment theory (Ainsworth, Blehar, Walters, & Wall, 1978; Bowlby, 1988) suggests that the more anxiety parents experience, the greater the probability of their child developing an anxiety disorder. Mothers of children with atypical development consistently experience higher levels of anxiety and depression than mothers of typically-developing children (Raj, Ranjan, & Pereira, 2017; Shobana & Saravanan, 2014). When a parent responds to their child with anxiety, the child naturally infers that the world is unsafe and they are incapable of coping with it (Meadan, Halle, & Ebata, 2010). Several studies have demonstrated that anxiety can be transmitted intergenerationally, within typically emerging, parent-child feedback loops (Rochat, 2001; Siegel, 1999; Sroufe, 1995).

The corrosive effects of anxiety on family systems demonstrated by Eley et al. (2015) highlighted the importance of recognizing such feedback loops as a central element of ASD-IP. Alongside the developmental aspect of ASD and anxiety, an understanding of the common features of ASD-1 suggests that living with this neurological profile in a fast-paced, sensory-stimulating, competitive culture is itself an anxiety-provoking experience. Psychotherapists who recognize how the common features of ASD contribute to anxiety, as well as the developmental and environmental elements of heightened anxiety in individuals with ASD-1, are better prepared to establish a working alliance with such clients than those who do not.

RECOVERY AND ASD

The principles of the recovery paradigm adopted by the Mental Health Commission of Canada (MHCC; 2015) are evident in the guidelines for a national mental health strategy. The MHCC guidelines promote recovery as a process of attaining and sustaining a mental state where a person with mental illness can "live a satisfying, hopeful and contributing life, even when … experiencing ongoing symptoms of a mental health problem" (MHCC, 2015, p. 11). Recovery recognizes the uniqueness of each individual and their right to determine their own path to mental health, as well as the many biopsychosocial and cultural factors that impact mental health and well-being (MHCC, 2015). Pertinent to any discussion of ASD, the concept of recovery is distinct from the concepts of cure or remediation (MHCC, 2015). McDonald-Wilson, Deegan, Hutchison, Parrotta, and Schuster (2013) emphasized that a recovery mindset "shifts the locus of control

from professionally mediated care to self-care, which is integral to recovery" (p. 263). Because ASD is a DSM-5 diagnosis, a discussion of ASD-IP is appropriately framed within the recovery paradigm.

Currently, there is no evidence in the literature suggesting that individuals with ASD-1 have access to mental health care that is adapted to their needs and aligns with the recovery paradigm. Rather, the literature is replete with evidence-based practices such as behavioural intervention (McGrew, Ruble, & Smith, 2016) and psychopharmacology (Earle, 2016). Inconsistent with the concept of recovery in this context, behavioural intervention assumes that other people have greater expertise than the individual with ASD-1 about what constitutes their mental health and well-being, and how they might navigate it. In addition, behavioural intervention can minimize the individual's own ideas and goals, thus putting them at risk of displacement by those of the dominant (neurotypical) culture. When discussing behavioural interventions for people with ASD-1, therefore, recovery is a moot point because the goals of these therapies involve learning to imitate other people who do not live with the same condition. Lal (2010) underscored our limited understanding of recovery in individuals whose needs have traditionally not been well met by the mental health care system. I believe that this describes the usual experience of individuals with ASD-1 in psychotherapy.

Attachment, Relationships, and ASD

At all life stages, healthy relationships support and promote mental and physical health and well-being (Woods & Denton, 2014; World Health Organization, 2014). Alfred Adler (1956) first identified the pivotal element of "belonging" for developing optimal mental health. Henley (2013) posited that "although we often take it for granted, our belonging with one another is the very stuff of life, equally … important than [sic] the food and drink which nurtures us" (p. 18). Attachment theory (Ainsworth et al., 1978; Bowlby, 1988) recognizes the infant's experience of belonging as foundational to mental health in adulthood because it undergirds all future relationships. The vast body of literature on attachment indicates that an inability to form healthy relationships is a painfully isolating experience (Hughes, 1998; Rushton, Monck, Leese, McCrone, & Sharac, 2010; Zeanah & Gleason, 2015). Cross-culturally, satisfying relationships feature responsive communication, the ability to resolve conflict safely, and agreement on what kind of commitment exists within the boundaries of enduring relationships (Canevello & Crocker, 2010; Gottman & Gottman, 2017). Positive relationships are typified by back-and-forth interactions—communicative exchanges of opinions, ideas, emotions, perspectives—that meet the human needs for autonomy, competence, and relatedness (Tang, Bensman, & Hatfield, 2013; Vanhee, Lemmens, & Verhofstadt, 2016). I observe that it is often the element of communication that stymies the formation of healthy, long-term relationships between individuals with and without the common features of ASD.

From infancy, neurotypical babies recognize momentary glitches in communication between themselves and their caregivers, and initiate attempts to repair the breakdown (Tronick & Beeghly, 2011). Such recognition and repair becomes persistent in typically-developing infants at approximately 12 months (Rogoff, 1990), and continues to develop until it is seamless enough as to be barely perceptible within interactions in typically-developing children. This developmental milestone is referred to as *intersubjectivity,* and it is an early iteration of the developmentally critical, dyadic communication that emerges between baby and parent/caregiver (Tronick & Beeghly, 2011). Nagy and Molnar (2004) identified the "drive to provoke other persons" (p. 54) as a feature of typical infant development, noting that it is accompanied by heart-rate deceleration, indicating a degree of social expectation because typically-developing infants expect caregivers to respond to their attempts to initiate interactions. However, Muratori and Maestro (2007) noted that in babies who were later diagnosed with ASD, such expectation is diminished, obstructing parents' ability to create back-and-forth interactions with the baby and thwarting the developmentally essential parent-child feedback loop.

Muratori, Apicella, Muratori, and Maestro (2011) subsequently demonstrated that intersubjectivity was reduced or absent in infants who were later diagnosed with ASD. Building on the important findings of the Still-Face Experiment by Tronick, Als, Adamson, Wise, and Brazelton (1978), Gutstein (2009) posited that when ASD prevents the emergence of typical, back-and-forth communication patterns within the infant-parent relationship, the baby cannot develop communicative resilience. Rather, the foundations of ASD result in infant and parent having difficulty sustaining back-and-forth interactions, both verbal and nonverbal (Gutstein, 2009). Without the reinforcement of satisfying back-and-forth communication, baby and parent gradually reduce their communicative efforts, and the opportunity to develop communicative resilience is reduced accordingly. The baby's gradual withdrawal from back-and-forth interactions with their parent is proposed by Gutstein to initiate the developmental pathogenesis of ASD. Viewed through an attachment lens, it is no surprise that interactions regularly break down as the child with ASD matures.

Typical relationships are often described by adults with ASD as confusing (Carley, 2008), frustrating (Stanford, 2003), or aversive (Blackburn, personal communication, October 27, 2006), because communication is a cornerstone of human relationships, and it inevitably requires repair in every interaction. Temple Grandin, a professor and activist with ASD, commented that she "only has autism when she is with other people" (Grandin, personal communication, April 6, 2006), meaning that ASD is only problematic to her at times when she is required to communicate with others. This insight is helpful to the neurotypical psychotherapist intending to establish a working alliance with an individual with ASD-1. The combined communication and social features of ASD that may appear to suggest disinterest in relationships, coupled with anxiety in anticipation of change (Carley, 2008) heightens the risk of rapid therapeutic rup-

ture (Newirth, 2000). Therefore, in the presence of ASD, the risk of *premature termination of therapy*, defined as occurring when a client abruptly leaves therapy with goals unmet and without warning to the therapist (Swift, Greenberg, Whipple, & Kominiak, 2012), is significant. The painful irony in this for clients with ASD-1 is that therapeutic rupture may inadvertently reinforce their self-perception as a person who can neither understand nor sustain relationships.

