Guidelines for Counsellors & Psychotherapists working with **Adult Autistic Clients**

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Table of Contents

Introduction

Welcome to this resource, which is designed to help therapists better understand Autistic people and provide guidance around best practice when working therapeutically with Autistic clients. In the material you may be introduced to new language, new concepts and practical advice towards providing the best foundation for a successful therapeutic relationship.

At times you might feel challenged by some of the ideas that are set out in this resource, and you may need to have patience with yourself and your practice as you adapt and amend your current methods of working towards becoming a more inclusive Neuro-Affirmative therapist.

We hope that we can offer you an opportunity to challenge your current perspectives around working with Autistic clients and we hope that we demystify any preconceived concerns or curiosities you may have.

The resource explores the history of Autistic people, the prevalence and the language of Neuro-Affirmative practices as we explore current models of disability. It looks at common characteristics of Autistic people and outlines sensory, perceptual, cognitive and communication differences, methods of processing emotions, differences in executive function and ways to support overwhelm and burnout. The focus then moves to common co-occurring conditions, a brief explanation of some neurodivergences and exploring intersectionality. Finally, we outline the practical ways to prepare for the therapy process. This includes outlining pre-therapy steps, exploring the ways we can develop a therapeutic relationship, the maintenance of a therapeutic alliance and the importance of clear communication as well as the role of supervision and feedback.

Autistic clients will naturally be the experts in their own lived experience of being Autistic and may be well versed in the ideological and historical debates around Autistic neurology; however, not all Autistic people will have invested in research around the Autistic community and it is important that therapists do not make assumptions about their client's knowledge of the topic.

Additionally, a lot of the content in this resource is Western-centric and clients from other communities and cultures may well have a different understanding and background to their take on Autistic neurology. This can be influenced by non-Western medical practice, language, family, religious and community set-ups.

This resource

Autistic people do not require therapy because they are Autistic; however, most therapists are likely to encounter Autistic people needing therapy for similar reasons as neurotypical people navigating their way through life.

Our research has shown that many therapists wish to expand their knowledge around Autistic neurology so that they can practice in a more Neuro-Affirmative manner and provide the best support they can when working therapeutically with an Autistic client. This resource was compiled by a neurodiverse team of Neuro-Affirmative advisers and qualified/accredited counsellors, psychotherapists and psychologists who have many years' experience working with Neurodivergent clients including those who also have lived experience of being Autistic. The group took 2.5 years to research and devise this resource and every effort has been taken to ensure that it is an accessible document that provides the most up-to-date information around best practice when working therapeutically with Autistic clients.

The resource is divided into four modules:

1. An introduction to neurodiversity and the Autistic community
2. Common characteristics and common strengths and challenges for Autistic clients
3. Understanding your Autistic client and the lived experience of Autistic people
4. The therapeutic process with an Autistic client

Research shows that Autistic people often feel that therapists, albeit willing and well-intended, are not sufficiently informed around the fundamentals of Neuro-Affirmative practices in therapy, and because of that the process regularly fails to meet the needs of Autistic clients, who often end up receiving inappropriate support for their mental health needs.

Adaptations may need to be made at every point of an Autistic person's journey through mental health services (NAS, 2021), and this resource outlines the models of best person-centred practice that will offer Autistic clients the greatest hope for a positive outcome from their therapy experience.

The best way to use this resource is to work through the four modules in order. As you do that, you'll become better informed about how Autistic people have been viewed through the decades, you'll understand common characteristics of Autistic neurology, understand your Autistic clients' lived experience and develop your practice to be as Neuro-Affirmative as possible.

This resource is accompanied by a free online video training programme for Irish Association of Counselling and Psychotherapy (IACP) members that can be accessed via their website: www.iacp.ie.

A word from Lisa Molloy, CEO IACP

I am delighted to be sharing with you this important resource for counsellors and psychotherapists. This resource provides the most up-to-date information around best practice when working therapeutically with Autistic clients and will be a very useful tool for any therapist who strives to operate their practice in a Neuro-Affirmative manner.

The resources were developed in partnership with the IACP and AsIAm, Ireland's national autism charity, and a working group made up of autism specialists, therapists and researchers who have a tremendous amount of experience and expertise in working with Neurodivergent clients.

I would like to sincerely thank Adam Harris, the CEO of AsIAm, for joining with us in this important collaboration. I also wish to thank Michael Ryan (MIACP), chairperson of the working group, for his hard work and dedication to this paramount project. Many thanks to the working group members: Jessica K. Doyle (Thriving Autistic), Kevin Flynn (Autism Initiatives), Tara O'Donnell-Killen (Thriving Autistic), Bethan Davies (Autistic advocate, UK), Lorraine Mooney (MIACP) and Gillian Fagan (MIACP) for their invaluable contributions in developing this helpful and timely resource for IACP counsellors and psychotherapists.
The publication of this resource is an important step in supporting Neurodivergent clients to have the best possible outcome from their therapeutic experience.

Lisa Molloy,
IACP CEO

A word from Adam Harris, CEO ASIAM

On behalf of AsIAm, Ireland's Autism Charity, we are delighted to present this timely and much-needed resource in partnership with the Irish Association of Counselling and Psychotherapy. This publication/training programme is the culmination of extraordinary work by a committed, highly skilled and Neuro-Affirmative working group, under the leadership of Michael Ryan, to whom we owe a great debt of gratitude.

Everyone deserves the same chance in life; however, Autistic people face barriers that others often do not even see. These barriers are dually at play when it comes to the experiences of Autistic people seeking access to mental health care. On the one hand – exclusion, stigmatisation and a lack of support across Irish society means that many Autistic people find ourselves in need of mental health care during the course of daily lives (in addition to the needs that anyone can have to access such support), and on the other hand, those barriers exist in accessing appropriate and Neuro-Affirmative support for our mental health.

Owing to structural discrimination within the public mental health system and a lack of sufficient knowledge and training in the private system, Autistic people are frequently unable to access the right support at the right time. This in and of itself exacerbates the challenges a person may be experiencing and further adds to the sense of isolation and exclusion.

This publication/training programme marks an important moment on the road to change. Knowledge is power that can change attitudes and inform practices for the better. We hope that many counsellors and psychotherapists will avail of this training with a view to meeting the needs of the many thousands of potential clients who simply want the same chance as neurotypical people to access their expertise and support. Small changes can make a big difference and I have no doubt that those engaging with this training will be presented with opportunities to reflect on their practices more generally with a view to creating client-centred care that is as accessible as possible. What is often essential for Autistic people is beneficial for many more if not everyone.

Adam Harris,
AsIAm CEO

Learning outcomes

- Become familiar with the language of Autistic neurology and the language used to talk about Autistic experience
- Familiarise yourself with the relevant history of Autistic people
- Learn what it means to work therapeutically within a Neuro-Affirmative approach
- Explore the models of disability and the neurodiversity paradigm for working with Autistic clients
- Examine common Autistic characteristics and differences
- Understand communication considerations for Autistic clients
- Obtain an overview of common neurodivergence
- Gain an understanding of common co-occurring conditions that can accompany neurodivergence
- Consider your Autistic clients' intersectional identities
- Review some modalities and approaches in preparing for and working therapeutically with your Autistic clients

Resource team

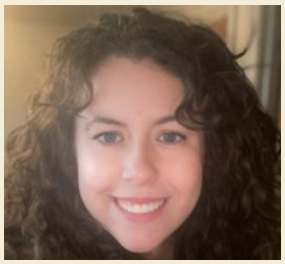
This resource was compiled by a neurodiverse team consisting of a mix of Neurodivergent and neurotypical people. Together they have experience working in the field of mental health and neurodivergence, and are passionate about the development and provision of Neuro-Affirmative therapy for Neurodivergent clients.

Michael Ryan

MIACP – Neurodivergent: Neuroaffirmative Counsellor / Psychotherapist, Author, Lecturer

Jessica K Doyle

M.Ps.S.I - Autistic & Adhd: Autistic Perception, Sensory Analysis & NeuroAffirmative Consultant. Director at Thriving Autistic; Adventurer, Speaker, Filmmaker & Author

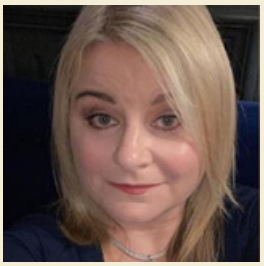


Bethan Davies

Patient Involvement and EDI specialist, Samaritans volunteer and Trustee for Central London Samaritans

Gillian Fagan

MIACP – Neurodivergent/ Autistic: Equality, Diversity and Inclusion Psychotherapist



Lorraine Mooney

MIACP – Neurodivergent: Neuroaffirmative and Trauma Informed Counsellor/ Psychotherapist

Tara O'Donnell-Killen (she/her)

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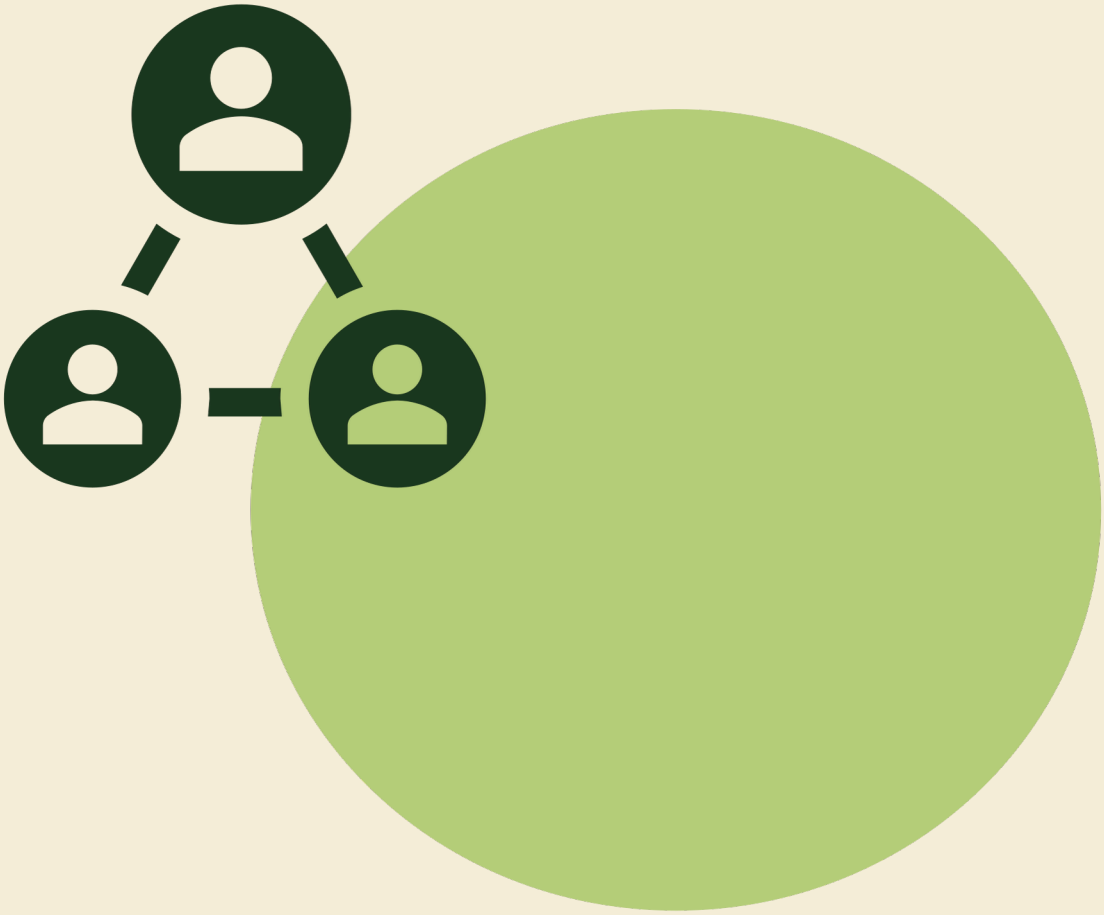
Kevin Flynn

Neurotypical: MSc Psychology (TCD), MSc Systemic Psychotherapy (UCD). Systemic Psychotherapist (FTAI)

Acknowledgements

We wish to acknowledge the assistance of the many people who have helped to shape, proof, test and develop this resource. The project was funded through AsIAm (Ireland's Autism Charity) and the Irish Association of Counselling and Psychotherapy (IACP) and supported by Thriving Autistic. Special mention to Jessica K. Doyle for her involvement in the design, layout, structure and review of this resource.

We wish to thank Adam Harris (CEO of AsIAm) and Lisa Molloy (CEO of IACP) for supporting this resource, along with Iwona Blasi from IACP for her guidance throughout the process. Special thanks to Rob Barry (MIACP), Tim Nicholls (National Autistic Society, UK), Victoria Woodside (copyeditor), Ciara Whooley (graphic designer) and Barry Hunt (Hunt Films). Thanks also to the AsIAm Adult Groups, the D15 Counsellors Network (and other therapists), and members of the Autistic community and autism community for their feedback and suggested amendments through the project's evaluation process.



Module 1 – An Introduction To Neurodiversity And The Autistic Community

Defining Autistic neurology

There is no one set definition of Autistic neurology or a definition that encompasses the diversity of Autistic experiences. A person is Autistic for their entire life but they may not be identified as Autistic until much later in life. Autistic people perceive, experience, understand, process and interact with the world around them in a way that differs from neurotypical people. Attempting to define what it means to be Autistic is as complex as defining what it means to be neurotypical – both tasks are virtually impossible due to the immense variability within each group. Often, society tries to describe being Autistic in terms of how it differs from being neurotypical, which is an oversimplified and flawed comparison. It's akin to contrasting cumulonimbus with nimbostratus clouds: while we can observe distinct differences and acknowledge similarities — such as their capacity to produce rain — no straightforward explanation can capture the full extent and fluid nature of their diversity. Both types of clouds represent different yet equally valid forms of existence in the atmosphere. Similarly, being Autistic or neurotypical encompasses a vast range of valid human experiences.

Labelling Autistic neurology as a disorder or deficit creates safety for the neurotypical power system. Words such as “disorder”, “deficit” or “condition” implies that there is something innately wrong with being Autistic at the expense of Autistic legitimacy. Othering Autistic people and denying their different yet valid ways of being allows society to disempower them. Continued use of terms such as “autism spectrum disorder” (ASD) or “Autism Spectrum Condition” (ASC) strips Autistic people of their validity and ostracises them from forming a worthy position within society that respects their right to their own unique and equally legitimate Autistic culture.
Autistic neurology is often defined in terms that compare it against neurotypical. In these cases neurotypical neurology is often put on a pedestal as the gold standard way of being human, and any deviations from neurotypical ways of being are explained as deficits. Differences are just differences, not deficits.

Some core differences between Autistic and neurotypical people that are broadly agreed upon include:

1. **Perception:** Autistic individuals often have a different way of forming perceptions. The balance between sensory information and beliefs or predictions based on past experiences is combined differently, leading to a distinct perception.

2. **Cognition:**There are differences in how Autistic and neurotypical individuals experience the intensity of their interests, allocate attention, and approach learning and thinking.

3. **Communication:** Both groups exhibit differences in communication styles, stemming from variations in cultural and social expectations, as well as values.

For a short doodle on these three differences see: *The Autistic Neurotype* on YouTube (Doyle, 2023).

The language of Autistic neurology and experience

When considering the ways in which we refer to Autistic neurology and Autistic people, we first have to understand the difference between the Autistic community and the autism community. The Autistic community is made up of people who are Autistic. The autism community is made up of both Autistic people and the people connected to Autistic people, such as non-autistic parents, relatives and friends of Autistic people, non-autistic professionals working in the area of autism and non-autistic allies to Autistic people. Simply put, members of the Autistic community are also members of the autism community, but not all members of the autism community are members of the Autistic community.

The American Psychological Association (APA, 2020) states:

> The members of some groups of people with disabilities – effectively subcultures within the larger culture of disability – have particular ways of referring to themselves that they would prefer others to adopt. When you use the disability language choices made by groups of disabled individuals, you honour their preferences ... Honoring the preference of the group is not only a sign of professional awareness and respect for any disability group but also a way to offer solidarity.

Thus when it comes to the language used to refer to and describe Autistic neurology and Autistic experience, it is important to understand that it is the views of the Autistic community – not the autism community, that should be the decider, and when working with people on an individual basis, the individual preference of the Autistic person should always be respected. However, when it comes to a more general position, such as writing research papers, articles or reports, the majority preference of the Autistic community should be used.

Most research conducted on the opinions of the Autistic community (Kenny et al., 2016) has now established that the majority of Autistic people prefer identity-first language: Autistic person/child/adult rather than person-first language: person/child/adult with autism.

> In 2016, the National Autistic Society (NAS), the Royal College of General Practitioners and the UCL Institute of Education conducted a study of people connected to autism across the UK. Its purpose was to inquire about preferences regarding the use of language. Amongst the autistic adults that it surveyed, "autistic person/people" was the most commonly preferred phrase. (AsIAm Autism Charity, 2021)

The 2023 *Autism Innovation Strategy – Analysis of Initial Public Consultation Submissions* states that there is a clear message from all submissions that identity-first language "Autistic person" is the preference of Autistic people rather than person-first language "person with autism". (Government of Ireland, Department of Children, 2023) Terms such as "high and low functioning" or levels of autism such as those described in the DSM-5-TR and ICD-11 are harmful to Autistic people because they do not recognise the complexity of an Autistic person's identity and experience. They do not allow for how people are affected by familiar or unfamiliar situations, by pressure from others or by prejudice. They also do not consider how strengths and challenges can change as the day develops and also across a person's lifespan.

Evans (National Autistic Society – UK, 2021) states that: "Somebody might have a day when they are functioning okay. They might be able to go to work, meet with friends. But the next day, they might crash. They may have used up all of their reserves. They may be experiencing sensory overload. They may have been out and gone to a place where their sensory stimulation has gone into overdrive. It is moving all the time. So you have met one autistic [person]. But you have met one autistic [person] on one day."

The terms "high and low functioning" are limiting to Autistic people and increase barriers and prevent access to support. They do not capture the unique strengths and support needs that Autistic people may experience. "Low functioning" is viewed as a limiting label that can impact expectations around the individual's capacity to thrive. The label "high functioning" can impact on the assumed supports that an individual may need, limiting what is made available to them (Autism Awareness Australia, 2021).

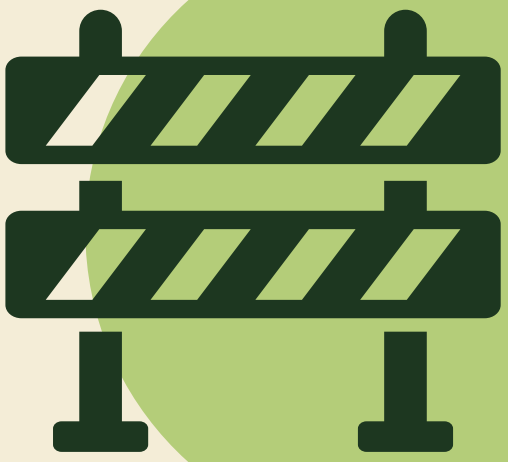
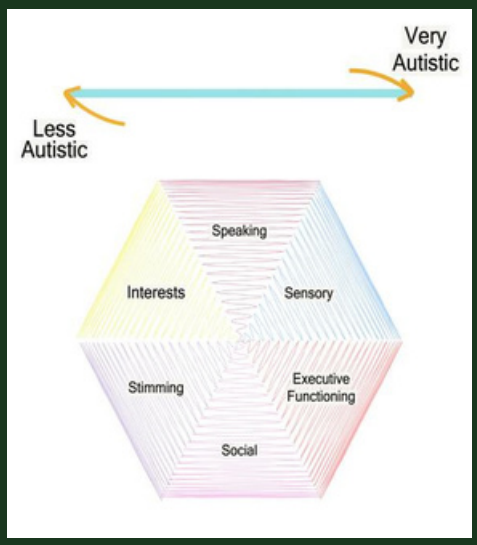


TABLE 1: LANGUAGE, PHRASES AND CONCEPTS TO AVOID

To avoid	To use
On the spectrum, has autism, your autism	Is Autistic
Asperger's syndrome	Autism/Autistic*
Restricted and repetitive behaviour	Passions and areas of interest
Repetitive behaviour	Stimming
ASD, ASC, AS	Autism/Autistic neurology
Neurodiverse person/people/individual/child/adult	Neurodivergent or neurotypical person/people/individual/child/adult
Neurodiversity-lite, taking time to learn only a superficial, shallow and inaccurate understanding of neurodiversity and Neurodivergent difference. Continued use of the inaccurate term "neurodiverse person" and glazing over it as "only semantics" Using neurodiversity-lite and Neurodivergent people in ways that are harmful and stigmatising or are purely for financial gain.	Learn why the term "neurodiverse person" is inaccurate and problematic to fully understanding what neurodiversity means and how neurodiversity involves all humans and is not a synonym for non-neurotypical but includes neurotypicals too. Take time to understand how the language we use informs our comprehension of concepts and theories and do not exploit Neurodivergent people.
High functioning/low functioning/levels of autism	Talk and learn about the diversity of Autistic experience. There is as much diversity across the Autistic population as there is across the neurotypical population.
We are all a little bit Autistic	You either are or are not Autistic, but we are all human and therefore can have similarities.
We are all somewhere on the spectrum	We are all somewhere on the spectrum of human, but we are not all somewhere on the spectrum of Autistic.

The spectrum understood as binary or categorically binary: 	Autistic diversity is infinitely more complex and layered than any simple binary or multi-item system. 
Risk factors, red flags, warning signs, symptoms	Characteristics, features, aligns with Autistic development
Autistic Disorder, Autism deficit, Autistic condition	Autistic Neurotype, Neurodivergence,
Developmental delay	Autistic developmental trajectory
Sensory sensitivities	Perceptual differences, sensory differences
Infantilising Autistic Adults	Recognise that Autistic children grow and change and become Autistic adults. Respect that their experience is different and acknowledge that you may not understand their experience of the world but do not infantilize Autistic adults or treat Autistic adults as if they were children just because you might not understand their experience.
Comparing Autistic children to Autistic adults and not recognising difference of age.	As neurotypical children are different to neurotypical adults, so too are Autistic adults different to Autistic children, both should not be seen as the same compared as if they were the same. Autistic adults can be of help understanding Autistic children as they were Autistic children before they were Autistic adults.

*Asperger's syndrome does not exist in the *DSM-5-TR* or the ICD-11; however, the old diagnosis of Asperger's syndrome has now amalgamated with autism and should be referred to as "autism" or "Autistic" apart from when it is an individual's preference for individual use.

"Knowing that a therapist understands neurodivergence is a massive comfort as many late-diagnosed adults have had a lifetime of struggling to navigate a neurotypical world and building trust with the therapist is important."

Autistic adult

Neurodiversity and the neurodiversity paradigm

Neurodiversity refers to the natural diversity within areas of the brain and between different brains. Similar to biodiversity, where there are different varieties of animals and organisms, neurodiversity recognises that there are different types of human brains. This means that there are different ways in which brains are structured and function; none of them inherently superior or inferior (Myers, 2022).. The neurodiversity model moves away from a deficit medical-based model. It takes into account that all people have areas of strength, challenges, cognitive profiles and perception styles that are adaptive in certain environments and present as a disability in others.

The term "neurodiverse" refers to groups that consist of people with different neurology. A neurodiverse group could be made up of a combination of neurotypical, Autistic or otherwise Neurodivergent individuals, but a group of Autistic people alone could not be considered neurodiverse, there is also no such thing as a neurodiverse person.

The neurodiversity paradigm allows for a more nuanced understanding of the diversity of Autistic experiences with all its context-dependent strengths, challenges and neutralities. The neurodiversity movement challenges the medical model's interest in causation and cure and fitting people into boxes, and instead focuses on celebrating Autistic neurology as an inseparable aspect of identity with a diversity of ever-changing presentations (Kapp et al., 2013).

Therapists are encouraged to recognise the biological, neural, perceptual and cognitive Autistic features and to understand that the mission of therapy is to validate Autistic experience and expression, and to avoid a process that tries to assist the client in hiding their authentic selves or encourages or facilitates them to appear and operate in a "neurotypical" manner.

Neuro-Affirmative practice is an approach to working with people that views each neurotype as equally valid. The Neuro-Affirmative practitioner recognises and values neurodivergence and takes care to address their own internalised ableism while appreciating the diversity of cultural, racial, gender and sexual identities their clients embody. The committed Neuro-Affirmative practitioner reflects deeply on their practice, seeks out learnings and training from Autistic professionals and lived-experience accounts to deepen their understanding, and works to create an inclusive, collaborative service.

The aim of this resource is to equip counsellors and psychotherapists with some of the tools and thinking around creating Neuro-Affirmative practices that provide pathways for Autistic clients to accept their authentic selves and live the best lives they can. It is important to acknowledge that for Autistic clients, most of their experience happens in a world that daily creates barriers and is disabling to them because the majority of society is designed exclusively and inequitably for neurotypical individuals at the exclusion of Autistic needs. Awareness of this is crucial for helpful rational compassion to be shown when working with Autistic clients.

Conclusion

- The neurodiversity model argues that human brains differ in the way they function, perceive and process the world. These different types of human brains add strength and richness to the human population, allowing it to thrive.

- Strengths and challenges are dependent upon the environment the person is in.

- There is a focus on understanding each person, their unique differences, needs and strengths rather than making a judgement of deficits and viewing a person as either high or low functioning.

What does it mean to be a Neuro-Affirmative practitioner?

A Neuro-Affirmative practitioner aspires to follow and embody the set of commitments for Neuro-Affirmative practice (below). The neurodiversity movement is constantly evolving, and a Neuro-Affirmative practitioner continues to work on their own understanding of the human-rights approach, work on unpacking their own internalised ableism and continually seeks out training and supervision from professionals who have lived experience (rather than those adjacent to) of the neurodivergence they seek to serve. This is aligned with the principle of a rights-based approach, centring the voice and power of the communities they work for and supporting the wider disability rights movement's position of "nothing about us, without us".

Set of commitments for Neuro-Affirmative practice

- Recognise that Neurodivergent people are a minority group living in a world not designed for them as opposed to people with an inherent deficit.
- Work to develop cross-neurotype cultural competence within yourself.
- Presume competence.
- Offer multimodal communication methods including Augmentative and Alternative Communication methods (AAC).
- Advocate for self-determination.
- Advocate for inclusion.
- Advocate for systems change.
- Facilitate the development of self-advocacy skills.
- Reject "compliance" or "reward/punishment" behaviourist methodologies including but not limited to Applied Behaviour Analysis (ABA), Positive Behaviour Support (PBS) or any other methodologies that use positive or negative external motivators or have "normative" behaviour including non-autistic social norms as therapeutic goals.

- Take a strengths-based approach, appreciating that all neurotypes have strengths and challenges.
- Understand and appreciate the medical model of disability as a significant barrier to Neurodivergent people achieving equitable access to society.
- Respect and uphold each client's autonomy.
- Respectfully appreciate intersectionality in both ourselves and our clients and work to unpack any privilege we may have.
- Hold an LGBTQIA+ affirmative position, acknowledging that many of our Neurodivergent clients will belong to the community.
- Hold an anti-racist position and appreciate the additional barriers to identification of neurodivergence in Black, Brown and Indigenous and other minority communities. Develop cultural competence in working with Neurodivergent people of colour and appreciate the additional harm and danger "unmasking" may pose to racially minoritised peoples.
- Actively seek out continuing professional development (CPD), research and learnings from Autistic, Adhd and otherwise Neurodivergent adults.
- Use identity-first language in accordance with the majority of the Autistic community while respecting individual clients' preferences.

(Thriving Autistic, 2023)

Conceptualising disability: three models of disability

In therapeutic work with Autistic people there are models of Autistic neurology that are important for non-autistic, Autistic professionals and Autistic clients to be aware of. Models can be bluntly broken down into medical models or social models of Autistic neurology and the bridging paradigm, the neurodiversity paradigm, which acknowledges both disability and the role of the environment and societies on the individual. For an in-depth understanding of the neurodiversity paradigm, see Dr Nick Walker's book, *Neuroqueer Heresies* (Walker, 2021).

Table 2: Comparison between the medical model, the social model and the neurodiversity paradigm

Medical model	Social model	Neurodiversity paradigm
Focus		
What is "wrong" with the person? The model follows the path of diagnosis, intervention and treatment.	Recognises that people are disabled by barriers in society, not by their impairment or difference.	The neurodiversity paradigm is founded on these principles: Neurodiversity is a natural, valuable form of human diversity. All brains are good brains – there is no "right way" to process, sense or communicate. Neurodivergence is a part of someone's identity in the same way as gender, ethnicity or culture. Just as with these other identities, culturally constructed assumptions about favoured ways of being can lead to social inequalities.

Assumptions about Autistic neurology		
An impaired version of "normal" functioning. A deficit, a disorder, something that is "wrong" with a person.	Autistic neurology is a result of the inequitable design of the environment and society to exclude Autistic people. Autistic people are disabled not because of something internal but because the world is not set up for them and they are disabled by the world.	Autistic neurology is aneurodivergence that is part of life's neurodiversity, similar to how botany understands the difference between a willow and a maple tree. Both are equally authentic but different parts of a natural biodiversity.
Objective of support in relation to Autistic neurology		
Treat and cure or recovery. Early intervention to make the individual appear more neurotypical.	Develop and create a society that is accessible and provides equity of opportunity for everyone. Disabled people have a right to be fully participating citizens on an equal basis with everyone else.	Celebrate being Autistic as a part of neurodiversity that is a natural and vital aspect of human strength and diversity. To adapt and develop society to embrace diversity. Neurodiversity also recognises the effect of being disabled by living in a world not designed for everyone.

Assumptions about disability		
(Trigger Warning) Assumes that a person is disabled due to "autism". "Autism" (Autistic neurology) is viewed as an internal impairment/ disorder.	Assumes that disability results from external societal and environmental barriers and inequalities.	Assumes that there are no "normal" or "right" ways of being; however, diversity in biology can lead to disability, as can societal and environmental design that favours neurotypical ways of being.

"I would give the following example here to explain: I am extremely short-sighted. Medically, I am profoundly disabled. But I am not disabled under the social model, not so much due to the existence of glasses, but because of their ubiquity and acceptance in society along with how readily accessible they are for the vast majority of people."

Autistic adult

Prevalence of Autistic neurology

The prevalence of Autistic people in the world does not have a definitive figure because of diagnostic variance. Some countries have assessment programmes and unified healthcare systems while others do not, so gathering national figures is not always possible (The Borgen Project, 2021). In Ireland the figure varies from one source to another; however, the most common statistic cited from a meta-analysis of studies across the UK and Ireland put the prevalence at one Autistic person per 100 births (National Disability Authority, 2014; World Health Organization, 2019), although more recent research by AsIAm suggests that the rate of people who are Autistic in the general population in Ireland in 2024 is one Autistic person per twenty seven births.

Variations and changes in autism prevalence rates reported may have several explanations:

1. An increased awareness among adults, parents, professionals and the general public (HSE, 2018).
2. Differences in the methods used to study prevalence (sampling procedures and application of statistical methods).
3. Changes or broadening of the diagnostic criteria.
4. Increasingly sensitive diagnostic tools.
5. Financial capacity for families and individuals to access private assessment processes.

In the past statistics quoted gender variance of 4:1 male to female in the prevalence of autism, but this figure is now widely criticised and the gap is narrowing as research improves (HSE, 2018). It transpires that many females and those identifying with non-cisgenders have been, and continue to be, undiagnosed or underdiagnosed and less likely to be included in research. To date, a lot of the research that has informed our understanding of Autistic neurology and Autistic experience has been biased to a white, male, middle-class sample and has excluded the wider demographic of the Autistic population in terms of gender identity and diversity and also those who are non-speaking or have high support needs.

While research is improving and samples are becoming more diverse, societal understanding of Autistic neurology is still influenced by this historical biased research. Autistic people who are female or identify with non-cisgenders continue to suffer because of this. They are also more likely to be encouraged to internalise their diversity or receive societal reinforcement for engaging in masking or camouflaging their authentic Autistic selves (Halladay et al., 2015).

Autistic history

When working with Autistic clients it's not necessary to give a history lesson on Autistic people, but understanding the history of the Autistic community and Autistic neurology and how it has been pathologised, abused and exploited throughout history can provide valuable insight into the challenges Autistic people face today. This knowledge can help you better understand key debates in the field and gain a deeper appreciation for what it means to be Autistic.

Historically, discussions and research about Autistic experiences and neurology were conducted by neurotypical individuals. In recent times, however, there has been a movement towards Autistic people reclaiming their identities and agency through the concept of "nothing about us, without us". This movement has led to a push for participatory and co-produced research and design, and an increase in Autistic researchers.