Kramer (2000) observed that effective psychotherapists tend to be intelligent, sensitive, psychologically-minded people, who "believe in possibility" (p. 77). This is critical when reflecting on ASD-IP because it is probable that facilitating change in clients with ASD will necessitate most therapists adopting a less-familiar way of being in the service of managing countertransference, reducing anxiety in the client, and facilitating the emergence of a robust working alliance. Therapists will need support to take this approach, which provides little by way of relational feedback. I propose that ASD-IP requires temporarily rendering the therapeutic relationship *more* predictable than relationships outside of therapy have been in this individual's experience. The goal here is to reduce anxiety, creating opportunities for the client with ASD to discover their own relational competence, develop resilience, set and pursue personally meaningful goals, and reorient toward (rather than away from) the risks, challenges, and growth possibilities of change.

common factors and the working alliance

The debate in psychology on what facilitates change for clients has tended toward polarization, with those espousing the common factors of change on one side and champions of specific techniques or interventions on the other. Proponents of the common factors of change (Bohart & Tallman, 2010; Fraser & Solovey, 2007; Norcross, 2010; Orlinsky, Rønnestad, & Willutzki, 2004) argued that in the presence of a robust therapeutic alliance, all genuine approaches to psychotherapy facilitate change equally well, for most clients. The common factors of change include the client (Bohart & Tallman, 2010; Orlinsky et al., 2004), the therapeutic relationship (Bordin, 1979; Norcross, 2010; Fraser & Solovey, 2007), the therapeutic environment (Cacioppo & Cacioppo, 2012), the therapist (Simon, 2006), and the presence of hope or positive expectancy (Weinberger & Eig, 1999). I propose that a developmental perspective of ASD within a recovery mindset opens the possibility of change for clients with ASD, regardless of the therapist's theoretical leaning and preferred techniques, provided we hold our focus upon the client.

The common factors of change positions the working alliance as a specific kind of relationship that acts as the bedrock of therapy. Orlinsky et al. (2004) and Bohart and Tallman (2010) posited that, among the common factors of change, the client is the critical one. Bohart and Tallman asserted that change occurs because clients are generatively involved in the therapeutic process, and are not "submissive recipients of an intervention" (p. 95). Orlinsky et al. proposed that establishing

a working alliance depends on the client bringing a collaborative disposition, rather than a dependant one, into therapy. Although seemingly an innocuous requirement, the development of a collaborative disposition is a tall order when the client lives with ASD, as the pathogenesis of the diagnosis has thwarted the development of such a disposition by limiting reciprocity in the parent-infant relationship (Hobson, 2002; Muratori et al., 2011).

When an individual has missed developmental milestones that are typically met in infancy through dyadic interactions with permanent caregivers, and this has resulted in repeated relational breakdown, intentional compensations are required of the therapist to bolster the working alliance against being undermined by the common features of ASD. In other words, the therapist must carry more than their usual share of the responsibility for the alliance, to compensate for what the client is unable, rather than unwilling, to bring to therapy. Because the quality of the relationship between client and therapist is what facilitates change, in the next section I will describe how an ASD-informed therapist can scaffold the working alliance to withstand the relational impacts of the common features of ASD.

COMPETENCE IN ASD-IP

In the mental health field, competencies—specific, measurable knowledge, skills, and attitudes needed to perform a role well—are critical for professional effectiveness (www.psrrpscanada.ca). Although harder to measure, competence in psychotherapy also consists in listening and responding to individuals such that they feel heard. Bohart and Tallman (2010) asserted that "you are not listening until the client says you are" (p. 99). When a therapist acknowledges the impacts of the common features of ASD on relationships and integrates them into the working alliance, clients with ASD-1 receive the message that the therapist is truly listening. Brookman-Frazee, Drahota, Stadnick, and Palinkas (2012) noted that therapists want training on ASD to help them establish therapeutic relationships with people living with this diagnosis. Some progress in this direction is evident in Cashin, Browne, Bradbury, and Mulder (2013), who reported successful use of narrative therapy with young adults with ASD, helping them recognize the experience of being heard, and inviting them to privilege their experiences and worldview over their diagnoses.

The ASD-informed approach emerges from combining what is known about the common features of ASD (Greenspan & Weider, 1999; Gutstein, 2009) with what is known about the role of attachment in developing healthy relationships (Ainsworth et al., 1978; Bowlby, 1988) and then viewing the landscape through the lens of common factors. This process illuminates the gap between the kinds of psychotherapy that clients with ASD need and those that are currently available. For example, with regards to communication, the therapist's willingness to slow down their own verbal communication by shortening sentences and intentionally adding processing time between utterances (Gutstein, 2009) immediately

increases accessibility for the client with ASD-1. Therapists' openness to adapting the sensory environment, to collaborating with the client in creating individualized memory supports, to increasing routine and predictability within and between sessions, and to support the individual in self-advocacy are additionally helpful (Strunz, 2016).

By integrating awareness of the sensory disturbances commonly experienced by individuals with ASD (Simone, 2010), we approach a framework for ASD-IP. By kindly and directly addressing the organization and memory-related challenges that co-occur with ASD, we collaborate with clients in developing self-awareness, reducing anxiety, and reorienting toward change. In the context of multicultural psychotherapy, Comas-Diaz (2011) challenged psychotherapists to "value diversity, and to learn to manage the dynamics of difference" (p. 251). A comparable mindset will inform and support the emergence of ASD-IP by encouraging therapists and clients to collaboratively explore and address the needs of this population and the obstacles to progress in psychotherapy.

Communication

A deficit in communication is one of the common features of ASD (APA, 2013). Typical communication is dynamic, featuring the verbal and nonverbal sharing of ideas or experiences that elicit unpredictable responses from one's communicative partner (Gutstein, 2009). This "messy business" of communicating (Gutstein, 2009, p. 37) was described by an adult living with ASD in Holliday-Willey's (2001) assertion: "I could talk to people better if we didn't have to talk" (p. 49). The dynamics of typical interpersonal communication, partnered with sufficient self-awareness to let the individual with ASD-1 perceive the differences between their communication style and that of neurotypical individuals, provokes anxiety (Kerns et al., 2014; Thompson et al., 2011). The interplay between communication and anxiety in ASD-1 poses a veritable obstacle to the building of healthy relationships.

Effective communication has expressive and receptive elements. ASD-related difficulties with expressive communication may manifest as a tendency to talk at an inappropriate volume for the context, or with reduced awareness of verbal and nonverbal feedback from listeners (Attwood, 1998). Clients with ASD may talk persistently about a narrow range of topics, omit soliciting the therapists' perspective, struggle to express emotions effectively, and use scripted phrases instead of spontaneous self-expression (Attwood, 1998). They may avert or fix their gaze, physically withdraw or turn away from an interaction, or find themselves unexpectedly unable to speak at all—selective mutism arises contextually, often at challenging developmental stages (Simone, 2010). Atypical expressive communication may inadvertently convey disinterest or self-absorption, increasing the likelihood of the therapist misinterpreting it to suggest that the client has disengaged from the therapeutic relationship.