The word "autism" comes from the Greek word *autos*, which means "self" or "of itself", and "ism", which signifies the practice or teaching of a thing. "Autistic" comes from *autos* and "ist", which means one who does or makes, and "ic", which means having to do with or having the nature of. Therefore "Autistic" means "one who does have the nature of natural self".

Despite a controversial history, "autism" and "Autistic" reflect the authenticity and genuine nature of Autistic individuals. Autistic people often need to undertake self-learning to understand their unique development, learning styles and perception to thrive in a world that usually excludes them. Unfortunately society has often focused on making Autistic people more neurotypical rather than accepting and celebrating Autistic differences as a wonderful part of human diversity.

The table below explores key historical events related to autism and their ongoing influence today.

Table 3: History

The early years, probable plagiarism and a mostly white, male-dominant sample: what happened
1908 "Autism" was first used by Swiss psychiatrist Eugen Bleuler to describe a childhood version of schizophrenia. He used it to describe a schizophrenic child patient who had withdrawn into his own world (Bleuler and Jung, 1908).
1924 Dr G. E. Ssucharewa, well known in Russia, worked in the Pedagogical Sanatorium School in Moscow for children orphaned after World War I. There she identified five boys with Autistic tendencies. Ssucharewa saw Autistic tendencies as rooted in brain development. She described features of Autistic tendencies that are extremely similar to those listed in the *DSM-5-TR* today.
1925 Dr G. E. Ssucharewa published research on six boys with Autistic features (Ssucharewa, 1925). The paper was not translated into English until 1996 and did not become well known until 2013.
1931 Austrian paediatrician Hans Asperger worked in Irwin Lazar's clinic in Vienna, which was similar to a school and had an ethos that treated children who were not sick or disordered, but whose challenges, they believed, were because of neglect from a society that had failed to provide suitable teaching methods for their unique styles of learning. In the clinic Asperger examined more than 200 children who displayed "Autistic thinking" previously identified by Bleuler. Asperger also identified Autistic thinking in several adolescents, adults and mothers of the children. He coined the term "Autistic pathology". Autistic characteristics included social awkwardness, precocious abilities and obsession with routine and rules. Asperger acknowledged that Autistic pathology remained present throughout an individual's life and involved a broad spectrum of people from the most talented and intelligent individuals to the most disabled (Silberman, 2016).
1938 Austrian psychiatrist Leo Kanner worked with two of Asperger's former colleagues from Lazar's clinic who had emigrated to America to escape Jewish persecution by the Nazis.

The early years, probable plagiarism and a mostly white, male-dominant sample: what happened

1943 In America Kanner published "Autistic Disturbances of Affective Contact", a study of 11 children (8 boys and 3 girls) in which he described autism as a rare childhood disorder (Kanner, 1943). Kanner's autism was characterised by a state of self- absorption present from birth. Kanner reported that parents of these children were often extremely successful and intelligent in their careers but were bad at being around other people (Rotatori and Deisinger, 2015). From this came "refrigeration mothers" – a theory proposing that Autistic disturbance was caused by distant and cold parents (Chown and Hughes, 2016). Kanner made no reference to Ssucharewa's or Asperger's work despite working with Asperger's former colleagues. The independence of Kanner's and Asperger's observations are debated, with some historians suggesting that Kanner may have been aware of Asperger's work prior to publishing his 1943 report (Silberman, 2016).

1944 Asperger published a study (in German) on four boys with Autistic pathology that was not translated into English and remained mostly unknown until 1981 when it was translated by Lorna Wing. Asperger made no reference to Ssucharewa's research; however, it is unclear whether he would have known about it.

1964 Bernard Rimland published a book claiming that autism was a biological disorder and not an illness caused by unfeeling parents. Rimland had an Autistic child and founded the Autism Society of America.

1965 Austrian-born and widely respected in his lifetime, American "psychologist" (later discovered to have no psychology qualifications) Bruno Bettelheim wrote a book, *The Empty Fortress: Infantile Autism and the Birth of the Self*, that described his captivity in Nazi prison, and how it gave him an insight into what it was like to be Autistic. He compared mothers of Autistic children to Nazi prison guards and home environments to concentration camps. Bettelheim advocated for the removal of Autistic children from their parents. He was the director of a residential treatment centre, the Sonia Shankman Orthogenic School for "disturbed children" (as it was referred to back then), where he conducted most of his research on Autistic children.

The early years, probable plagiarism and a mostly white, male-dominant sample: the impact

Early research into Autistic neurology focused primarily on White males, which has led to a historical exclusionary approach in autism research; however, researchers are now working to correct this by studying the diversity of Autistic experiences across genders, socio-economic status, race, ethnicity and other factors. Unfortunately, the previous male-dominant bias has resulted in a misconception that only boys can be Autistic, and there is still much less research into Autistic girls and women and gender-diverse children and adults.

People of colour are also affected, with White children being 30 per cent more likely to receive a diagnosis than Black children and 50 per cent more likely than Latino children, despite no racial or ethnic differences in when and how parents noticed Autistic features in their children. This bias extends to support. With most studies focusing on the needs of White boys, support has been focused wholly on one demographic and has led to the development of an autism stereotype, hindering public awareness and acceptance of Autistic people and their experiences. It has also resulted in a lack of understanding and assistance for those whose Autistic experiences differ from the restricted stereotype. This has created barriers to inclusion and underdiagnosis for individuals who are not disruptive.

The myth of refrigerator mothers also impacted public perceptions of autism for Generations. Despite the lack of evidence for this theory, it led to the separation of many Autistic children from their parents, who were blamed for their child's "autism". In some countries, such as France, psychoanalytic approaches continue to focus on the Autistic child's unconscious feelings towards their mother rather than their rights and well-being. This has resulted in the removal of Autistic children from their homes and their subsequent placement in psychiatric units with inefficient psychoanalytical therapies, overmedication and institutionalisation being common. The United Nations has stated that Autistic children in France "continue to be subjected to widespread violations of their rights" (United Nations, 2016) with the majority of Autistic children being denied access to mainstream education and the supports they need to thrive.

The enduring myth of 'refrigerator mothers,' which historically blamed parents for their child's autism, continues to impact families today, as evidenced by the findings in Luke Clements' research on Fabricated or Induced Illness (FII). His work reveals the widespread nature of FII allegations, particularly against disabled parents, with 74% of English children's services authorities reporting such cases. These allegations, often arising from complaints against public bodies, result in significant trauma for families. The effects on families are profound, highlighting the need to revise guidelines that currently overlook the harm caused by FII allegations and may breach the Equality Act 2010 (Clements, 2023).

Diagnosis, theories and treatment: what happened

The history of autism interventions is marked by a long and troubling legacy of harm to Autistic individuals.

1940s to 1960s Behaviour modification techniques such as those developed by B. F. Skinner were widely used to try and "cure" Autistic individuals of their "abnormal" behaviours.

1960s and 1970s Ole Ivar Løvaas developed applied behaviour analysis (ABA), an intensive behavioural intervention that involved punishing Autistic behaviours and rewarding "normal" neurotypical behaviours. This approach has been criticised for being overly punitive and harmful to Autistic individuals.

1970s and 1980s Psychoanalysis was the treatment of choice during the 1970s and 1980s but has since been considered ineffective and is refuted in many parts of the world (Ghaziuddin et al., 2002).

1980 Autism was added to the Diagnostic and Statistical Manual published by the American Psychiatric Association.

1980s The rise of early-intervention programmes led to the widespread use of ABA with very young Autistic children, often in restrictive settings. Many Autistic adults who underwent these interventions report experiencing significant trauma and abuse.

1981 Lorna Wing, UK, coined the term "Asperger's syndrome" having studied 34 clients using Asperger's concepts in an attempt to separate it from the general term of "autism" (Paxton and Estay, 2007).

1985 Baron-Cohen proposed the theory of mind hypothesis, suggesting that Autistic individuals lack the ability to understand the mental state of others (Baron-Cohen et al., 1985). Criticisms of the theory of mind hypothesis include its oversimplification of social cognition and its ignorance of the diversity of Autistic experiences.

1989 Frith proposed weak central coherence theory (Frith, 1989) suggesting that individuals with autism have difficulty seeing the "big picture" and instead focus on details. Criticisms of the weak central coherence theory include its pathologising of Autistic strengths and its ignorance of the context and motivation behind attention to detail.

Diagnosis, theories and treatment: what happened

1990s The concept of "evidence-based practice" led to a proliferation of interventions that claimed to be effective for autism, but many were not based on sound scientific evidence and did not benefit Autistic individuals.

1994 Bolton et al. (1994) studied the first evidence for genetic factors in Autistic Neuology.

1997 Dinah Murray and Wenn Lawson (Lawson, 2021) proposed the concept of "monotropism" to describe the way that Autistic people tend to focus intensely on a small number of interests or activities.

2000s The popularity of ABA and other behaviour modification techniques led to the development of "autism industry" businesses that promised to cure autism, often at great cost to families and with little or no benefit to Autistic individuals.

2001 The broken mirror theory of autism was introduced (Williams et al., 2001), suggesting that "autism" may be related to a dysfunction in mirror neurons, which are thought to play a role in social learning and imitation. This theory had a neuro-normative slant and sparked a lot more investigation into the function of mirror neurons in Autistic neurology. Most of these theories and studies into mirror neuron function in Autistic neurology were quickly dismissed and assessed as unlikely to add any significance to our understanding of Autistic neurology. The subject of mirror neurons has since fallen out of popularity.

2010s Autistic individuals and their allies have been speaking out against harmful interventions for years, but it wasn't until the twenty-tens that this critique gained wider recognition.

2012 Damian Milton proposed the concept of "double empathy" (Milton, 2012) to describe the idea that difficulties in communication and social interaction are a two-way street, with both Autistic and neurotypical people having their own unique ways of communicating, and problems arise from the mismatch between these communication styles.

2013 Erin Human created tendril theory (Human, 2013), which suggests that Autistic people have a different pattern of cognitive connectivity that may lead to strengths and challenges in different areas.

Diagnosis, theories and treatment: what happened

2013 The terms "Asperger's syndrome", "Rett syndrome", "PDD-NOS" and "childhood disintegrative disorder" were all removed from DSM-5 and now come under the umbrella term of "autism spectrum disorder", which cites three levels that clinicians use for guidance.

2014 Van de Cruys et al., 2014 proposed the predictive coding model of Autistic Neuology. The theory suggests that differences in predictive coding, or the brain's ability to make predictions about sensory information, is the core feature of Autistic neurology that leads to all other features.

2019 The Autistic Self Advocacy Network released a report detailing the harm caused by ABA and calling for an end to its use.

Diagnosis, theories and treatment: the impact

The harmful legacy of autism interventions has had a profound impact on the Autistic community, and many individuals are now working to reclaim their rights and advocate for more ethical and supportive approaches. Theories such as central coherence, theory of mind, and mirror-neuron have contributed to stigma, misunderstandings and harmful interventions, namely ABA therapy and other behavioural interventions that continue to marginalise Autistic voices and hinder progress towards more respectful and accurate understandings of Autistic neurology. It is crucial to centre the perspectives and experiences of Autistic individuals in research and theory development to challenge harmful misconceptions and promote a more inclusive society.

One of the most damaging effects of theory of mind has been the misconception that Autistic people lack empathy. This idea is not only incorrect, but it also contributes to harmful stereotypes and reinforces the idea that Autistic neurology is a disorder. Autistic individuals may experience and express empathy in different ways to neurotypical individuals, and many experience hyper empathy. It is essential to listen to and centre their voices to challenge harmful misconceptions and promote a more respectful and inclusive society.
The Autistic community has long criticised the use of the term "disorder" to refer to autism as it implies a negative or pathological condition that needs to be cured or fixed. Instead, they suggest using more respectful and inclusive language that centres on the individual's unique strengths and challenges.

Diagnosis, theories and treatment: the impact

The categorisation of Autistic people into mild, moderate or severe levels is also seen as arbitrary and subjective, and it fails to capture the diversity of Autistic experience. The term "profound autism" is also criticised as dehumanising and stigmatising, reducing individuals to their level of functioning rather than recognising their full humanity and potential, and not aligning with the principles of neurodiversity.

The Autistic community also criticises Asperger's syndrome. Autistic individuals argue that the distinction between Asperger's and autism is arbitrary and reinforces stereotypes of "high" and "low" functioning, and that the diagnostic criteria rely on subjective assessments of social communication that can be discriminatory. Advocates and researchers call for a more inclusive approach to diagnosis that recognises the diversity of Autistic experiences and challenges harmful stereotypes.

Critics of mirror-neuron theories point to their lack of evidence and ignorance of the complexity of social cognition in Autistic neurology, while Van de Cruys's predictive coding model has sparked new research into sensory processing and perception in Autistic neurology and inspired new ideas for supporting Autistic individuals. Murray's monotropism and Milton's double empathy, both Autistic-led theories, resonate with the experiences of Autistic people and have played an important role in promoting a more respectful and nuanced understanding of Autistic experiences, although they did not come to mainstream attention until later.

Autistic neurology in the media and research controversies: what happened

1960s Early studies suggested a genetic component to autism.

1988 The film Rain Man, which portrays a character with Autistic experience and extraordinary abilities, is released.

1990s First candidate gene studies are conducted.

1998 Tony Attwood published Asperger's Syndrome in 1998 and followed it up in 2008 with a second book, The Complete Guide to Asperger's Syndrome. Both books became the go-to reference textbooks for professionals and parents at the time.

2001 The first genome-wide scan for autism susceptibility genes was conducted.

2003 Mark Haddon's novel The Curious Incident of the Dog in the Night-time was published.

2004 In Ireland, the Education for Persons with Special Educational Needs (EPSEN) Act supported the rights of children to an educational assessment, an individual education plan and to an independent appeals process. It was also strongly acknowledged that many children were being identified in school as Autistic, but that many others continued not to have access to the supports they required.

2005 Autism Speaks, an autism advocacy organisation, was founded by Bob and Suzanne Wright, grandparents of an Autistic child. The organisation has had a problematic history and its actions are heavily criticised by the Autistic community.

2007 The Autism Genome Project was launched to identify common genetic variants associated with autism.

2014 The Simons Foundation announced the launch of the Simons Variation in Individuals Project to study genetic variations in individuals with autism.

2018 The Autism Innovative Medicine Studies-2-Trials (AIMS-2-TRIALS) were a series of clinical trials conducted by the European Union to investigate new treatments for autism. The trials aimed to test the effectiveness of drugs and behavioural interventions for Autistic neuology.

Autistic neurology in the media and research controversies: what happened

2021 The Spectrum 10K project was a research study that aimed to collect and analyse genetic and clinical data from 10,000 Autistic individuals and their families in the UK. The project was launched in 2021 and was set to continue until 2026. Its objective was to identify genetic variants associated with autism and to understand how these variants interact with environmental factors to cause autism. The project was led by Simon Baron-Cohen and involved collaboration with multiple research institutions and organisations. However, just weeks after the Spectrum 10K project was launched, it was put on pause because of a boycott led by the Autistic community.

Autistic neurology in the media and research controversies: the impact

The portrayal of Autistic neurology in media and entertainment has perpetuated harmful stereotypes about Autistic experience. Rain Man, for example, presents the stereotype that all Autistic individuals are savant or are emotionally detached. This misrepresentation has had a lasting negative impact on public understanding of Autistic experience. The same can be said for Mark Haddon's novel, The Curious Incident of the Dog in the Night-time, which portrays the protagonist as a stereotype of Autistic experience, exhibiting a lack of empathy, social skills and communication abilities. The novel also perpetuates the idea that Autistic experience is a tragedy that needs to be fixed or cured rather than a natural variation of human experience.

The Autistic community has criticised Autism Speaks' approach to advocacy, which emphasises finding a cure and portrays Autistic neurology as a disease. This has had a negative impact on society's understanding of Autistic individuals, perpetuating negative stereotypes and marginalising them further. Additionally, the organisation's lack of representation of Autistic individuals and funding priorities have limited society's knowledge of the diverse experiences of Autistic individuals. The use of dehumanising language that refers to Autistic people as "burdens" and "sufferers" and the stigmatising "Light It Up Blue" campaign and puzzle piece symbol are disrespectful and ableist.

Autistic neurology in the media and research controversies: the impact

In terms of research, both the Spectrum 10K project and AIMS-2-TRIALS have faced criticism from the Autistic community. An Autistic-led group boycotted the Spectrum 10K project over fears of potential misuse of genetic information and the lack of enough consultation with Autistic people. AIMS-2-TRIALS has been criticised by members of the Autistic community for its potential to perpetuate a deficit-based model and its potential to stigmatise Autistic culture further.. Autistic advocates are calling for greater transparency and collaboration in research and for a shift towards a more holistic understanding of Autistic experience that addresses social and environmental factors.

The overall message is that involving the Autistic community in research and advocacy is crucial for ethical and sensitive approaches. Perpetuating harmful stereotypes and promoting a deficit-based model of Autistic experience only further marginalises Autistic individuals and limits society's understanding of the diverse experiences of Autistic individuals.

The neurodiversity movement is gaining ground: what happened

1990s The neurodiversity movement emerged, led by Autistic advocates Jim Sinclair, Donna Williams and Harvey Blume. They emphasised the importance of recognising and celebrating neurological diversity and rejecting the idea that autism is a disease or a tragedy.

1990s Donna Williams, an Autistic author and advocate, wrote several books about her experiences, including Nobody Nowhere and Somebody Somewhere. Her work raised awareness of Autistic individuals' experiences and the need for more acceptance and support.

1991 Judy Singer coined the term "neurodiversity" to describe the idea that there is natural variation in the human brain and the range of differences in neurological functioning, including differences in cognition, behaviour and sensory processing. Neurodiversity emphasises that these differences are a normal and valuable part of human diversity rather than something that needs to be fixed or cured.

The neurodiversity movement is gaining ground: what happened

1992 Autistic pioneers Donna Williams, Jim Sinclair and Kathy Grant (then Kathy Lissner) met in person to discuss what led to the founding of Autism Network International (ANI), a network for Autistic people run by Autistic people (Sinclair, 2005).

1993 In Toronto in July at a joint conference run by the Autism Society of America and the Autism Society Canada, ANI had its own exhibition stand and a group of ANI members met for the first time and held a gathering in a hotel room for evening discussions among Autistic people. It was at this conference that ANI co-founder Jim Sinclair presented his legacy "Don't Mourn For Us" that directly challenged the ethos of the conference, which saw autism as a tragedy. `

1996 The first Autreat run by ANI was hosted in New York. Autreat was a retreat and conference hosted by ANI for Autistic people, designed by Autistic people. Autreat ran every year from 1996 to 2013, bar 2001. Autreat inspired similar retreats for and by Autistic people that continue to run today, such as Autsape in England and Projekt Empowerment in Sweden.

2000s The online Autistic community began to grow with blogs, forums and social media platforms allowing Autistic people to connect and organise.

2003 Christine Miserandino developed the spoon theory metaphor to describe the limited amount of energy that people with chronic illnesses or disabled people have available for daily activities.

2005 The first Autscape conference was held in the UK, providing a safe and supportive environment for Autistic people to come together and discuss issues and interests related to Autistic experience.

2005 The first Autistic Pride Day was held, celebrating Autistic identity and challenging negative stereotypes.

2005 Nick Walker wrote about the concept of "neurocosmopolitanism", which emphasises the importance of diversity and acceptance of different ways of thinking and being in the world.

2006 Ari Ne'eman co-founded the Autistic Self Advocacy Network (ASAN), which has since become a leading voice in the neurodiversity movement.

The neurodiversity movement is gaining ground: what happened

2010 The documentary film Wretches & Jabberers was released, featuring Autistic advocates Tracy Thresher and Larry Bissonnette, who travelled around the world to promote understanding and acceptance of Autistic Neurology.

2010 Ari Ne'eman, an Autistic self-advocate, was appointed to the National Council on Disability in the United States, becoming the first Autistic person to hold a presidential appointment.

2012 The Autistic Self Advocacy Network published Loud Hands: Autistic People, Speaking as part of The Loud Hands Project. The book is a collection of essays and artwork by Autistic people that celebrates neurodiversity and challenges the negative stereotypes and stigma surrounding Autistic neurology.

2014 AsIAm is established. It is now Ireland's Autism Charity.

2015 Steve Silberman published NeuroTribes: The Legacy of Autism and the Future of Neurodiversity, which became a pioneering publication in the neurodiversity movement.

2019 The Autistic Women and Nonbinary Network (AWN) launched the #AutisticWhileBlack campaign, highlighting the unique challenges faced by Autistic people of colour. Ausome Ireland ran Ireland's first Autistic-Led conference

2020 Thriving Autistic is founded in Ireland as a nonprofit social enterprise, becoming the world's first therapeutic support service for Autistic people led by Autistic professionals (therapists, psychologists, counsellors and coaches), with a global impact

2023 The Adult Autism Assessment Handbook: A Neurodiversity-Affirmative Approach (Hartman et al., 2023) was published. It is the world's first handbook on adult autism assessment for professionals. The government of Ireland is currently undertaking research on developing an Autism Innovation Strategy that will examine how Ireland can become a more inclusive society for Autistic people across all aspects of life. The Autism Innovation Strategy will seek to change the narrative around Autistic neurology in Ireland and move towards developing a society that is Neuro-Affirmative and person-centred with a rights-based approach involving the appreciation of difference.

The neurodiversity movement is gaining ground: the impact

The current state of neurodiversity and the Autistic community today is a mixed picture. On one hand, there has been progress in recognising and valuing Autistic neurology as an essential aspect of human diversity. Many advocates and organisations are pushing for a shift away from pathologising Autistic individuals and towards a more inclusive and accepting society. Fundamental theories of Autistic neurology, such as Autistic perception, monotropism and double empathy have become more recognised in the mainstream understanding of Autistic neurology. There is growing recognition that Autistic-led research is of utmost importance as it prioritises the perspectives and needs of the Autistic community and fosters a more inclusive and accessible approach to autism advocacy and research. In recent years there has been a greater emphasis on promoting the strengths and abilities of Autistic individuals and on creating more accommodating and accessible environments that allow them to thrive.

Many barriers still exist, though: stigma, discrimination and exclusion continue to be major issues for the Autistic community and other Neurodivergent individuals. Despite some progress there is still a significant lack of understanding and acceptance of Autistic neurology, particularly outside specialised communities. Many still view Autistic people and other Neurodivergent people as having a negative condition and something that needs to be fixed or cured rather than as having a different but valid neurotype that is a unique and valuable aspect of human diversity.

Autistic individuals continue to face significant challenges in accessing the support and accommodations they need to thrive. There are still significant gaps in services and resources for Autistic individuals, and many of the available resources may not be designed to meet their unique needs. This means there's a pressing need to continue advocating for the rights and well-being of Autistic individuals and to work towards a more inclusive and accommodating society that values and celebrates neurodiversity.

There is also the growing problem of neurodiversity-lite, which involves an inaccurate understanding of neurodiversity and a shallow acceptance of Neurodivergent differences, including Autistic neurology, without addressing the systemic issues and barriers that Neurodivergent individuals face. Often driven by profit-making motives, companies and individuals who exploit Neurodivergent individuals for financial gain, leading to harmful consequences such as promoting stereotypes and stigmatising those who don't fit the narrow definitions of neurodiversity-lite. This superficial approach to accepting neurodiversity does more harm than good as it impedes genuine progress towards creating an inclusive society for Neurodivergent individuals.

Myth: Poor parenting or “Refrigerator Mothers” cause people to become Autistic

Autistic people are born Autistic so parenting style is not a factor. There is no one scientifically proven reason why Autistic people are born Autistic.

Summary of Module 1

In Module 1, we delve into the concept of neurodiversity. A neurodiverse group comprises individuals with varying neurotypes, including neurotypical and Autistic persons, among otherwise Neurodivergent individuals. It's crucial to understand that while a group can be neurodiverse, an individual is not. The neurodiversity paradigm promotes both a more nuanced and rich understanding of the varied Autistic experiences, highlighting the many context-dependent strengths, challenges, and neutralities.

The world is primarily tailored for neurotypical needs, often overlooking the unique needs and abilities of Neurodivergent individuals. This oversight can lead to barriers in education, employment, social interaction, and other areas. Standard practices and environments often exclude or disadvantage those who are Neurodivergent, challenging the misconception that they have inherent deficits. While acknowledging that biological diversity can manifest as disability and it's imperative to respect and value the lives of those who are disabled.

Neuro-Affirmative practitioners recognise and value neurodivergence and take care to address their own internalised ableism while appreciating the diversity of cultural, racial, gender and sexual identities their clients embody. In a Neuro-Affirmative practice there is a focus on assuming competence and understanding each person with their unique differences, needs and strengths rather than making a judgement of deficits. Practitioners hold an LGBTQIA+ affirmative position and will use identity-first language, hold an anti-racist position, respectfully appreciate intersectionality in both themselves and their clients and appreciate the additional barriers to identification of Neurodivergence in Black, Brown, Indigenous and other minority communities. They will develop an appreciation of the additional harm and danger “unmasking” may pose to racially minoritised people.

The module compared the medical model of disability and the social model of disability with the neurodiversity paradigm, which assumes that there are no “normal” or “right” ways of being. Diversity in biology can lead to disability, as can societal and environmental design that favour neurotypical ways of being. The paradigm views neurodivergence as integral to someone’s identity in a similar way as personality, gender, ethnicity and culture does, and shows that Autistic neurology, the same as neurotypical neurology, should be celebrated as an integral part of human neurodiversity that is a natural and vital aspect of our population’s strength and diversity.

The paradigm asks that we adapt and develop society to embrace diversity and recognises the effect of being disabled by living in a world not designed for that neurodiversity, and being disabled in a world that often does not respect and value the lives of the disabled. Neurodivergence does not deny disability.

The prevalence of Autistic neurology nationally is considered to be approximately one person per twenty seven people although figures vary greatly from continent to continent. Traditionally more males than females were identified as Autistic; however, recent studies indicate that the statistics are skewed as females and non-cisgenders have been grossly underrepresented in the identification, assessment and diagnosis process.

This module looked at the history of Autistic neurology and the complicated and controversial development of the medical processes that leaned heavily on deficits, that has plagued (and continues to impact) the Autistic community. Professionals developed this stigmatising and damaging model of Autistic neurology, and the Autistic community has had to painstakingly unravel the untruths, myths and misunderstandings that have arisen from this systematic failure. Some movies and books further cast confusion upon the public's understanding of Autistic neurology and deepened the deficit perception. Slowly the Autistic community is reclaiming their power and shifting the narrative around how it is accepted and included in mainstream society through ensuring public and private services are Neuro-Affirmative. They are addressing the damaging terminology that permeates the medical reports and public perceptions and steadily casting off the cloak of confusion and misunderstanding about what Autistic neurology is and what it actually means to be Autistic.

Module 1
COMPLETE

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Module 2 – Common characteristics and common strengths and challenges for Autistic clients

Introduction

In this module we will examine the common characteristics of Autistic neurology and explore the sensory needs and differences that Autistic people usually experience. We will discuss Autistic perception and sensory cognition, the common challenges that present in therapy and how we can support Autistic clients when emotional management becomes overwhelming. We will look at the differences in Autistic communication and explore areas to consider to ensure you communicate effectively and equitably with clients.

Common Autistic characteristics

All Autistic people are different. Their life experiences are unique and the way they experience being Autistic is unique. It is important to understand the variety of communication preferences or ways of processing information that may impact how comfortable your client is when working with you. It's also important to understand some of the other potential challenges or differences that may impact Autistic people's lives and the ways that they engage with the therapy process.

There is as much diversity across the Autistic population as there is across the neurotypical population. Like everyone, Autistic people have their own strengths and challenges. Below is a list of characteristics that Autistic people may share, which may impact on how they engage with the therapeutic process.

Autistic sensory experiences

We tend to focus on just five senses:

Auditory (sound), Visual (sight) , Tactile (touch), Olfactory (smell), Gustatory (taste)

But all people encounter a range of sensory experiences:

- Vestibular/equilibrioception (balance)
- Proprioception (awareness of the body parts and the body in a space)
- Interoception (the dashboard of the body – hunger, thirst, temperature)
- Kinaesthesia (awareness of the position and movement of body parts)
- Nociception (the ability to recognise and feel pain)
- Chronoception (how we sense the passing of time)

Every experience we have is, in part, experienced through our sensory perception. Even something as seemingly simple as handwriting at a desk can involve a broad interaction of the senses. To write something down, your brain needs to integrate a huge amount of sensory information: to stay upright at your desk (proprioceptive and vestibular senses), to hold the pencil with an appropriate grasp using the appropriate force (tactile and proprioceptive senses), to create the letters appropriately with space where needed (visual and vestibular senses), to keep attending to the activity (vestibular and proprioceptive senses), to filter out sensory distractions (auditory, tactile, olfactory and visual senses).

Autistic brains have a different mechanism of creating perception compared to neurotypical brains, and Autistic people's sensory perception functions in a different way to neurotypical people's sensory perception. Autistic brains often use detailed or "non-task" related sensory information that neurotypical brains usually ignore or do not even register to learn and expand their rich and complex understanding of the world. Autistic people may experience hyper- or hyposensitivity to sensory input when compared to neurotypical people. Many can experience a mixture of both as well as seeking out different sensory experiences and having different sensory preferences to neurotypicals.

Hypersensitivity

A person who is hypersensitive may experience an increased perception of and reaction to their sensory environment in one or more of their senses as compared to those who don't experience hypersensitivity. They may notice sensory information that others do not. This can be a source of immense joy when hypersensitivity is experienced in the right context for them, but at times their senses can feel overloaded, causing anxiety and even physical pain in the wrong context. Sensory overload is distressing and can lead to meltdowns, shutdowns or a need to escape a sensory unfriendly situation.

“And I didn’t really understand what that’s like for them till I spoke to an Autistic person who said that certain woollen clothing for them was like wearing a jumper made of broken glass. So that’s what it felt like.”

School Deputy Principal

Hyposensitivity

A person who is hyposensitive may experience a decreased perception of and a decreased reaction to sensory information in one or more of their senses as compared to those who don't experience hyposensitivity. They may not notice sensory information that others do and thus may seek out sensory information to stimulate their senses to get to their right balance. They may like to engage in activities where there are high amounts of sensory stimuli, like dancing in a crowd at a concert, going to a gym to lift weights or sleeping under a weighted blanket. They may find it easier to concentrate when moving. Some may bite their nails, pull their hair or engage in self-harm to try to regulate. They may frequently bump into things or bang doors due to a lack of awareness of the amount of pressure exerted. Some people who are hyposensitive may be less sensitive to pain. They may be less able to control balance or physical coordination as they are less able to sense their body's position. Some Autistic people who experience hyposensitivity may be more susceptible to physical injury. They may have difficulty sensing and attending to things in their environment as they aren't receiving enough sensory stimuli to draw their attention.

"My dad always gives out that I will break the couch from sitting down on it too hard or I'll shatter the glass in the door from banging it. A small push for me end up in the noise of a bang. Pressure is confusing for me. I do like it in other ways, though. I have a tyre swing and I love to sit outside and spin on it for ages looking up at the stars. I can spin for ages and it is joyfully calming. I don't get dizzy the way other people do. If I've had an overloading day, spinning at night can really help."

Kate, Autistic Adult

Everyone has their own balance when it comes to amounts of sensory stimuli that feels right for them. Some Autistic individuals might be hypersensitive in many of their senses but also be sensory seekers in relation to specific stimuli. They may appear hyposensitive but actually be hypersensitive and enjoying certain sensory stimuli so much that they seek out more of it than most people or need more of certain stimuli (which may look like excess amounts to people who have less sensitive sensory systems) to be balanced and content. For example, one person could have hypersensitive hearing and vision while having hyposensitive proprioception and vestibular sense. Thus, this person may wear headphones and sunglasses but also seek movement, like to swing or pace, and like to wear heavy clothing to get that proprioceptive input.

It is important to note that what is termed hyposensitive and hypersensitive is only relevant when comparing to neurotypical experience. It is unclear whether Autistic people's senses are actually more or less sensitive than neurotypical senses. It may be the case that Autistic brains and nervous systems use sensory information in different ways and in different amounts as compared to neurotypical people (Vermeulen, 2022; Van de Cruys et al., 2014; Friston, 2010). As such, an Autistic person's senses may work in the same way as a non-autistic person's but how the sensory information is encoded and used to perceive may be different.