Communication deficits also affect receptive language by reducing the individual's ability to process multiple channels of communication simultaneously

(Gutstein, 2009). When listening to someone speaking, neurotypical people use sight and hearing together to interpret what is said, simultaneously and continuously processing inflections, tone, volume, gestural, and facial expressions and body orientation with the spoken words (Gutstein, 2009). Because people with ASD have difficulty processing these layers of communication simultaneously (Gutstein, 2009), the process of receiving, interpreting, and responding is often prolonged, contributing to communication breakdown. ASD-informed therapists resist the urge to repeat questions or solicit client feedback in these moments, recognizing that providing additional processing time is a support that increases the opportunity for the client to sustain a therapeutic, back-and-forth conversation.

A final point on communication with clients with ASD-1 is pertinent. Duncan (2010, p. 12) encouraged therapists that "when in doubt, ask the client," proposing that the working alliance is enhanced by the therapist asking the client for feedback. When working with individuals with ASD-1, therapists' self-care includes readiness for the solicited feedback to be delivered in a straightforward manner and with untrammelled honesty. Given the individual with ASD's penchant for direct communication (Holliday-Willey, 2001), the psychotherapist may or may not appreciate what they hear, but will hopefully appreciate the resulting clarity on whether therapy is helping and, if not, what exactly the client believes should change.

Repetitive Behaviours and Restricted Interests

Repetitive behaviours (APA, 2013) in individuals with ASD may manifest as specific words, phrases, gestures, or gestural sequences that are repeatedly enacted, disrupting the flow of social interactions. They show up outside of therapy as ritualized ways of doing everyday things that cannot be changed without heightened anxiety. Recognizing that individuals with ASD-1 often function in a state of high arousal (Ghaziuddin, 2005), repetitive behaviours that occur during therapy may be self-soothing for the client. However, they may distract or confuse the therapist, potentially disrupting therapy just as they disrupt outside relationships for this individual.

A link was established by Boyd et al. (2010) between ritualistic and repetitive behaviours in children with ASD and hypersensitivity in sensory processing, highlighting the role of sensory awareness in ASD-IP. Therapists can offset the potentially damaging effects of repetitive behaviours on the working alliance by regarding them as self-regulatory mechanisms, much like a neurotypical individual might sip a beverage or use mindful breathing to stay focused in the moment.

Restricted interests (APA, 2013) enter the therapy room when the individual defaults to discussing a very limited number of interests with which they are deeply familiar and may have significant expertise. Unproblematic in and of themselves, restricted interests become social obstacles when the communication feature of ASD results in the individual talking about them without awareness of their listeners' attempts to convey limited interest (Attwood, 1998).

I propose that ASD-IP invites the therapist to provide feedback about their own internal state in such moments. When communication within therapy is impacted by restrictive interests to the extent that a meaningful back-and-forth interaction is precluded, providing this feedback to the client draws their attention to how this issue impacts relationships outside of therapy.

Sensory Processing

As noted in DSM-5 (APA, 2013), many individuals with ASD live with atypical sensory processing (Glod, Riby, Honey, & Rodgers, 2017). Many individuals with ASD-1 agree that this aspect of their lived experience contributes to anxiety (Carley, 2008) and confusion in social interactions (R. Blackburn, personal communication, October 26, 2006). Additionally, Bitsika et al. (2016) demonstrated a positive correlation between sensory hyposensitivity and major depressive disorder in boys with ASD.

Atypical sensory processing may be understood as distorted information about the physical world flowing from the individual's sense organs (e.g., eyes, ears, skin) to their brain. Individuals with ASD may feel warm when others feel cold or may find certain tastes and textures attractive or aversive where others find them nondescript. These phenomena are the outcomes of sensory hypo- or hyper-reactivity (Schaaf & Lane, 2015; Tavassoli et al., in press). Visual disturbance is common, and individuals with ASD may find gazing at moving fans or lights pleasurable, or find patterns on furniture or fabrics distracting (Tavassoli et al., in press). This information helps ASD-informed therapists to plan how to dress or decorate their workplace when supporting clients with visual hypersensitivity. Auditory hypersensitivity is common, making school or work life and social gatherings that feature loud, unexpected sounds very challenging (T. Grandin, personal communication, October 27, 2006).

The scents of cleaning and personal care products are regularly experienced as intense or sickening (R. Blackburn, personal communication, October 26, 2006). Food and beverage smells may be aversive and a hyper-responsive tactile sense will affect the individual's physical comfort in the therapy room and waiting area (Schaaf & Lane, 2015). Access to a quiet area with soft cushions and blankets is experienced by many individuals with ASD-1 as welcoming and supportive.

In addition to the commonly regarded senses (i.e., sight, hearing, touch, taste, and smell), the vestibular (movement) and proprioceptive (body awareness) senses may be distorted in individuals with ASD (Bluestone, 2005). Some individuals use physical movement to feel secure or to facilitate communication, suggesting that their vestibular sense needs increased input (Bluestone, 2005). Small fidget items can help individuals achieve and maintain focus, emotional self-regulation, and communication during therapy sessions. Individuals with proprioceptive disturbances may benefit from the compression provided by a hammock chair or a blanket to enclose their legs or body during therapy (Bluestone, 2005). Although it is impractical to anticipate every possible combination of sensory sensitivity, by

soliciting client feedback (Duncan, 2010) and collaborating with clients to create *their version* of a supportive sensory environment, psychotherapists enact ASD-informed counselling competencies.

Organization and Planning

Many individuals with ASD live with challenges to organization and planning, the impact of which increases as they mature and life and relationships become more complex (Rosenthal et al., 2013), while parental or family support is often decreasing. For this reason, and because many individuals with ASD are visual thinkers/learners (Attwood, 1998) who live with memory deficits that compromise their ability to organize and retain emotionally based information (Williams, Goldstein, & Minshew, 2006), ASD-informed therapists write notes, lists, or therapeutic letters for clients to review later.

Many individuals with ASD-1 develop unique, personally effective organizational strategies that may or may not work well for others, sometimes solving one relationship problem while creating another (Strunz, 2016). Clients with ASD-1 whose goals include aligning their organizational strategies with those of significant others in their lives may benefit from visually based coaching, using supports such as datebooks, visual timers, checklists, or online calendars. When this is delivered as psychoeducation, the therapist can hold the focus of the session on the relational aspect of the organizational tool, rather than the technical. Dishion and Stormshak (2007) emphasized the importance of informing significant people in the client's life of their goals to support them in sustaining change beyond therapy. Clients with ASD-1 may also need support to recognize how their plans, actions, and decisions impact other people.

Clients with ASD-1 benefit from a high level of routine and predictability within therapy until the working alliance is established, and often beyond. This is a necessary compensation for the inflexible thinking feature of ASD rather than suggestive of low motivation. As therapy progresses, the therapist and client may intentionally collaborate in increasing opportunities for the client to experience uncertainty, by including unanticipated elements in the experience. For example, they might initially sit in the same places each time they meet, but as they deepen the working alliance they could switch places (allowing the client to take a new perspective of a familiar situation). Alternatively, they may experiment with changing their appointment schedule slightly, and exploring the impacts of such change on the client's experience. These small changes are intended to increase uncertainty but not to provoke anxiety for the client, allowing them to notice (or discover) their own ability to competently navigate change, to "go with the flow" (Gutstein, 2009, p. 251).