While it may be hard for people who do not experience these ways of perceiving and reacting to the sensory world to understand their impact, it is important to acknowledge that these different ways of perception have an immense effect on a person's experience in the world. Such sensory perception can be extremely enjoyable but can also cause real distress. Many Autistic people may feel forced to avoid or limit their engagement with everyday situations because of the sensory environments involved; however, in environments where the Autistic person has more control of the sensory stimuli or in an environment that has natural stimuli more suited to their system, an Autistic person can get immersed in beautiful flow states of sensory activities. Busy environments like schools, workplaces and shopping centres can be overwhelming for those who experience hypersensitivity, but quieter environments like therapy rooms may feel calmer for them. Conversely, calmer environments may present challenges for those who crave more sensory information to be able to process.

It is important to note that a space that appears quiet and calm to some people may not be experienced that way to another. For example, some people might notice small sounds like a fly in the room or even the crawling of insects. Others might find it difficult to listen if they have to sit on a scratchy surface or if they can hear the pipework from the toilet upstairs. They may be distracted by people walking outside or traffic passing by, while some people might not notice this at all or may be energised by it. Some people don't notice the buzz of a light bulb that is about to blow or the flicker of a fluorescent light. Some people may only notice the smell of a candle when it is burning,

while others may smell the lingering scent for days after it's been put out. Some people might experience this smell as lovely if they like the scent, while others might experience it as uncomfortable or painful if they don't. Some people may not be able to focus while sitting still and need to move around, others may not be able to focus if there is movement in their vision or if there are irregularities or clutter in front of them.

There is vast diversity in the experience of Autistic sensory perception across individuals. It can be a challenge but can also be a great benefit and can be investigated, understood and harnessed to support an Autistic person in a therapeutic process. It is important to explore each Autistic client's unique sensory perception and consider the effect this can have in a therapeutic setting.

Too often those seeking to support an Autistic person focus only on reducing sensory stimuli in an environment; however, it is important to understand that too little sensory stimuli can be just as problematic and can create as many barriers as too much sensory stimuli. What defines too much or too little will be different for each Autistic person. Balance is key, and understanding that each individual has a balance that is right for them. There is no one-size-fits-all but sensory needs and preferences can be explored during the therapy process.

"I love the sound of rain and car tyres over gravel. I love to paint with my hands and get stuck in thunderstorms. If I could live in a thunderstorm as a hand-painting artist, I'd be happy, but on my own maybe with one quiet person who could make a fire because I don't like other people. They change their tone a lot and never know they are doing it. I can't stand the crunching and the slurping of eating or the awful oohs and aahs of admiring outfits. It's thunderstorms and wolves and the quiet fire man for me."

Jody, Autistic Adult

Vestibular/equilibrioception (balance)

The vestibular system is located in the inner ear and helps regulate our balance and body control. It tells us about the movement, rotation and position of our head relative to gravity. It influences our posture, head and eye movement and breathing. Equilibrioception is the combination of several senses (visual, skeletal, vestibular and proprioception) working together to maintain the body's balance.

"I have no sense of balance and it varies from day-to-day. It can be as simple as tripping going up stairs, like missing a step or tripping on nothing on the floor."

Sarah, Autistic Adult

Proprioception

Proprioception is the ability to tell where parts of the body are in relation to each other. Some Autistic people struggle with hyposensitive proprioception and may appear distracted, uncoordinated or clumsy. For other Autistic people, this sense is as important to their well-being balance as air. It may have a huge impact on their energy, mood or emotions. They may require more proprioception than others do to get their right balance, such as needing to sit under a weighted blanket, wearing multiple layers of clothes or enjoying heavy bear hugs.

“My good days are days where I get my proprioceptive input. If I go swimming in the morning and feel that amazing sense of floating, which is both relaxing and energising. If I get my morning proprioception, even if I can’t swim, I try to lift some weights or walk in my bare feet, then my day is way better. I can concentrate better on work, and I feel good. My bosses know that too, and we make sure to schedule my working hours so I can swim before work because they know too that without my breakfast of proprioceptive input I won’t work half as well.”

Kate, Autistic Adult

Interoception

Interoception is the perception of sensations inside the body. Many Autistic people have a different perception of this internal sense compared to non-autistic people.

Interoception is like a messenger sense that relays messages from all the other senses. It regulates hunger and thirst, bodily functions and sensations. Interoception is at work when you get a headache because you haven’t had enough food or water. Some Autistic people can have hypersensitive or hyposensitive interoception. For example, someone with hypersensitive interoception may feel like they need to go to the bathroom a lot as even a slightly full bladder feels like too much. Someone with hyposensitive interoception may not notice if they are hungry or thirsty, so they may forget to eat or drink. They might get a headache but not realise that headache is indicating that they need food.

"It's quite annoying. My interoception is out of whack. I can't tell the difference between hungry and full. When I'm hungry I can't eat, but when I'm full all I want to do is eat."

Bridget, Autistic Adult

Differences with interoception can impact on a person's understanding of their emotions. While someone might be anxious, they may struggle to recognise if their heart is racing, their breathing is shallow or their muscles feel tense. Without feeling these sensations, it may be more difficult to identify an emotion as it's happening. A person with hypersensitivity might be extremely aware of their breathing and may find activities such as deep breathing or meditation uncomfortable or anxiety producing.

Kinaesthesia (awareness of the position and movement of body parts, can also be seen as a part of proprioception and vestibular)

Kinaesthesia is the cognizance of joint movements where mechanoreceptors act together to give sensory awareness of joint position, movement, acceleration and strain via afferent pathways to the central nervous system, which is essential for stabilising body posture and coordinating body movement and balanced positioning.

"When I was younger having a shower was like every droplet was pinching my skin and I would need time to recover as my skin was so sensitive. Baths are fine though, that feels nice."

Sarah Autistic Adult

Nociception (the ability to recognise and feel pain)

Nociception is the body's nervous system's process of recognising painful stimuli and converting pain to a molecular signal that triggers a defence response. Some people are hypersensitive to this process, which results in a lack of this response or a different response. An example is touching something very hot or very cold and not realising the effect on the skin.

Chronoception (how we sense the passing of time)

Chronoception is the sense and perception of time. The experience of excitement can increase levels of dopamine and time can appear to pass quickly, whereas boredom can decrease levels of dopamine and thus the perception of time is experienced at a slower pace. Some people have sharp internal chronoception that means they experience time quite close to the concept of time as we universally know it, while others may gauge the passing of time differently, and thus have difficulty apportioning appropriate time to tasks or work on different times to other people, resulting in missed deadlines or being too early/too late for scheduled events.

"I have no concept of time. Like, if someone said see you in thirty minutes, I wouldn't know how long that was. I would have to put an alarm on my phone to let me know and that can be overwhelming. I also can't understand the 24-hour clock."

Mary, Autistic Adult

When I make plans with my sister she always asks is this regular time or Pam time. I can go out to the shops, which are like ten minutes away but am not back for two hours. I couldn't tell you precisely what I've done but I've lost that time somewhere, pondering and thinking about life. I like having my time. It's sometimes tricky when things are due or with work, but I've got good at advocating and making adaptions at work, and they know too that if they let me work in my time instead of pushing me into their time, I will be way more productive because I won't be spending all this energy trying (and mostly failing) to change a natural part of me to fit with the world."

Pam, Autistic Adult

"I had to stop going to therapy as I was late on a few occasions and the therapist wasn't understanding that I find managing time difficult and this made me very anxious."

Sarah, Autistic Adult

Sensory needs

Physical space

Autistic sensory perception in an environment primarily designed for neurotypical perception can be a major barrier to someone when interacting within that space. Small adaptations that allow control of the sensory environment within the space for the diversity of the individuals who use that space are vital for accessibility and can make the interaction within the space more comfortable and allow for better focus. Uncertainty plays a role here too. Having a consistent space is important. While uncertainty cannot always be avoided, being aware of the sensory information that could be perceived in a space and collaborating with the user to make it a safe place for them is important.

Tips on creating sensory control in spaces

- Be aware of lighting. Lights with controllable levels are useful, and lamps or lights that can change the direction of the glare are advantageous. Avoid fluorescent lighting. Natural light sources can be beneficial but having a curtain or blind is useful to control the level of light. Avoid slatted white blinds because this can create a distorted optical movement for some people. Letting clients know they can turn off or change lighting at the start of the session is helpful.

- While sound isn't always something that can be controlled completely, and background noise will inevitably seep into your counselling space, there are steps you can take to manage this so that your client knows what to expect. Offering to have some background noise playing can help clients who find the quiet overwhelming and can help reduce unexpected noises from your surroundings. For those who don't want any background music, noise-cancelling headphones that block background noise but allow in conversational sound can help, or letting clients know about any expected sounds (like people leaving other rooms or school children walking past) will help them prepare for the disruption. Giving them a moment to regroup afterwards will help too. You could also install some sound-absorption panels to block out noise. These are quite easy to make yourself.

- Smell is another sense that can be easy to forget but can make a huge difference to an Autistic person's comfort. Perfume, deodorant, room scents, candles and diffusers all give out scents that can be overloading and distracting. While the longer a neurotypical spends around a scent the less they notice it, this is often not the case for an Autistic person because of differences in the mechanisms of Autistic perception and cognition. Mechanisms of habituation are also different. A smell that a neurotypical person has filtered out can remain as strong for an Autistic person every time they experience it. This can be both wonderful for scents an Autistic person enjoys but also problematic for scents they find overwhelming or unbearable; scents that others might not even be aware of.

- How you organise the room can make a difference, and again individuals will have different preferences as to what works for them. Having a choice of places for your client to sit so that they can choose to face the window or away from the window, for example, is helpful. Choosing if they wish to sit directly in front of you or at an angle will also help the client feel in control of their session and space. Clutter or busy patterns in artwork can have a big effect on ability to focus or overload. Texture and comfort of furniture needs to be considered too. Having rugs can be useful for those who prefer to sit on the ground. Rocking chairs can be suitable for those who find proprioception calming and/or energising, but having the option of stationary furniture is important too.

During your first session, talk about how your client can use the space and make it work for them. This will remove uncertainty around what is right and what isn't, as well as set up boundaries on how your sessions will work. Points might include whether it is okay to get up and move around the room during sessions. You can establish if they are welcome to touch and play or fidget with any items in the room or with any items they might bring themselves. You can explain if you are happy for them to adjust any settings in the room or if you would rather they ask if they want anything adjusted.

It's important to note that many Autistic people – and many neurotypical people, are unaware of the mechanisms of their sensory perception, sensory profile and its effects. They may need guidance to explore and understand their sensory profile and what adaptations can be made to contexts to make them more accessible for them. "Sensory" has become a buzzword that is often only associated with being Autistic or with challenges. Some Autistic people may think they don't have any sensory requirements, but it's important to remember that every human has a sensory system and sensory affects everyone every day. Day-to-day we take part in sensory activities to manage our well-being – whether drinking coffee in the morning, going for walks, cuddling our pets, going to the gym, working in places with natural light or sleeping in a dark, tidy and non-cluttered room. Sensory affects each of us every day; it's just many people are unaware of it. However, with support to develop sensory awareness and an understanding of their own sensory perception and what the optimum sensory balance means for them, such knowledge can harness your client's sensory awareness to help in times of challenges to improve their daily well-being.

Sensory overload

An Autistic person may experience an imbalance of sensory perception in all or some of their senses. For example, a hotel lobby or busy shopping centre may prove overpowering with the smell of food, loud talking, flashing display screens, background music, bright lights and lots of movement. A person's capacity to endure this sort of sensory environment may be impacted by numerous things such as their tiredness, energy levels, previous experiences and the people with them. Too much sensory information can cause anxiety, stress and, for some, physical pain. Sensory overload can result in shutdown, meltdown (see Module 2: Emotions and overwhelm), distressed behaviour or the need to withdraw from the situation.

For those supporting Autistic people, there are helpful steps to minimise the likelihood that an environment will create sensory overload:

- → Take time to pay attention to the sensory environment. What may cause difficulties? What can be removed or adapted to limit the overload and uncertainty?
- → Focus on internal states. Ask the person how they are feeling. Tiredness or anxiety will impact how they experience the sensory environment.
- → Focus on positive sensory experiences. What can be introduced to make the environment more comfortable?
- → Plan ahead. Ask the person about their sensory preferences and challenges. As much as possible adapt experiences and the environment in response.

"Sometimes when I get overloaded it feels like my heads a hot air balloon going higher and higher and higher, It feels like beetles are crawling about under my skin and every small touch is like activating the beetles to suddenly have a race and it feels awful but people don't usually understand what I mean when I try explain that"

Sarah Autistic Adult

Autistic Strengths: Autistic perception and sensory cognition

Autistic perceptual mechanisms and uncertainty

Autistic people have a distinctly different perceptual mechanism from neurotypical people. Human perception is not created simply by incoming external information through our senses. That is only one part. Our predictions about what we think we will perceive based on our past experiences and beliefs about the world also interact with incoming sensory information to create our individual perception.

Another part of the process is that when these two sources (raw sensory information and our predictions) are different, and they are always different because no two situations are ever precisely the same, it causes a surprise signal – and human brains do not like lots of surprises, so the brain has evolved to reduce the level of surprise and remain in balance.

Different brain types deal with these surprise signals in different ways:

- Neurotypicals tend to ignore a lot of the day-to-day surprises that indicate differences between what we think about the sensory environment and how it actually is in the present moment, and only pay attention to surprises they think will help them learn more about the world. This is an unconscious process – a default way their perceptual system works. Neurotypicals don't notice a lot of the uncertainty and surprise that exists in the world, which is useful for moving from task to task or being in sensory-intense environments because they can filter many of the surprises out, but on the flip side it means they miss out on rich and detailed learning.

- Autistic people's perceptual system works in a different way: Autistic people pay a lot more attention to many of those surprises and use them to create a rich, detailed and complex internal model of the world. The flip side of that means they are much more aware of all the uncertainty in the world and can find being in a sensory-intense environment with lots of surprises overloading.

It's important to remember that Autistic people are not more intolerant of uncertainty, just more aware of the uncertainty that exists in the world, which neurotypical brains ignore and do not perceive for the most part. The world and how society is built and run has primarily been designed for neurotypical not Autistic perception, and so the level of uncertainty is often not considered at a contextual or environmental design level because neurotypical people are unaware of it and this can make the environment highly inaccessible for the Autistic person.

“I find when I am talking to people in a crowd, it can be sometimes hard to concentrate on everything the person that I am talking to is saying, because I can also hear all the other conversations going on around me. I can feel the air as it moves around, the light and its shadows that move through the room. I pay attention to the dust particles by the window, the clink of cups and cutlery. I am absorbing it all while listening to one person. I am learning as much about all the details of my environment, how shadows can change a whole room, how light can impact others’ facial expressions, how sound is different if the room has a few people in it or is very crowded. I might sometimes miss in the moment all that the person is saying to me because there is so much going on, but my brain normally catches it, holds onto their words and I generally find I have the perfect response later (when it’s too late) to whatever they have said when I’m back in my environment and my mind can finally process the rest.

Autistic Adult

Reducing uncertainty and understanding stimming

Neurotypical people and Autistic people have similar ways of reducing surprise, such as removing themselves from an overloading environment and designing their space to suit them, but much of the world is already designed for neurotypical perception so often it is Autistic people who experience challenges with environmental design and therefore it is left to Autistic people to make the changes.

Stimming is an essential self-regulation strategy that Autistic people use to counterbalance the dysregulation of excess surprise and reduce uncertainty. It helps keep their brain healthy and well-balanced. Neurotypical people also stim, but it is not as essential for neurotypical people as it is for Autistic people because neurotypical people have other methods related to their neurotypical perceptual mechanisms that regulate surprises, such as filtering out and not learning from certain surprises or thinking.

As well as being self-regulating and balancing for Autistic people, stimming can be a great means of joy and self-expression that celebrates Autistic culture. Autistic people stim in multiple ways and different types of stimming facilitates different needs. Stimming for Autistic people is an activity that functions with the same importance as eating, sleeping, exercising and breathing.

Some common stims include tapping or shaking your hand or foot, biting nails, chewing on something or fiddling with hair, jewellery or clothing, flapping hands, rocking, pacing or bouncing. Autistic people may use vocal stims by repeating words (echolalia), humming or squeaking.

"Stimming brings me so much joy, and my stims are quite versatile and so important to my well-being. I don't just stim when I'm overloaded in a way-too-much way, but also when I'm really excited. Stimming lets me express me best. Stims can calm me down and give me energy. They help when I'm nervous and when I'm happy. And my stims aren't always the same – sometimes I really need to jump around and hum, other times I just like my invisible stims like flicking paper on my fingers. I once went to a therapist who tried to help me by getting me to stop stimming, to look more normal or some rubbish like that. I told him that would be like me suggesting to him that he cut off one of his limbs to look more normal and fit it. Well, he did not last long."

Siún, Autistic Adult

Synesthesia

The National Autistic Society (2021) describes synesthesia as a passive involuntary sensation where the person experiences one or more sense through more than one sense. For example, they might hear something through their ears but also get a visual representation of that sound through their sight, or a person may smell numbers or taste a colour. There is a range of experience and intensity of synesthetic possibilities. Some people see letters in different colours, but the rest of their perception is unaffected, while others experience visuals when they hear all sounds. An individual can also have more than one type of synesthetic experience; they may feel tactile sensation in response to certain sounds and taste certain words.

Synesthesia can be a very positive and fulfilling experience and provides a unique way of experiencing the world. For many people it can also help with memory recall. Some research suggests that all babies are born as synesthetes but as the brain develops many lose their synasthesia ability (Maurer et al., 2013).

Ideasthesia

Ideasthesia is a similar experience to synesthesia but refers to an internal rather than external experience. Individuals with ideasthesia construct an internal version of the world with synesthetic features. Concepts evoke a perception-like sensory experience.

While synesthesia is related to the matching of two or more senses, ideasthesia is the matching of one non-sense element (cognition) with one or more sensory experience. An example of ideasthesia is that you could be experiencing emotional concepts in colours or shapes or both. For example, we associate blue with cold and red with hot. This is something we often learn to do. Ideasthesia, on the other hand, is often an involuntary occurrence. For example, a person with ideasthesia may know the mainstream association between red and hot, but their brain makes hot feel more like a purple lake of sludge that smells like gravy. They may categorise living beings into shapes or tones or systematic maps of dots; they may see relationships as string diagrams or blurred shapes as tense whereas spiky shapes are calming. Their sensory association might bear no resemblance to what we learn from society and the world, such as to associate blue with cold and red with hot. This can get confusing when working with emotions if feeling bright red means feeling relaxed and peaceful rather than the societal expectation of red being associated with feeling angry. Conversely, feeling yellow could mean feeling suicidal rather than yellow being happy.

"When I try to tell people about my experience of synesthesia and ideasthesia, they always jump in with, 'Oh, yeah, we all have that. You just speak your language, accept you as you. Of course everyone knows what feeling red today means,' but they never get it. It's like their need for me to be like them is a barrier for them appreciating my experience as different from theirs but just as valid. Suffice to say things always get quite confusing, and even though I always really try from the start it seems me being Autistic is always what they blame. It's really annoying."

Sam Autistic Adult

Monotropism

Monotropism is a theory of Autistic cognition developed by Dinah Murray (Murray, 2018). Neurotypical people tend to have polytropic focus, which means they have lots of different interests that are explored at a surface level and are engaged with in a fleeting way. Autistic people tend to have monotropic focus, which means they focus on a few intense interests at deep levels, exploring all the details and incorporating many of the surprises to build a rich and complex understanding. Monotropic focus can help regulate perceptual overload while also providing an enriching, joyful and beautiful experience. Such intense focus, however, can at times have an impact on allocating resources and attending to secondary tasks such as interruptions, awareness of time, bodily sensations of tiredness or hunger or planning tasks to do later.

Monotropism makes a lot of sense for Autistic people and it can help make sense of a lot of areas of an Autistic person life, For an in-depth understanding of Monotropism in particular in relation to mental health please visit https://monotropism.org/in-practice/ for a list of resource and information on monotropism.

Common presentations

Masking

Masking involves consciously or unconsciously hiding or controlling behaviours that make a person stand out as Autistic. Often these behaviours may be viewed as negative or inappropriate by neurotypical people. As well as hiding some of the natural ways they present, Autistic people may feel the need to perform other behaviours that are considered more neurotypical, such as forcing themselves to make eye contact or repress their stims or only talking about topics that interest their neurotypical peers and not talking about their own interests.

Masking, for some, is a social survival strategy that Autistic people may consciously or unconsciously engage in. Autistic people have differing experiences and reasons for engaging in masking. They may mask to keep themselves safe in social situations or they may feel social pressure to mask to be included. It may be something they consciously or unconsciously learnt as a child that has been reinforced as they have grown and now do not know how to stop doing. Masking can be experienced as a safety strategy for some Autistic people. While masking may be very stressful and energy draining, it may be viewed as preferable to feeling unsafe in environments that are not accepting. For others, their mask may feel alien and threatening – something they have no control over and something that makes them feel unsafe in environments when trapped under the mask.

"I feel my experience of masking was different to my other Autistic friends. For me it felt similar to how I've heard anorexia experience described as. Where there's two people – there is Ana, who is in control, and then the real person who has lost all control. Except for me it was that the mask had all the control and the real me had no control. I hated the mask so much."

Jessica K., Autistic Adult

For a personal account of an Autistic person's experience of masking, watch *When I grow up I want to be*, which is an experimental self-reflective artistic lived-experience account of Jessica K. Doyle's journey of growth from 11 years old to late twenties in finding a space in the world to be her authentic self and the battle she had with "the mask/fake Jess" to survive and thrive (Doyle, 2022).

Masking can take a huge toll on an individual. It requires an immense amount of resources to mask on a daily basis. It can make real connections difficult and can lead to decreased well-being and loneliness. Equally, constantly feeling a need to hide or being unable to live life, learn and grow within the world as your authentic self can negatively impact an individual's self-esteem as well as sense of self.

Knowing the toll that masking can take, professionals may feel driven to encourage their Autistic clients to stop masking, but it is important to remember that some Autistic people view masking as a safety mechanism, so suggesting that they move away from masking may feel unsafe. The process may need to begin with understanding and accepting their Autistic identity and finding more accepting social spaces where they can be themselves. A beneficial initial step may be to support someone to start recognising the circumstances in which they mask. Given the exhaustion associated with masking, it may also be helpful to support a client to budget their energy resources, ensuring that if they have to mask, they have time before and after to feel comfortable, build energy resources and regulate themselves. For others, being encouraged to stop masking can be frustrating if they feel they have no control over the mask or no choice in what the mask does or when it arrives. They may have no idea how to take back control from the mask.

For more general information on masking, see Autism and Masking: How and Why People Do It, and the Impact It Can Have by Sedgewick et al., 2021.

For more information on supporting clients to understand how masking impacts them personally, see *Unmasking Autism: Discovering the New Faces of Neurodiversity* (Price, 2022)

"Masking almost destroyed me. I was exhausted at the end of every working day, masking my anxiety and creating a false version of myself just to try and fit in with my colleagues."

Autistic Adult

Aphantasia

Aphantasia is the inability to generate visual images in the brain. People who experience aphantasia may not be able to create visual imagery cues in their mind's eye. Imagination is thus created in concepts and words instead of images or pictures.

Therapeutically, people with aphantasic minds may move past trauma quicker than others as they do not have the image replaying in their minds, and therapeutic practices that rely on visual imaging may not work with the aphantasic mind.

Zimmer (2021) contends that the mind's eye acts as an emotional amplifier, strengthening both the positive and negative feelings produced by our experiences. People who experience aphantasia can have strong feelings from their experiences, but they don't amplify them later through mental imagery.

Aphantasia is not just a feature of the sense of sight. Some aphantasic brains may not have the ability to recall the air of a song or replay a piece of music in their mind. Conversely, people whose brains create extremely vivid images are known to have hyperphantasia.

Face blindness (prosopagnosia)

Face blindness is a difficulty or inability to recognise familiar faces. Many people with face blindness (or prosopagnosia) are unable to recognise family members, partners or friends. Research suggests that over 35 per cent of Autistic people without an intellectual disability experience prosopagnosia as compared to around 2 per cent of the general population (Minio-Paluello et al., 2020).

People who experience face blindness may cope by using alternative strategies to recognise people, such as remembering the way they walk or their hairstyle, voice or clothing. They may also depend strongly on the context in which they usually see people to predict whom a person might be. However, these types of strategies do not always work – when a person with face blindness meets someone in an unfamiliar location, for example. For some, face blindness can cause anxiety that impacts on personal and workplace relationships.

Alexithymia

Alexithymia is a difficulty understanding and describing your own emotions. Research suggests that between 65 and 85 per cent of Autistic people may struggle with alexithymia (Bird and Cook, 2013; Brewer et al., 2015; Kinnaird et al., 2019).

Alexithymia can make it more difficult for some Autistic people to be aware of and regulate their emotions. For example, someone who does not struggle with alexithymia may expect to feel anxious in a stressful situation and they may recognise physical cues such as sweating hands or a sore stomach as signs that they are anxious. This expectation and being able to recognise the physical indicators of anxiety flags anxiety early and helps the person manage their anxiety before it gets worse. An Autistic person with alexithymia may find it harder to regulate their feelings or identify physical indicators. They may also push them away, which can make things worse. Some Autistic people may struggle to show or feel emotions that are seen as neurotypically socially appropriate, such as happiness on a joyous occasion.

Misidentification of alexithymia can happen when Autistic people describe their emotions and how they are feeling in vastly different ways to neurotypical people. And the issue in fact is that others don't understand how the person communicates about their emotions rather than the person not understanding their emotions. This can particularly be an issue for Autistic individuals who also have synesthesia, ideasthesia or aphantasia (see above).

"It's taken me awhile to understand that that hot clammy electric feeling I get is what other call happiness which doesn't seem very descriptive at all and the hard metallic reflective itch I feel is what others call anger, again doesn't seem very descriptive because when the metallic turns green I think that's is what they call agitation. But when it turns orange it also agitation, I think, but a different type of agitation and others just don't seem to have a word for that, but I think the distinction is important because what helps the green metallic "agitation" is totally different to what helps orange metallic "agitation", so why would they have the same word?"

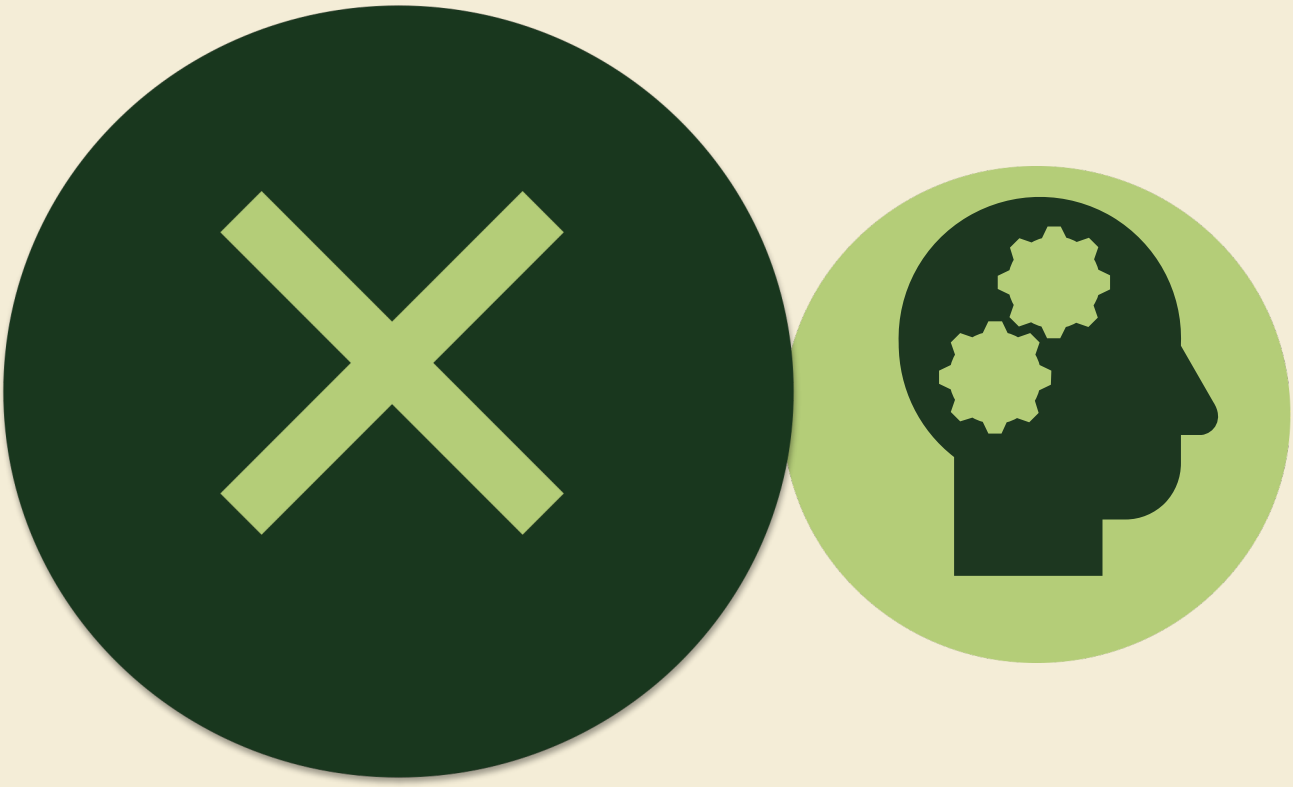
Autistic Adult

Persistent Drive for autonomy (formally Pathological Demand Avoidance)

These terms describe an overwhelming need to avoid and/or resist demands. This resistance is closely linked to anxiety and a drive for autonomy that can result in strong reactions from Autistic people of all ages. Autistic people may avoid demands to an extreme extent, even to their own detriment, including activities they enjoy. Similar to meltdowns, these reactions are often mistaken for tantrums or aggression.

Some Autistic people question if it is helpful to pathologies this behaviour. They suggest that for some, demand-avoidant responses make sense when someone is really struggling to cope with being in an environment where they have been denied autonomy.

Limited research has focused on Demand avoidance behaviour, and no agreed-upon definition remains; while no diagnostic criteria exist, some argue that there may be a Persistent Drive for Autonomy profile in which a person is driven to avoid everyday demands and expectations. Many autistic adults who experience this Persistent Drive for Autonomy highlight the extreme anxiety that often accompanies it. Research has yet to establish how many autistic people are impacted by this Persistent Drive for Autonomy. nor has it clarified whether it represents a stable trait or a situational state that may emerge in specific settings or times and diminish in others.



Emotions and overwhelm

Meltdowns/shutdowns

Some situations can be negatively stimulating. They could be challenging from a sensory and/or social perspective, and they may produce high levels of anxiety and dysregulation. In such a situation the reaction may be fight, flight, freeze or fawn. If the person cannot leave the situation, their options are fight, freeze or fawn.

Meltdowns may be understood as similar to the fight response because they are an externalised response to anxiety and the real pain that can be caused by sensory challenges. While in the meltdown state, the person may cause themselves injury or (more rarely) they may act out towards a person with them. For this reason it is important to reduce difficult sensory stimuli and support the individual through their meltdown (see Module 4 for ideas on how to do this). However it is worth nothing that meltdowns can accompany masking and become internalised, the person still experiences all the features of an externalised meltdown such as anxiety and pain and risk of self-injury, however all of this is felt internally and on the outside they seem calm.

For those experiencing hyposensitivity, a lack of sensory stimuli and boredom can result in overload that, with prolonged exposure, can lead to low mood, agitation, exhaustion and meltdowns.

Meltdowns are very different to “temper tantrums” in that they are a natural response that the person cannot control. They are physically tiring and emotionally draining for the person experiencing the meltdown. Even though they are a natural response to a build-up of difficult circumstances, the person may feel embarrassment and immense shame afterwards.

If meltdowns originate from the fight response, shutdowns originate from the freeze response. In a shutdown, an Autistic person may be so overwhelmed by a situation that they struggle to process what is happening and they may also struggle to communicate in their usual way.

Both meltdowns and shutdowns are often caused by an accumulation of events rather than one single negative event. For example, it may be that a person has slept poorly, is ill or lacking energy and/or missed lunch; their planned train may have been cancelled and they may have had to travel to an important meeting in an overcrowded, overheated train. This combination of sensory challenges, unpredictablity, anxiety and social expectation may build to create a meltdown or shutdown. However if one event is significant enough it can also cause a meltdown or shutdown.

Burnout

Autistic burnout is a period of intense emotional, physical and/or mental exhaustion. It is often accompanied by a loss of skills, which can impact relationships, employment and daily living. An Autistic person going through burnout may experience memory loss, difficulty with self-care, loss of executive functioning skills, physical illness, an inability to mask and loss of speech. They may more easily experience sensory overwhelm and meltdown.