When skillfully enacted, these changes are beneficial to the individual with ASD-1 and should be the subject of a shared reflective process to support the client in recognizing and remembering their successful navigation of planned or unexpected change. Should these small changes provoke anxiety for the client, the dyad can temporarily return to the baseline level of predictability

until the client feels ready for a renewed attempt to explore the experience of uncertainty. In this section, I have outlined how therapists can filter the common factors of change through the common features of ASD-1, scaffolding the experience of a new, non-anxious response to change for the client living with this diagnosis.

MICROAGGRESSIONS AND ASD

Microaggressions were defined by Sue et al. (2007, p. 273) as "brief and commonplace verbal, behavioural or environmental indignities" that communicate derogatory messages to individuals about themselves, and that may be intentional or unintentional. Sue et al. emphasized that perpetrators may be unaware of inflicting microaggressions, calling for self-monitoring by psychotherapists. Because the ritualized behaviours that are intrinsic to ASD may manifest as words, phrases, or gestures that are repeatedly enacted, or as repetitive behaviours such as rocking, an uninformed therapist may misconstrue these behaviours as compulsive or inappropriate rather than recognize them as the client's attempts to self-regulate within and outside of therapy (Mazefsky et al., 2013; Torrado et al., 2017). Similarly, the client's atypical communication may be interpreted as a reduced desire to connect with others through experience-sharing communication (Gutstein, 2009), rather than a neurologically determined obstacle to doing so.

The risk of microaggressions (Sue et al., 2007) exists in unconsciously counselling the individual to try to behave and/or communicate *as if they do not have ASD* (Holliday-Willey, 1999). In so doing, the lived experience of the individual with ASD is negated and made invisible, rather than explored with curiosity and genuine interest. Insight into the impacts of the common features of ASD on relationships (of which the working alliance is one) will enable both client and therapist to recognize how ASD has affected the formation and maintenance of healthy relationships in everyday life.

Given the wide variance in how the common features of ASD are expressed, psychotherapists who work with individuals with ASD (diagnosed or not) must recognize them and resist attributing every problem in the client's life to them. Importantly, for many individuals, having ASD is not inherently problematic (Carley, 2008; Holliday-Willey, 1999; Wylie, 2014). Hobson noted that ASD exists, not so much in the individual as "in the space that lies between that individual and the rest of the world" (P. Hobson, personal communication, 2008). ASD-informed therapists must therefore resist articulating the problem until the client has described it in their own terms.

Simone (2010) noted that ASD-1 brings gifts as well as challenges, which may include a voracious appetite for information, the ability to see order in chaos and establish relationships between seemingly unrelated things, and the ability to focus attention deeply for prolonged periods. Holliday-Willey (1999) described herself and others with ASD as "creative, intelligent, interesting, productive and learned, in countless ways" (p. 121). This highlights the importance of psychotherapists

exercising caution to avoid inflicting microaggressions on clients with ASD by assuming that the condition is necessarily problematic to that individual (Osanloo et al., 2016; Sue et al., 2007).

I propose that overattribution of problems to the common features of ASD undermines the client's goals for recovery while inadequate recognition of the relational impacts of ASD minimizes the impact of the diagnosis on mental health. Either situation heightens the risk of inflicting microaggressions and weakens the therapeutic alliance to the point of risking rupture (Safran & Muran, 2000). Among their other roles, the ASD-informed therapist is an interpreter, collaborating with the client to build bidirectional bridges of communication and experience between the neurotypical and the ASD worlds.

ethical concerns and social justice

CPA's (2017) *Code of Ethics for Psychologists* directs counsellors to self-monitor regarding the limits of their competence and to refer any client whose need for professional help exceeds their competence. Similarly, members of the College of Registered Psychotherapists of Ontario (2014) are directed by their *Professional Practise Standards* to refer clients to another professional when the member lacks the knowledge, skills, or judgement to offer needed services. Because counselling competency requires working within one's scope of practice, I propose that if the therapeutic relationship is impacted by the core features of ASD to the extent that the client and therapist are struggling to establish a working alliance, client referral, additional supervision, and/or professional development are appropriate.

When working with individuals with ASD-1, psychotherapists will encounter opportunities to contribute to the development of society (CPA, 2017) by taking up the invitation to pursue social justice. Such opportunities arise through identifying previously unrecognized systemic barriers to inclusion and by joining clients with ASD-1 in addressing such barriers (Crethar, Rivera, & Nash, 2008). Opportunities may also arise to help the individual living with ASD-1 in educating partners and family (or chosen family) about their lived experience, what they need for full inclusion (Helps, 2016), and how others can provide support. Additionally, therapists may need to advocate for additional funding for clients with ASD-1 because additional sessions may be needed to compensate for the client's processing speed. They may also advocate for sensory adaptations to the public areas and therapy room to offset adversity and increase accessibility, within the setting.

research implications

With disarming rapidity, diagnosis of ASD has increased to the current level of 1 in 68 children in Canada (www.autismspeaks.ca). As this generation matures, psychotherapists must understand how the common features of ASD impact the

building and sustaining of relationships to competently meet their mental health needs. Along with a call for research into ASD-IP for individuals who have lived with ASD since childhood, Wylie (2014) highlighted a second research priority by accentuating the unique needs of people who receive their diagnosis of ASD in adulthood. Many of these individuals have lived with a misdiagnosed psychotic disorder (and the associated treatments and stigma) since adolescence or young adulthood (Van Schalkwyk, Peluso, Qayyum, McPartland, & Volkmar, 2015; Wylie, 2014).

This article provides an experience-based proposal for ASD-IP that is grounded in the literature and recognizes the common features of ASD from the diagnostic and developmental perspectives. There is a pressing need for interdisciplinary research into ASD-IP to enhance our ability to establish and maintain reciprocity in relationships between neurodiverse and neurotypical individuals. Helps (2016) proposed an encouraging approach featuring shared practice-based experience supported by small-scale qualitative studies of process and practice. Restricted funding presents an obstacle to such research in a political climate that adheres rigidly to exclusively funding behavioural interventions for ASD. Additionally, the requirement of managed care funders to identify ever-briefer models of therapy and to prioritize crisis management (Keith, 2013) makes it difficult to meet the therapeutic needs of this growing population because of their increased need for communicative, organizational, and sensory support within psychotherapy.

Training Framework for ASD-IP

Brookman-Frazee et al. (2012, p. 365) identified that psychotherapists perceive working with children with ASD as "challenging and frustrating," which they attributed to limitations in their training. Therapy for children and adults with ASD has focussed on promoting social skills or reducing aggressive behaviours rather than on understanding their lived experience and helping them to attain personal satisfaction as defined by themselves (Koenig & Levine, 2011). I propose that given the prevalence of ASD, awareness of the elements of ASD-IP, framed by the recovery paradigm, is a practice competency for psychotherapists.