Burnout can be caused by several life events and states, often in combination. For example:

- Stress and anxiety
- Long-term masking
- Sensory overstimulation
- Prolonged periods of uncertainty
- Change
- Life transitions (such as starting a new school/job, becoming a parent, moving house, ageing)
- Physical health challenges (such as lack of sleep, poor nutrition or dehydration, co-occurring conditions)

To address burnout it is necessary to take time off to recover. It can also be helpful for a person to reduce social interactions and general demands, create a comfortable sensory environment, engage in focused interests and give time to fully be themselves without a need for masking. Given the psychological and physical toll that masking can take on Autistic people, providing Neuro-Affirmative support that allows the person to be their authentic Autistic self can offer a positive route to overcoming burnout, while unsupported burnout can lead to or co-occur with depression or other psychiatric challenges (Raymaker et al., 2020).

Burnout is different from depression or other psychiatric challenges. It is a different experience with different causes and needs different responses. Some Autistic people who experience more hypersensitivity might need lots of time alone in a calm, low-sensory stimulus environment, while some Autistic people who experience more hyposensitivity may find sitting in a room on their own too much and may need to vent or monologue on what's going on for them in the moment before they are able to take time to recover. Engaging in this sort of live spoken processing can be misunderstood as mania or a personality disorder.

It's important to note that burnout may look a lot like depression to an outside observer with limited understanding of Autistic people's recovery needs. Research demonstrates that treating burnout as if it were depression can make burnout worse (Raymaker et al., 2020). The person may need a lot of time alone, in their room for example, without interacting socially, and this can easily be misunderstood as a warning sign of depression.

Communication differences

Double empathy

Autistic people experience the world, express themselves and interact in Autistic ways, which are different to neurotypical ways; however, these different ways of communicating can cause issues when Autistic and neurotypical people communicate with each other. They may often have differing values, expectations and ways of communicating. To some level, this mismatch in communication can be present when any two groups of differing cultures and experiences of the world are communicating together. Both groups can lack insight into the other's way of being and experience of the world.

A theory developed to explain this situation, which also relates to Autistic and neurotypical interaction, is the double empathy problem (Milton, 2012). This theory focuses on how we understand communication differences and difficulties between groups who are different, including Autistic and neurotypical people. The double empathy problem shows us that it is a shared problem: there is disconnect or mismatch and breakdown in mutual understanding on both sides that causes a problem for both.

Historically, however, the responsibility for this problem was placed solely on the Autistic person by neurotypicals. The problem was framed as Autistic people having "communication deficits" and the onus was put on the Autistic person to change their behaviour and interact in a neurotypical way. The double empathy problem highlights that neither Autistic nor neurotypical people are wrong or challenged in their communication. Rather, they are both simply communicating in a way that fits their experience, values and expectations, but they are communicating across two different cultures.

Increasingly, research is showing a clear mismatch in Autistic and neurotypical communication styles (Heasman and Gillespie, 2018; Sasson et al., 2017), and an ease in communication experienced when Autistic people communicate together (Crompton et al. 2020). Research also suggests that neurotypical people can show even less understanding and acceptance for Autistic ways of being by expecting Autistic people to radically adapt their communication style to meet neurotypical norms.

This could be a missed opportunity to see the challenge as a problem that requires collaboration to create a new mutual form of communication that validates both cultures. Successful social interaction requires the participation of two or more people. If an interaction between an Autistic and neurotypical person is challenging, both parties should acknowledge the challenge and take mutual responsibility for finding a new common way to communicate. These negative attitudes to Autistic communication can mean that Autistic people are left feeling judged, misunderstood and isolated if their communication style and culture is perceived as less valid by non-autistic family, peers, service providers and neurotypical society.

An example may be where a therapist is used to explaining theories and processes through metaphors, sayings or idioms which their Autistic client may misinterpret as they might prefer to use practical and factual terms. The therapist can adjust their vocabulary to stick to rational, practical language to maintain a flow in the session.

Autistic communication

Although the definition of what it means to be Autistic has changed over the years, differences in communication compared to neurotypicals have remained a core Autistic feature. Within the Autistic community there is a wide range of differences in how people can and prefer to communicate. This reflects both the variability that exists within the Autistic population and the complex nature of any type of communication, which can involve words, the order and tone that they are used; facial expressions; eye contact; gestures; and other nonverbal cues. **Some common differences in communicating may include:**

- Differences in responses to verbal communication compared to neurotypicals. Sometimes Autistic people may not respond or they may respond after a pause. As Autistic people tend to perceive significantly greater amounts of data within any interaction, it may take longer to process.

- Autistic people may experience eye contact as either unimportant, overwhelming, uncomfortable or excruciatingly painful. Alternatively, some may find it intensely enjoyable and like to stare at eyes.

- Nonverbal gestures (for example, nodding or gesturing with hands) may rarely be used or may be used very regularly or used in ways that differ from neurotypicals.

- Autistic people tend to prefer direct communication and explicit cues, whereas neurotypical social cues are often hidden or latent. This can be a source of confusion for both neurotypes. Non-autistic people may experience Autistic communication as blunt or rude, whereas Autistic people may experience non-autistic communication as manipulative, lies and confusing.

- Autistic people may process language literally, which can mean that metaphors or idiomatic language causes confusion for some.

- Autistic people may prefer to talk at length about topics of interest, experiencing an enjoyable sense of flow in doing so. Autistic people may talk and connect with each other in these threads of intense flow. Neurotypical people tend to prefer conversation that has more back-and-forth and doesn't go into so much detail.

- Some Autistic people may have difficulty recognising and communicating emotions (see alexithymia above) and some may express their emotions and feeling in vastly different ways to neurotypicals which can lead to miscommunication. .

- Autistic people may experience a disconnect between their words and body language. They may seem calm even though they are actually feeling distress. It's crucial not to rely on observation of body language and to listen to what the person is saying.

- Many Autistic people use non-spoken words to communicate either all or some of the time (intermittent speech). Sign language and AAC devices are methods of communication that must be equally respected to spoken words.

"Most therapeutic interventions offered to Autistic people ... place significant emphasis on the use of verbal speech and forms of communication viewed as atypical are discouraged. This denies Autistic people agency and ignores the specific importance of nonverbal or non-traditional communication in Autistic culture." (Submission to Autism Innovation Strategy, Government of Ireland – Department of Children, 2023).

Myth: Non-Speaking Autistic People Don't Understand Language And Cannot Speak For Themselves

Some Autistic people don't use words to communicate their thoughts. This does not mean they don't understand language. Many Autistic people have intermittent speech or are multimodal communicators, which means they may communicate their thoughts through text or sign language or images. Many non-speaking people (both Autistic and non-autistic) have a medical condition called apraxia of speech. This does not mean they don't understand language, just that they may not be able to access the muscles needed to vocalise words.

Preferred communication

Everyone has a preferred way to communicate, whether Autistic or not. While many neurotypical people favour verbal communication, Autistic people may favour a variety of forms such as speaking, writing, texting, drawing or using assisted communication devices. When stressed or overloaded or lacking in energy, some Autistic people may become less able to access speech in their communication and struggle to communicate their feelings and thoughts in spoken words.

Myth: Just Because She Isn't Speaking Doesn't Mean She Doesn't Have Anything To Say

Some Autistic people are non-speaking while others choose not to speak as a form of communication.

Myth: Autistic People Do Not Like To Be Touched

Some Autistic people prefer not to be touched, as do some neurotypical people. Always check with people in advance as to their comfort levels with touch, including handshakes.

Additional challenges navigating a neurotypically designed world

Autistic people can face unique barriers as they navigate a world that has largely not been built to include them. Understanding some of these elements can help you to better understand, affirm and support their Autistic experience.

Communicating

- Communicating about individual Autistic identity
- Talking about emotions
- Processing speed
- Executive function

Communicating about individual Autistic identity

Just as every Autistic person is different, every Autistic person will have a different relationship with being Autistic. This can depend on personality, the age of diagnosis, influence of parents and professionals, internalised ableism and any co-occurring conditions they might have, and the support they have been able to access through their life. When talking about Autistic neurology or experience, it is important to reflect the language of the person you are talking to, while avoiding reinforcing negativity around Autistic identity.

Medical language around Autistic experience can be quite negative with terms like "disorder", "deficit" and "co-morbid" being used as part of the diagnosis process. As mentioned earlier, many Autistic people prefer to be referred to as "Autistic" rather than "person with autism", and this move in language reflects the move in understanding Autistic experience as more than a neurological condition but integral to a person's identity, the way they experience themselves and the world around them. (See Jim Sinclair's 1993 essay "Don't mourn for us" for more information around this shift.)

"I remember the moment I realised I was Autistic so clearly. I was at work and clicked on an article about the lack of Autistic girls in further education that had appeared on the Twitter feed of the account I was managing – not because I was particularly interested in knowing where the Autistic girls were, but because I was bored and had finished my work and had learnt quickly that grown-ups didn't announce that they were finished without causing some confusion. But reading this article, everything changed. It was me they were describing, almost exactly. Parts of my life that I had never even put into thought, let alone words, were there written on the page, and as part of a description of a group of people – I wasn't alone."

Autistic Adult

This is not to say that every Autistic person feels positively about being Autistic. As discussed, the relationship is different for everyone, and this is why it is so important to reflect the language being used by the person while remaining positive. An example of this might be where a client is talking about how, because they have autism, they can't do anything well and feel isolated and hopeless. You can reflect their use of person-first language and refer to them as someone with autism (rather than an Autistic person) while being careful not to reinforce the idea that being Autistic is something negative that makes them "less than".

Myth: Autistic People Don't Or Can't Make Eye Contact

Autistic people have a variety of different experiences when it comes to eye contact. Autistic culture does not put the same emphasis on eye contact as neurotypical culture does. For Autistic people, eye contact does not hold the same status or necessity for communication or connection as it does for neurotypical people. Some Autistic people choose not to engage in eye contact for a variety of reasons. Some may not like it or may find it intimate and reserve it for people whom they feel comfortable with, while others might find it uncomfortable, overloading, distracting or even excruciatingly painful. Some Autistic people use eye contact in the same way as neurotypicals do, while others might pretend to do this but may actually be looking at the nose or the space between the eyes. Others will make eye contact regardless of feeling uncomfortable, and this could be because they feel pressure from neurotypical society to do this to be afforded the same opportunities or acceptance, or they want to avoid being misunderstood as rude due to a lack of understanding in the difference between Autistic and neurotypical cultural values. Other Autistic people may love making eye contact and might stare at people for longer amounts of time than neurotypical people tend to.

Talking about emotions

Some Autistic people have co-occurring alexithymia (see above). Alexithymia can make it difficult for someone to register the physical sensations that might be associated with emotions (such as a racing heart rate or a rush of adrenaline). It can make it difficult for people to regulate their emotions. If a person cannot recognise an emotion, they cannot become aware of it or simply make changes to ease it. Your Autistic client may need extra support to recognise, label and express their emotions.

Some Autistic people have synesthesia, ideasthesia or aphantasia and the way they perceive the world may be vastly different to others. People with synesthesia and ideasthesia may have a strong self-awareness and be sharply in tune with their emotions, but how they communicate their emotions may be vastly different to others, which can lead to miscommunication and issues with translation can result in a double empathy problem (see above), this can also be misidentified as Alexithymia People with aphantasia may experience challenges with activities that involve visualising emotions or concepts.

Processing speed

Autistic people tend to take in more of the details of an environment to learn about and expand their understanding of the world. When perceiving the whole picture, Autistic people tend to do this through building the whole picture from **all** of its details. This means processing a lot more information, which takes longer, and can be overloading in situations where there's a lot of information or distracting sensory stimuli. To a neurotypical person who is unaware or who is ignoring the details, this can look like Autistic people have a slower or delayed processing, but it often just takes Autistic people longer to process because they are perceiving and processing more information. And often environment are not set up to allow for this increased level of processing.

Executive function

Executive functioning is the cognitive process that helps us regulate, control and manage our thoughts and behaviours. These processes can impact what we pay attention to, how we remember things and how we use information to make plans. Given the different perceptual and monotropic experiences that Autistic people have in comparison to neurotypical people, it makes sense that elements of executive functioning may differ also.

This can impact the therapeutic experience in a number of ways:

- Differences in memory or attentional focus may mean that it is useful to send reminders for appointments and offer written or recorded session notes.
- Post-session "homework" tasks may be most useful if broken down into clear steps to accommodate different ways of planning. If questionnaires with likert scales are used it is important to let Autistic people know it's okay to make notes on answers or give more details when they feel they need to.
- If a client has patterns of executive functioning that differ from other clients, a therapist may need to actively work with them to establish the strategies and supports that might be most useful.
- If clients are working on challenges in therapy it is important for therapists to be aware of how elements of executive function may cause barriers in solutions.

"I went to therapy a while ago to try help with eating and how I see myself and the first thing they asked me to do was to keep a food/emotion diary where I was to write what I ate and how I felt every time I ate something, for a whole week. Well I lost the diary on the way home and I find it hard to remember to eat, never mind having to keep track of what I eat or how I feel. I tried for a day but I couldn't keep it up, I just didn't ever go back to see them cause it was all just too stressful"

Autistic Adult

Summary of Module 2

In collaborating with Autistic individuals, it's crucial to honour the vast diversity within this community, from communication preferences to sensory experiences. Neuro- Affirmative approaches delve deeper than the five senses, embracing unique sensitivities such as vestibular perception and proprioception. Sensory responsiveness among clients can vary and may fluctuate, impacting their comfort and engagement during interactions.

Autistic people often possess heightened awareness of environmental "surprises" or uncertainties, enriching their internal model of the world while potentially leading to sensory overload. A consistent, calming atmosphere can support sensory well-being and enable authentic connection. Self-regulatory actions, known as stimming, provide essential balance for sensory input and should be respected as valid coping mechanisms.

Many in the Autistic community exhibit monotropic focus – intense interest in specific subjects, which can offer a fulfilling, joyful experience and may be integrated into collaborative processes. The act of masking or suppressing Autistic characteristics can be emotionally draining; supportive exploration and understanding of Autistic identity can help alleviate this emotional burden.

Various cognitive experiences like aphantasia or alexithymia may also be present, affecting how individuals conceptualise and express their feelings and surroundings. Meltdowns and shutdowns represent natural coping mechanisms in response to overwhelming sensory or emotional environments and should be understood as distinct from neurotypical reactions.

Communication styles can range widely – from monologing, sign language, aac use to artistic expression, and all hold equal validity. Recognising the double-empathy problem, it's essential to acknowledge that both Autistic and neurotypical people have their own culturally informed communication styles. Neither approach is flawed; rather, they arise from unique perceptions and understandings of the world. Remaining flexible and open to diverse communication methods promotes genuine and effective collaboration.

MODULE 2
COMPLETE

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Module 3 – Understanding your Autistic Client and the lived experience of Autistic people

Introduction

In this module we outline the benefits of assessments and identification of Autistic neurology. We look at some co-occurring conditions and neurodivergences and how they might impact your client's mental and physical health. We explore the potential experiences that your client might be facing as they work through major life events so that you can gain a better understanding of your client's unique experiences and challenges. We also examine the possibilities around your client's previous experiences of counselling and finally we explore some of your client's possible intersectional identities.

"Prior to therapy, I didn't even know that there was a 'more true' version of myself, more authentic. I just didn't."

Autistic Adult

The benefits of Autistic assessment and identification

A person can be diagnosed and/or identify as Autistic at any time in their life. Some people are diagnosed in childhood, yet for others Autistic identification may not come until much later in life.

Adult assessment processes vary from person to person. Autistic assessment can be pursued publicly or privately; however, currently there is a lack of public routes for adult Autistic assessment. Due to financial factors, long waiting lists, misunderstanding, diagnostic overshadowing, misdiagnosis or even outdated ideas relating to Autistic neurology (such as gender), there are large numbers of Autistic adults who have never received a formal diagnosis.

Adult Autistic identification can sometimes be more complicated or can be overlooked due to learnt factors such as masking (see Module 2) or poor understanding of the diversity across the Autistic population. It is important to be aware that there is as much diversity across the Autistic population as there is across the neurotypical population. Many Autistic adults will discover they are Autistic by themselves or by connecting with the Autistic community rather than identification by a professional. Some Autistic adults may have no access to or choose not to seek out a formal assessment and are content with self-identification.

A variety of professionals can assess and conduct Autistic identification. These include a psychologist, psychiatrist, developmental paediatrician, a neurologist or a multidisciplinary team that consists of a number of different professionals working together.