The following training framework would position therapists to provide ASD-IP within any bona fide model of therapy:

1. *Issue:* Psychotherapists need awareness of both the diagnostic criteria and the developmental perspective of ASD to understand how the common features of ASD impact attachment, relationship formation, and maintenance. Therapists working with this population should recognize ASD as a neurological condition with significant biopsychosocial implications that regularly impact interactions and relationships.
   Proposed solution: Psychotherapy training programs can provide a learning module that illuminates the neurological profile and lived experience of individuals with ASD in Western cultures. This module may fit within the

framework of coursework that addresses multicultural counselling competencies.

2. *Issue:* Psychotherapists need to understand how sensory processing impacts the capacity of the individual with ASD to enter, self-regulate, and remain engaged with the working alliance.
   Proposed solution: Psychotherapy training programs can provide opportunities for therapists to recognize and reflect on their own sensory profile, and to develop awareness of how to support themselves and their clients using sensory interventions within psychotherapy. Interdisciplinary learning between psychotherapists, occupational therapists, and other allied professionals is an appropriate approach that values collaborative practice.
3. *Issue:* Psychotherapists may not have access to a baseline for mental health and well-being in individuals with ASD-1 who are living well with this diagnosis.
   Proposed solution: Psychotherapy training programs can engage speakers who live with ASD-1 to further deepen understanding and empathy in trainees. In alignment with the recovery paradigm, psychotherapists who self-identify as living with ASD bring essential perspectives to the table. Additionally, authors with ASD (several of whom are cited in this article) can provide valuable insights for therapists intending to work with this population.
4. *Issue:* Psychotherapists may have difficulty establishing a working alliance with individuals living with ASD-1 (as suggested by Brookman-Frazee et al., 2012) and supporting them to use the therapeutic context to their advantage.
   Proposed solution: Consistent with the daily experience of clients with ASD-1, regular breakdowns in communication can be expected when doing therapy. Therapists and their supervisors should therefore explore transference and countertransference from an ASD-informed perspective. Good supervision (Vespia, Heckman-Stone, & Delworth, 2002) supports therapists to self-monitor, recognize challenges, and engage in reflective practice and self-care in the service of meeting their clients' needs without compromising their own.
5. *Issue:* Parents of children with ASD require specialized parent training and support to optimize their pivotal role in addressing their child's developmental needs.
   Proposed solution: Counselling agencies require at least one therapist with training in developmental intervention for ASD. Examples of such models include Relationship Development Intervention (Gutstein, 2009), DIR/Floortime (Greenspan & Weider, 1999), and the Early Start Denver Model (Dawson et al., 2010). Therapists who are not yet ready to work with these families should refer them to qualified colleagues rather than risking harm to client and family by addressing their relational ASD needs unprepared. Therapists in private practice can establish referral networks to use while increasing their own competency in ASD-IP.

6. *Issue:* Individuals with ASD have a deficit in communication that makes self-advocacy challenging. When supporting clients with ASD-1, therapists must recognize that the capacity for speech does not equate to the ability to communicate effectively.
   Proposed solution: Psychotherapy training programs must integrate the expertise of allied professionals (such as speech language pathologists) to heighten therapists' awareness of communication-related developmental obstacles to engagement.
7. *Issue:* Individuals with ASD-1 often encounter systemic obstacles to mental health and well-being within the educational and healthcare systems. Therapists are positioned to follow social justice guidelines in advocating with (and for) individuals with ASD-1.
   Proposed solution: Therapy training programs must support trainees to recognize and embrace their role in pursuing social justice and promoting systemic change when supporting individuals with ASD in psychotherapy.

CONCLUSION

Psychotherapists recognize the ethical imperative to provide accessible psychotherapy and to regularly adapt their practices and their settings to accommodate differently-abled populations. However, our work is about building relationship. It is our responsibility to recognize inaccessibility and address it. We need to make psychotherapy accessible to people whose neurological profile makes communication and social interaction (upon which humans typically build relationships) aversive. Because we know that connection with others promotes mental health, psychotherapy is both privileged and responsible to provide an informed and coherent response to this need. The current political commitment to align mental health care with the recovery paradigm alongside a significant increase in the prevalence of ASD (including late diagnosis of individuals in adulthood) suggests that the discussion can now proceed.

This article narrows a gap in the literature by outlining the pathogenesis of ASD and exploring how it impacts the development of healthy relationships. By introducing the common features of ASD-1 to the common factors of change, I have provided a framework within which psychotherapists can better understand and reflect upon the lived experience of individuals living with ASD-1, and mindfully adapt their work to engage and support these individuals in psychotherapy. I have brought together the voices of individuals with ASD-1 from the literature and from practice-based evidence and presented ways that therapists can integrate the common features of ASD-1 into the working alliance, kindly and competently. I have proposed seven adaptations to psychotherapy training programs that will increase the competence of psychotherapists who work with individuals with ASD-1.

My intention in this article was to introduce the lived experience and the neurologically determined psychotherapeutic needs of individuals with ASD-1 to

the common factors of change in the service of facilitating their recovery journeys by changing the way psychotherapists interact with them and their loved ones. Recognizing that ASD-IP requires additional effort from the therapist, I view such effort as meeting our social justice imperative. If our effort opens our doors so that individuals with ASD-1 can enter and do their own recovery-oriented work, it is an appropriate next step of the journey. Most importantly, the pace, direction, and destinations of the journey must be set by individuals living with ASD-1. As psychotherapists, it is our privilege to serve our clients, and not the other way around. We travel respectfully with the guidance, insights, and strengths of people with ASD, who bring navigational attributes to which the neurotypical individual simply does not have access.

References

Adler, A. (1956). *The individual psychology of Alfred Adler.* New York, NY: Basic Books.

Ainsworth, M. D. S., Blehar, M. C., Walters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum.

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Attwood, T. (1998). *Asperger's Syndrome: A guide for parents and professionals*. London, UK: Jessica Kingsley.

Bambara, L. M., Gomez, O., Koger, F., Lohrmann-O'Rourke, S., & Xin, Y. P. (2001). More than techniques: Team members' perspectives on implementing positive supports for adults with severe challenging behaviors. *Journal of the Association of Persons with Severe Handicaps, 26*(4), 213–228. https://dx.doi.org/10.2511/rpsd.26.4.213

Baron-Cohen, S., Scott, F. J., Allison, C., Williams, J., Bolton, P., Matthews, F. E., & Brayne, C. (2009). Prevalence of autism-spectrum conditions: UK school-based population study. *British Journal of Psychiatry, 194*(6), 500–509. https://dx.doi.org/10.1192/bjp.bp.108.059345

Bitsika, V., Sharpley, C. F., & Mills, R. (2015). Are sensory processing features associated with depressive symptoms in boys with an ASD? *Journal of Autism and Developmental Disorders 46,* 242–252. https://dx.doi.org/10.1007/s10803-015-2569-4

Bluestone, J. (2005). *The fabric of autism: Weaving the threads into a cogent theory.* San Rafael, CA: Handle Institute.

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble. (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed.; pp. 83–111). Washington, DC: American Psychological Association. https://doi.org/10.1037/12075-003

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Journal of Psychotherapy: Theory, Research and Practice, 16*(3), 252–260. https://dx.di.org/10.1037/h0085885

Bowlby, J. (1988). *A secure base: Parent–child attachment and healthy human development*. New York, NY: Basic Books.

Boyd, B. A., Baranek, G. T., Sideris, J., Poe, M. D., Watson, L. R., Patten, E., & Miller, H. (2010). Sensory features and repetitive behaviors in children with autism and developmental delays. *Journal of Autism Research, 3*(2), 78–87. https://dx.doi.org/10.1002/aur.124

Brookman-Frazee, L., Drahota, A., Stadnick, N., & Palinkas, L. A. (2012). Therapist perspectives on community mental health services for children with autism spectrum disorders. *Journal of Administration and Policy in Mental Health and Mental Health Services Research, 39*(5), 365–373. https://dx.di.org/10.1007/s10488-011-0355-y

Cacioppo, S. C., & Cacioppo, J. T. (2012). Decoding the invisible forces of social connection. *Frontiers in Integrative Neuroscience, 6*(51). https://doi.org/10.3389/fnint.2012.00051

Canadian Psychological Association (CPA). (2017). *Canadian code of ethics for psychologists* (4th ed.). Ottawa, ON: Canadian Psychological Association. Retrieved from http://www.cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf

Canevello, A., & Crocker, J. (2010). Creating good relationships: Responsiveness, relationship quality, and interpersonal goals. *Journal of Personality and Social Psychology, 99*(1), 78–106. http://dx.doi.org/10.1037/a0018186

Carley, M. J. (2008). *Asperger's from the inside out: A supportive and practical guide for anyone with Asperger's syndrome.* New York, NY: Penguin.

Cashin, A., Browne, G., Bradbury, J., & Mulder, A. (2013). The effectiveness of narrative therapy with young people with autism. *Journal of Child and Adolescent Psychiatric Nursing, 26*(1), 32–41. https://dx.doi.org/10.1111/jcap.12020

Cheak-Zamora, N. C., Teti, M., & First, J. (2015). "Transitions are scary for our kids, and they're scary for us": Family member and youth perspectives on the challenges of transitioning to adulthood with autism. *Journal of Applied Research in Intellectual Disabilities, 28*(6), 548–560. https://dx.doi.org/10.1111/jar.12150

College of Registered Psychotherapists of Ontario. (2014). *Professional practice standards for registered psychotherapists.* Retrieved from http://www.crpo.ca/wp-content/uploads/2014/11/CRPO-Professional-Practice-Standards.pdf

Comas-Diaz, L. (2011). Multicultural approaches to psychotherapy. In J. C. Norcross, G. R. VandenBos, & D. K. Freedheim, (Eds.) *History of psychotherapy: Continuity and change* (2nd ed., pp. 243–267). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/12353-008

Crethar, H. C., Rivera, E. T., & Nash, S. (2008). In search of common threads: Linking multicultural, feminist and social justice counselling paradigms. *Journal of Counseling and Development, 86*(3), 269–278. https://dx.doi.org/10.1002/j.1556-6678.2008.tb00509.x

Dawson, G., Rogers, S., Munson, J., Smith, M., Winter, J., Greenson, J., … Varley, J. (2010). Randomized, controlled trial of an intervention for toddlers with autism: The Early Start Denver Model. *Pediatrics*, *125*(1), 17–23. Retrieved from http://pediatrics.aappublications.org/content/125/1/e17. https://doi.org/10.1542/peds.2009-0958

Dillenburger, K., Keenan, M., Doherty, A., Byrne, T., & Gallagher, S. (2012). ABA-based programs for children diagnosed with autism spectrum disorder: Parental and professional experiences at school and at home. *Journal of Child and Family Behavior Therapy 34*(2), 111–129. http://dx.doi.org/10.1080/07317107.2012.684645

Dishion, T. J., & Stormshak, E. A. (2007). *Intervening in children's lives: An ecological, family- centered approach to mental health care.* Washington, DC: American Psychological Association. https://doi.org/10.1037/11485-000

Duncan, B. L. (2010). *On becoming a better therapist*. Washington, DC: American Psychological Association. https://doi.org/10.1037/12080-000

Earle, J. F. (2016). An introduction to the psychopharmacology of children and adolescents with autism spectrum disorder. *Journal of Child and Adolescent Psychiatric Nursing, 29*(2), 62–71. https://dx.doi.org/10.1111/jcap.12144

Eley, T. C., McAdams, T. A., Rijsdijk, F. V., Lichtenstein, P. L., Narusyte, J., Reiss, D., … Neiderhiser, J. M. (2015). Intergenerational transmission of anxiety: A children of twins study. *American Journal of Psychiatry, 172*(7), 630–637. https://dx.doi.org/10.1176.appi.ajp.2015.14070818

Fraser, J. S., & Solovey, A. D. (2007). *Second-order change in psychotherapy: The golden thread that unifies effective treatments.* Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/11499-001

Gerson, R. (1995). The family life cycle: Phases, stages and crisis. In R. H. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 91–111). Washington, DC: American Psychological Association. https://dx.doi.org/10.1037/10172-005

Ghaziuddin, M. (2005). *Mental health aspects of autism and Asperger syndrome.* London, UK: Jessica Kingsley.

Glod, M., Riby, D. M., Honey, E., & Rodgers, J. (2017). Sensory atypicalities in dyads of children with autism spectrum disorder (ASD) and their parents. *Autism Research, 10*, 531–538. https://dx.doi.org/10.1002/aur.1680

Gottman, J., & Gottman, J. (2017). The natural principles of love. *Journal of Family Theory and Review, 9*(1), 7–26. https://dx.doi.org/10.1111/jftr.12182

Greenspan, S. I., & Weider, S. (1999). A functional, developmental approach to autism spectrum disorders. *Research and Practice for Persons with Severe Disabilities 24*(3), 147–161. https://www.dx.doi.org/10.251/rpsd.24.3.147

Gutstein, S. (2009). *The RDI book*. Houston, TX: Future Horizons.

Helps, S. (2016). Systemic psychotherapy with families where someone has an autism spectrum condition. *Neurorehabilitation, 38*(3), 223–230. https://dx.doi.org/10.3233.NRE-161314

Henley, A. (2013). The necessity of belonging and other discoveries. In J. Chang (Ed.), *Creative interventions with children: A transtheoretical approach* (pp. 2–12). Calgary, AB: Family Psychology Press.

Hobson, R. P. (1995). *Autism and the development of mind*. East Sussex, UK: Lawrence Erlbaum.

Hobson, P. (2002). *The cradle of thought: Exploring the origins of thinking*. London, UK: Pan McMillan.

Holliday-Willey, L. (1999). *Asperger syndrome in the family.* London, UK: Jessica Kingsley.

Holliday-Willey, L. (2001). *Pretending to be normal: Living with Asperger's syndrome.* London, UK: Jessica Kingsley.

Hughes, D. (1998). *Building the bonds of attachment: Awakening love in deeply troubled children.* Lanham, MD: Rowman & Littlefield.

Keith, D. V. (2013). The self of the therapist in the empire of over-regulation. In M. Baldwin (Ed.), *The use of self in therapy* (3rd ed., chap. 13). New York, NY: Routledge.

Kerns, C. M., Kendall, P. C., Berry, L., Souders, M. C., Franklin, M. E., Schultz, R. T., … Herrington, J. (2014). Traditional and atypical presentations of anxiety in youth with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 44*(11), 2851–2861. https://dx.doi.org/10.1007/s10803-014-2141-7

Koenig, K., & Levine, M. (2011). Psychotherapy for individuals with autism spectrum disorders. *Journal of Contemporary Psychotherapy, 41*(1), 29–36. https://dx.doi.org/10.1007/s10879-010-9158-9

Kramer, C. H. (2000). *Therapeutic mastery: Becoming a more creative and effective psychotherapist.* Phoenix, AZ: Zeig, Tucker.

Lal, S. (2010). Prescribing recovery as the new mantra for mental health: Does one prescription serve all? *Canadian Journal of Occupational Therapy, 77*, 82–89. https://dx.doi.org/10.2182/cjot.2010.77.2.4

Maisel, M. E., Stephenson, K. G., South, M., Rodgers, J., Freeston, M. H., & Gaigg, S. B. (2016). Modelling the cognitive mechanisms linking autism symptoms and anxiety in adults. *Journal of Abnormal Psychology, 125*(5), 692–703. https://doi.org/10.1037/abn0000168

Martin, P. (2003). The epidemiology of anxiety disorders: A review. *Dialogues in Clinical Neuroscience, 5*(3), 281–298. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181629/

Mayes, S. D., Black, A., & Tierney, C. D. (2013). DSM-5 under-identifies PDDNOS: Diagnostic agreement between the DSM-5, DSM-IV, and Checklist for Autism Spectrum Disorder. *Research in Autism Spectrum Disorders*, *7*(2), 298–306. https://doi.dx.org/10.1016/j.rasd2012.08.011

Mazefsky, C. A., Herrington, J., Siegel, M., Scarpa, A., Maddox, B. B., Scahill, L., & White, S. W. (2013). The role of emotion regulation in autism spectrum disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(7), 679–688. https://doi.dx.org/10.1016/j.jaac.2013.06.006

Mazurek, M. O., Vasa, R. A., Kalb, L. G., Kanne, S. M., Rosenberg, D., Keefer, A., … Lowery, L. A. (2013). Anxiety, sensory over-responsivity, and gastrointestinal problems in children with

autism spectrum disorders. *Journal of Abnormal Child Psychology, 41*(1), 165–176. https://dx.doi.org/10.1007/s10802-012-9668-x

McDonald-Wilson, K. L., Deegan, P. E., Hutchison, S. L., Parrotta, N., & Schuster, J. M. (2013). Integrating personal medicine into service delivery: Empowering people in recovery. *Psychiatric Rehabilitation Journal, 36*(4), 258–263. https://dx.doi.org/10.1037/prj0000027

McFabe, D. (2016, May 31). *Can the gut control the brain? Bacteria's role in autism with Dr. Derrick McFabe* [Video file]. https://www.youtube.com/watch?v=7TlSxIWE93U

McGrew, J. H., Ruble, L. A., & Smith, I. M. (2016). Autism spectrum disorder and evidence-based practice in psychology. *Journal of Clinical Psychology: Science and Practice, 23*(3), 239–255. https://dx.doi.org/10.1111/cpsp.12160

Meadan, H., Halle, J. W., & Ebata, A. T. (2010). Families with children who have autism spectrum disorders: Stress and support. *Exceptional Children, 77*(1), 7–36. https://doi.org/10.1177/001440291007700101

Meade, M. (2011, October 4). *Are you your most unique self?* [Blog post]. Retrieved from http://www.huffingtonpost.com/michael-meade-dhl/the-divine-within-us_b_989805.html

Mental Health Commission of Canada (MHCC). (2015). *Guidelines for recovery-oriented practice.* Ottawa, ON: Mental Health Commission.

Muratori, F., & Maestro, S. (2007). Autism as a downstream effect of primary difficulties in intersubjectivity interacting with abnormal development of brain connectivity. *International Journal for Dialogical Science, 2*(1), 93–118. Retrieved from http://ijds.lemoyne.edu/journal/2_1/index.html

Muratori, F., Apicella, F., Muratori, P., & Maestro, S. (2011). Intersubjective disruptions and caregiver-infant interaction in early autistic disorder. *Journal of Research in Autism Spectrum Disorders, 5*(1), 408–417. https://dx.doi.org/10.1016/j.rasd.2010.06.003

Muris, P., Simon, E., Lijphart, H., Bos, A., Hale, W., & Schmeitz, K. (2017). The Youth Anxiety Measure for DSM-5 (YAM-5): Development and first psychometric evidence of a new scale for assessing anxiety disorders symptoms in children and adolescents. *Journal of Child Psychiatry and Human Development, 48*, 1–17. https://dx.doi.org/10.1007/s10578-016-0648-1

Nagy, E., & Molnar, P. (2004). Homo imitans or homo provocans? Human imprinting model of neonatal imitation. *Journal of Infant Behavior and Development, 27*(1), 54–63. https:// dx.doi.org/10.1016/j.infbeh.2003.06.004

Newirth, J. (2000). Impasses in the psychoanalytic relationship. *Journal of Clinical Psychology, 56*(2), 225–231. https://dx.doi.org/ 10.1002/(SICI)1097-4679

Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113–141). Washington, DC: American Psychological Association. https://doi.org/10.1037/12075-004

Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 307–390). New York, NY: Wiley.

Osanloo, A. F., Boske, C., & Newcomb, W. S. (2016). Deconstructing macroaggressions, microaggressions and structural racism in education: Developing a conceptual model for the intersection of social justice and intercultural education. *International Journal of Organizational Theory and Development, 4*(1), 1–18. Retrieved from https://www.researchgate.net/profile/Azadeh_Osanloo/publication/301201502.

Panayiotou, G., & Karekla, M. (2013). Perceived social support helps but does not buffer the negative impact of anxiety disorders on quality of life and perceived stress. *Journal of Social Psychiatry and Psychiatric Epidemiology, 48*(2), 283–294. https://dx.doi.org/ 10.1007/s00127-012-0533-6

Raj, G. R., Ranjan, K., & Pereira, D. S. (2017). Anxiety, depression and quality of life in mothers of children with intellectual disability. *Open Journal of Psychiatry and Allied Sciences, 8*(1), 71–75. https://dx.doi.org/10.5958/2394-2061.2016.00046.X

Robledo, J., & Donnellan, A. M. (2016). Supportive relationships in autism spectrum disorder: Perspectives of individuals with ASD and supporters. *Journal of Behavioral Science, 6*(4), 23. https://dx.doi.org/10.3390/bs6040023

Rochat, P. (2001). *The infant's world*. Cambridge, MA: Harvard University Press.

Rogers, S. J., & Ozonoff, S. (2005). Annotation: What do we know about sensory dysfunction in autism? A critical review of the empirical evidence. *Journal of Child Psychology and Psychiatry, 46*(12), 1255–1268. https://doi.org/10.1111/j.1469-7610.2005.01431.x

Rogoff, B. (1990). *Apprenticeship in thinking: Cognitive development in social context*. New York, NY: Oxford University Press.

Rosenthal, M., Lawson, R., Dixon, E., Wallace, G., Wills, M., Yerys, B., & Kenworthy, L. (2013). Impairments in real-world executive function increase from childhood to adolescence in autism spectrum disorders. *Neuropsychology, 27*(1), 13–18. https://dx.doi.org/10.1037/a0031299

Rushton, A., Monck, E., Leese, M., McCrone, P., & Sharac, J. (2010). Enhancing adoptive parenting: A randomized controlled trial. *Journal of Clinical Child Psychology and Psychiatry, 15*(4), 529–542. https://dx.doi.org/ 10.1177/1359104510365041

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology, 56*(2), 233–243. https://doi.org/10.1002/(SICI)1097-4679(200002)56:2<233::AID-JCLP9>3.0.CO;2-3

Schaaf, R. C., & Lane, A. E. (2015). Toward a best-practice protocol for assessment of sensory features in ASD. *Journal of Autism and Developmental Disorders, 45*(5), 1380–1395. https://dx/doi.org/10.1007/s10803-014-2299-z

Shobana, M., & Saravanan, C. (2014). Comparative study on attitudes and psychological problems of mothers towards their children with developmental disability. *East Asian Archives of Psychiatry, 24*(1), 16–22. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24676483

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* New York, NY: Guilford Press.

Simon, G. M. (2006). The heart of the matter: A proposal for placing the self of the therapist at the center of family therapy, research and training. *Family Process, 45*(3), 331–344. https://dx.doi.org/10.1111/j.1545-5300.2006.00174.x

Simone, R. (2010). *Aspergirls: Empowering females with Asperger syndrome.* London, UK: Jessica Kingsley.

Sperry, L. (2005). Case conceptualization: A strategy for incorporating individual, couple and family dynamics in the treatment process. *American Journal of Family Therapy, 33*(5), 353–364. https://dx.doi.org/10.1080/01926180500341598

Sroufe, L. A. (1995). *Emotional development: The organization of emotional life in the early years.* Cambridge, UK: Cambridge University Press.

Stacey, R. (2006). Theories of change in therapeutic work. *Journal of Clinical Child Psychology and Psychiatry, 11*(2), 191–203. https://dx.doi.org/10.1177/1359104506061446

Stanford, A. (2003). *Asperger Syndrome and long-term relationships*. London, UK: Jessica Kingsley.

Strunz, R. (2016). *Building connection: ASD and psychotherapy.* Unpublished manuscript. Retrieved from http://www.adlerontario.ca/docs/Conference2016/ONSAP2016_ASD.pdf

Sue, D. W., Capodilupo, C., Torino, G., Bucceri, J., Holder, A., Nadal, K., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286. https://dx.doi.org//10.1037/0003-066X.62.4.271

Swan, K. (2017). Pre-therapy in child-centered play therapy: A model for treating children with autism. In R. L. Steen (Ed.), *Emerging research in play therapy, child counseling and consultation* (pp. 112–123). https://dx.doi.org/10.4018/978-1-5225-2224-9.ch007

Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Journal of Professional Psychology: Research and Practice, 43*(4), 379–387. https://dx.doi.org/10.1037/a0028291

Tang, N., Bensman, L., & Hatfield, E. (2013). Culture and sexual self-disclosure in intimate relationships. *Interpersona: An International Journal on Personal Relationships, 7*(2), 227–245. https://dx.doi.org/10.5964/ijpr.v7i2.141

Tavassoli, T., Miller, L. J., Schoen, S. A., Brout, J. B., Sullivan, J., & Baron-Cohen, S. (in press). Sensory reactivity, empathizing and systemizing in autism spectrum conditions and sensory processing disorder. *Journal of Developmental Cognitive Neuroscience.* Retrieved from http://www.sciencedirect.com/science/article/pii/S1878929316301396

Thompson, E. D., Moree, B. N., Dempsey, T., Reuther, E. T., Fodstad, J. C., Hess, J. A., … Matson, J. L. (2011). The relationship between autism spectrum disorders and anxiety: The moderating effect of communication. *Journal of Research in Autism Spectrum Disorders, 5*, 324–329. https://dx.doi.org/ /10.1016/j.rasd.2010.04.015

Torrado, J. C., Gomez, J., & Montoro, G. (2017). Emotional self-regulation in individuals with autism spectrum disorders: Smartwatches for monitoring and interaction. *Sensors, 17*(6), 1359–1388. https://dx.doi.org/10.3390/s17061359

Tronick, E., Als, H., Adamson, L., Wise, S., & Brazelton, T. B. (1978). The infant's response to entrapment between contradictory messages in face-to-face interactions. *Journal of the American Academy of Child Psychiatry, 17*(1), 1–13. https://dx.doi.org/10.1016/S0002-7138(09)62273-1

Tronick, E., & Beeghly, M. (2011). Infants' meaning-making and the development of mental health problems. *American Psychologist, 66*(2), 107–119. http://dx.doi.org/10.1037/a0021631

Vanhee, G., Lemmens, G., & Verhofstadt, L. L. (2016). Relationship satisfaction: High need satisfaction or low need frustration? *Social Behavior and Personality: An International Journal, 44*(6), 923–930. https://doi.org/10.2224/sbp.2016.44.6.923

Van Schalkwyk, G. I., Peluso, F., Qayyum, Z., McPartland, J. C., & Volkmar, F. R. (2015). Varieties of misdiagnosis in ASD: An illustrative case series. *Journal of Autism and Developmental Disorders, 45*(4), 911–918. https://dx.doi.org/10.1007/210803-014-2239-y

Van Steensel, F. A., Bogels, S. M., & Dirksen, C. D. (2012). Anxiety and quality of life: Clinically anxious children with and without autism spectrum disorders compared. *Journal of Clinical Child and Adolescent Psychology, 41*(6), 731–738. https://www.dx.doi.org/10.1080/15374416.2012.698725

Vespia, K. M., Heckman-Stone, C., & Delworth, U. (2002). Describing and facilitating effective supervision behavior in counseling trainees. *Journal of Psychotherapy: Theory/Research/Practice/Training, 39*(1), 56–65. https://dx.doi.org/ 10.1037//0033-3204.39.1.56

Weinberger, J., & Eig, A. (1999). Expectancies: The ignored common factor in psychotherapy. In I. Kirsch (Ed.), *How expectancies shape experience* (pp. 357–382). Washington, DC: American Psychological Association. https://dx/doi.org/10.1037/10332-015

White, S. W., Ollendick, T., Albano, A. M., Oswald, D., Johnson, C., Southam-Gerow, M. A., … Scahill, L. (2013). Randomized controlled trial: Multimodal anxiety and social skill intervention for adolescents with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 43*, 382–394. https://dx.doi.org/10.1007/s10803-012-1577-x

Williams, D. L., Goldstein, G., & Minshew, N. J. (2006). The profile of memory function in children with autism. *Neuropsychology, 20*(1), 21–29. http://doi.org/10.1037/0894-4105.20.1.21

Wood, J. J., & Gadow, K. D. (2010). Exploring the nature and function of anxiety in youth with autism spectrum disorders. *Clinical Psychology: Science and Practice, 17*(4), 281–292. https://dx.doi.org/10.1111/j.1468-2850.2010. 01220.x

Woods, S. B., & Denton, W. H. (2014). The biobehavioral family model as a framework for examining the connections between family relationships, mental and physical health for adult primary care patients. *Journal of Families, Systems and Health 32*(2), 235–240. https://doi.org/10.1037/fsh0000034

World Health Organization. (2014). *Social determinants of mental health.* Retrieved from https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/

Wylie, P. (2014). *Very late diagnosis of Asperger syndrome (autism spectrum disorder): How seeking a diagnosis in adulthood can change your life.* London, UK: Jessica Kingsley.

Zeanah, C. H., & Gleason, M. M. (2015). Annual research review: Attachment disorders in early childhood–clinical presentation, causes, correlates, and treatment. *Journal of Child Psychology and Psychiatry, 56*(3), 207–222. https://dx.doi.org/10.1111/jcpp.12347

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