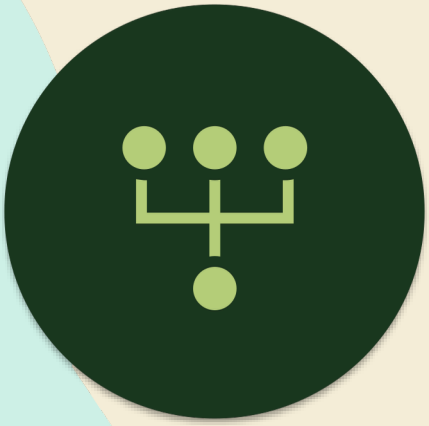
For adults, Autistic identity can be hugely beneficial. It can help make sense of so many things that in the past may not have made sense. Correct Autistic identification can help a person grow and become more self-aware. It can help a person understand themselves better and be a tool to help them navigate the world from their unique Autistic perception. Positive Autistic identification can also assist in gaining support such as reasonable accommodations in the workplace or university, accessing disability services and a disability allowance, supported housing and post-diagnostic support.

Many Autistic adults who are late identified may have experienced mental health challenges and barriers to accessing and communicating with psychological services. Many Autistic adults will have experienced trauma and/or have co-occurring mental health conditions or may have been misdiagnosed, for example borderline personality disorder, or they may have had their behaviour misinterpreted through a neurotypical (non-autistic/non-neurodivergent) lens, leading to frustration and adding to confusion about not being understood. Misdiagnosis can be a barrier to authentic Autistic growth. Being Autistic is not the same as having a mental illness, and poor understanding of this along with an uninformed approach in therapy can cause significant distress. With this in mind, an adult Autistic identification often comes as a relief.

Correct Autistic identification in adulthood can be extremely beneficial and illuminating because it can provide the opportunity for better understanding and more targeted and appropriately adapted mental health approaches.

"It's like you're constantly looking for an answer you don't know the question to ... When you get a diagnosis as an adult it's bizarre because everything and nothing changes at the same time. You're still you, but now you have the tools to understand who you are and how you work."

Autistic Adult, diagnosed at 27, AslAm, 2023



Diagnostic overshadowing

Diagnostic overshadowing is when Autistic identification is overlooked in the presence of other conditions or neurodivergence, or co-occurring conditions or other neurodivergence are overlooked in the presence of Autistic identity (Special Interest Group in Autism (SIGA), 2022).

For example, if a client is Autistic, then co-occurring neurodivergence, for example Adhd, bipolar, PTSD or an intellectual disability, may be left undiagnosed and untreated if clinicians assume that presentations or challenges are just due to being Autistic. Similarly, Autistic identification may be overlooked if a person is already identified as having a different co-occurring condition or neurodivergence.

The missed diagnosis of neurodivergence for females and non-cisgenders is particularly alarming as many females and non-cisgenders tend to mask their true identities through more complex methods than their male counterparts.

Clinicians, teachers, medics, family members and other support workers risk missing vital aspects of a person's needs by simply labelling all behaviours as "that's just their autism", and this can leave people without vital supports for other conditions that have some vital need fulfilments. Clinicians can use each presentation and emotional expression as an opportunity to explore the underlying need that drives the presentation to ensure nothing gets overshadowed.

Co-occurring conditions and neurodivergence

Some mental and physical health conditions are more commonly experienced by Autistic people compared to neurotypical people. It is important to consider what other conditions may be impacting a client's daily life or their ability to engage with therapy.

"When I was diagnosed as Autistic in my late thirties everyone said, 'Oh, are you sad because you've been misdiagnosed as bipolar all these years?' It's odd that people seem to have this idea that you can only have one or the other, not both, but I definitely have both, and my psychiatrist agrees. Knowing I'm Autistic really helps with managing my highs and lows too, and my mediation. My triggers are different to others with bipolar, like my sensory system really plays havoc with my hormones and dysregulates my meds and sends me into a spiral more than anything, so it's really helpful knowing I'm Autistic too but also knowing I'm bipolar. Being diagnosed Autistic doesn't necessarily cancel out all the other things. It can sometimes but not always."

Clara, Autistic Adult

Neurodivergence

What follows captures a brief overview of some of the co-occurring neurodivergences that Autistic people experience.

ADHD

ADHD, also referred to as AuDHD when coinciding with autism, is a form of neurodivergence focusing primarily on attention-related differences. Individuals with ADHD, or ADHDers, possess unique brain functioning compared to those without ADHD. This neurodivergence presents in various forms, including the inattentive type, hyperactive type, or a blend of both. ADHDers commonly experience sensory and perceptual differences similar to those observed in autistic individuals. The development of ADHD is significantly influenced by genetics, as it tends to be prevalent in families. Research has found that approximately 50–70% of autistic individuals are also ADHDers.

In adults, ADHD often results in a 'spiky profile', characterised by challenges in executive functioning skills like cooking, cleaning, self-care, and organising, paired with strengths in areas such as creativity, imagination, innovation, problem-solving, spontaneity, and sociability. ADHDers typically exhibit high compassion, a strong sense of fairness, resilience, and persistence—qualities they share with autistic neurology, developed from having to survive in a neurotypical world that often excludes Neurodivergence. (MacNamara, 2023).

A notable aspect of ADHD is its influence on time perception. ADHDers might lose track of time during hyper-focused states, excel under tight deadlines, or find it difficult to estimate the duration of tasks. Conforming to neurotypical standards can be a significant hurdle for ADHDers, impacting their ability to maintain focus, sit still during tasks, make eye contact while listening, and organise spaces in conventionally accepted manners.

Hyperfocus can alter their perception of time, enabling them to complete tasks rapidly but potentially leading to sleep deprivation, neglecting basic needs like eating or moving, or struggling to adhere to typical 9-5 work schedules. Daily activities can be challenging for ADHDers, often leading to exhaustion, burnout, and poor well-being. They frequently encounter stigma and misunderstanding from non-ADHDers, who may misjudge their behaviours as lack of effort or commitment. non-ADHDers may often struggle to understand the level of challenge that ADHDers can experience living in a world which is often designed to exclude their neurotype.

Traditional neurotypical work environments can pose challenges for ADHDers. However, they often excel in roles that capitalise on their creativity and adaptability, such as in freelance journalism, artistry, entrepreneurship, emergency services, or education. These fields benefit from the ADHDer's ability to perform well under pressure, engage in dynamic and unpredictable situations, and apply original thinking. The ADHD neurotype is often thought “to be designed to perform at their best in moments when others fall apart” (Doyle, 2020). It's important to note that with suitable adjustments, any workplace can become accessible for ADHDers.

For some, medications that regulate certain neurochemicals can be beneficial, helping align their functioning more closely with neurotypical standards and reducing disability. Available treatments include stimulant and non-stimulant medications, though obtaining them can be difficult without a diagnosis. Alternatively, some may find that medication interferes with their innate ADHD strengths, like creativity, and prefer activities which input to the proprioceptive system such as cardio, weight-lifting, swimming, playing sports, or manual work such as DIYing or construction, which in turn can regulate neurochemicals similar to medication. Customising these activities to accommodate individual ADHD needs is crucial, as managing the executive functioning requirements might be challenging.

"Being ADHD is challenging, especially in a society that stigmatises the neurotype. I was never the hyperactive child, but instead a constant daydreamer with drive to keep learning. These are all characteristics of ADHD, but the lack of understanding of how hyperactivity can be internalised as daydreaming meant I was not 'disruptive' enough in school to raise concerns. My drive to learn new things all the time meant I could sail through education with ease, until one day I couldn't. With no skills or support in place and no understanding of why I was suddenly struggling with motivation and procrastination in early adulthood, I burnt out quickly. I lost a job, would forget to pay bills, crashed two cars, and was a ball of unending stress. Realising I had ADHD gave me the ability to forgive myself and ask for help."

(MacNamara, 2023)

For individuals who are AuDHD there can be a conflict of traits, Autistic neurology may mean that routine is preferred, but being ADHD may mean that starting and maintaining routines is extremely difficult, but losing routines is very easy. Being Autistic may mean finding uncertainty overloading. But being ADHD may mean craving novelty. This can present as intense sensory seeking but easily overwhelmed. In the workplace or educational settings, this can present as craving structure and routine (Autistic) but then getting too bored to tolerate repetitive tasks (ADHD) or preferring newness and project-based work (ADHD) but also needing repetitive tasks to anchor themselves in a routine (Autistic). (Spectroomz, 2023) Autistic burnout can often result from trying to balance the opposing forces of ADHD and Autistic neurology for those with this combined neurotype (MacNamara, 2023).

"I'm Joey. My neurotype is AuDHD. I am an adrenaline junkie who will jump at sudden loud noises. I have a fight or flight response to emails but can get up and speak in front of a crowd of any size...inside my brain lives an incredibly social golden retriever that has had far too much sugar and a cat who really likes to be alone."

(MacNamara, 2023)

For a more in depth personal narrative of being Audhd see Joseph MacNamara's blog on "Being an AuDHD Oxymoron".

Dyslexia

According to the Dyslexia Association of Ireland, dyslexia is "a specific learning difficulty affecting the acquisition of fluent and accurate reading and spelling skills". This occurs despite access to appropriate learning opportunities. Dyslexia is characterised by cognitive difficulties in (1) phonological processing, (2) working memory, and (3) speed of retrieval of information from long-term memory. Dyslexic difficulties occur on a continuum from mild to severe and affect approximately 10 per cent of the population. Research suggests that roughly 1 in 7 Autistic people have co-occurring dyslexia (Hofvander et al., 2009).

Dyslexics may experience greater stress and frustration as they endeavour to learn, resulting in heightened anxiety, particularly in relation to literacy acquisition. Dyslexics may also have accompanying learning strengths. However, in some professions such as architecture, a dyslexic brain is sought after because dyslexic people often have superior visual and spatial reasoning skills (Eide and Eide, 2023).

Dyslexics, whilst facing greater stress and frustration in literacy acquisition due to their learning difficulties, may also exhibit notable learning strengths. These strengths are particularly evident in professions like architecture, where a dyslexic brain is highly valued for its superior visual and spatial reasoning skills. This unique cognitive profile, marked by enhanced abilities in areas such as visual perception, has been observed in their quick identification of complex visual patterns, such as 'impossible figures' in artworks. Despite the challenges associated with dyslexia, these individuals often possess heightened sensitivity to visual irregularities, offering them distinct advantages in certain fields, including science and medicine. This suggests that the challenges in dyslexia are accompanied by compensatory strengths, likely due to differences in brain structure or processing methods, emphasising the importance of diverse cognitive abilities in advancing society and scientific endeavours.

Dyspraxia

Dyspraxia, recognized as a neurodivergence, presents a unique set of strengths and challenges in adults. Approximately 6% of the general population is thought to have some form of dyspraxia, with a higher prevalence among autistic adults. Studies suggest that up to 50% of Autistic individuals may also experience features of dyspraxia (Kirby, 2019; American Psychiatric Association, 2013). Characteristically, individuals with dyspraxia often exhibit difficulties in coordination and fine motor skills, impacting everyday tasks such as writing or driving. They may also experience challenges in time management and organizational skills, leading to struggles in professional environments that demand strict adherence to schedules and detailed planning. However, dyspraxia is also associated with a myriad of strengths. Adults with dyspraxia frequently demonstrate exceptional creativity, problem-solving abilities, and innovative thinking. They are often adept at seeing the bigger picture and devising novel solutions to complex problems, skills that are highly valuable in many professional fields.

Additionally, their experiences navigating a world not designed for their neurotype can instill resilience, adaptability, and a unique perspective on overcoming obstacles. This blend of challenges and strengths highlights the diverse potential of Neurodivergent individuals in various aspects of adult life

Mental health

In the report *Aligning Disability Services with the United Nations Convention on the Rights of Persons with Disabilities* (2023) it was noted that international and Irish studies show that Autistic people have a higher overall prevalence of mental health problems, and it was noted at a public meeting on 4 November 2021 that it needs to be recognised that very few Autistic people do not have a co-occurring condition or other neurodivergence; many Autistic people have multiple co-occurring conditions and neurodivergence. Research has found that 70–80 per cent of Autistic individuals have mental health challenges (Lever and Geurts, 2016).

In Ireland, 63 per cent of Autistic adults cite symptoms of anxiety that would meet the threshold for a diagnosis of generalised anxiety disorder (GAD) with 65 per cent of the Autistic community experiencing depression. However, many Autistic people disagree with their co-occurring conditions, reflecting that health professionals can often confuse Autistic features with mental health conditions when they have poor understanding of Autistic neurology (Hartman et al., 2023.) often confusing features of Autistic burnout and the effect of Autistic masking with other mental health conditions. In a breakdown of genders within the Autistic community: 65 per cent of non-binary people, 53 per cent of cisgender males and 49 per cent of cisgender females will have suicidal ideation in their lifetimes (O'Connor, 2023).

Anxiety and OCD

Between 10 and 15 per cent of the neurotypical population have an anxiety disorder at some stage during their lives (Kessler et al., 2012), but research has shown that 40 per cent of Autistic people are thought to have at least one, and often more than one, anxiety disorder (van Steensel et al., 2011) with specific phobias and social anxiety most commonly diagnosed. Anxiety is not part of being Autistic; it is a co-occurring condition that can be identified, addressed and treated in its own right. Supporting an Autistic person to manage and decrease anxiety is an opportunity to significantly improve their quality of life.

For some Autistic people, anxiety may present in an atypical way (Kerns et al., 2014). For example, some Autistic people may have excessive worries about changes in routine or that they will be prevented from engaging in certain activities and behaviours (which are often self-regulatory). This may appear similar to obsessive compulsive disorder (OCD); however, OCD engagement with repetitive behaviours often functions to relieve anxiety short-term but in the long-term becomes a vicious circle.

Repetitive rituals brought on by OCD are often caused by intrusive and persistent unwanted thoughts, and the approach should be to support the person to reduce these behaviours in OCD. But for Autistic people, the purpose of repetitive behaviour is often self-regulating and is a natural and important Autistic expression that serves an important function of self-regulation and should be celebrated and accepted as an important part of Autistic culture.

Uncertainty

One potential cause of anxiety and mood dysregulation is the effect of experiencing excess uncertainty. It is important to note that uncertainty can come from too much or too little stimulus. Autistic perceptual mechanisms mean that Autistic people are more susceptible to experiencing excess uncertainty. This is sometimes incorrectly referred to as "intolerance of uncertainty", but it is not that Autistic people are more intolerant of uncertainty, just that they perceive more of the uncertainty that exists in the world. Much of this uncertainty doesn't register with or is ignored by neurotypical people. Most environmental design does not take account of this excess uncertainty because neurotypical people are unaware of it. For more on Autistic perception and the important role stimming plays in regulation, see Module 2.

Depression

Depression can affect anyone and the causes of depression for neurotypical people can also be causes for Autistic people.

They can include:

- a family history of depression
- experiencing difficult, stressful events
- experiencing trauma
- other mental or physical health conditions
- drugs, alcohol or medication.

Depression is not a natural part of Autistic neurology but rather depression often occurs as a result of an Autistic person feeling like they constantly have to adapt and change to somehow deal with a world that is designed only for neurotypical people.

Research has shown that masking (see Module 2) can be a significant factor in the development of depression (Sedgewick et al., 2021). Feeling that they are not accepted or that they are misunderstood can increase feelings of isolation and depression. Differences in understanding social interactions and relationships and lack of Autistic acceptance may also be linked to lower self-esteem, lower self-confidence, anxiety and depression. Difficulty recognising, managing and speaking about emotions (see alexithymia in Module 2) and also lack of appropriate services and supports available for Autistic adults may also increase the likelihood of depression because it may be from a lack of appropriate and timely support. Therapists (and society as a whole) should seek to address inequity for Autistic people in all aspects and elements of society, which will help to reduce the barriers that Autistic people face and thus lessen the prevalence of depression among the Autistic community.

Depression can also be linked to an increase in suicidal thoughts. Research shows that Autistic adults are much more likely to consider suicide than the general population (Hirvikoski et al., 2016; Autistica, 2016; Balfe and Tantam, 2010; Cassidy et al., 2014; Raja, 2014; Mayes, 2013).

Eating disorders and disordered eating

The HSE define eating disorders as: "When you have an unhealthy attitude towards food. It can involve eating too much, eating too little, becoming obsessed with your weight and body shape."

Some of the main diagnosed eating disorders are:

- Anorexia nervosa – not eating enough, exercising too much, or both.
- Binge eating disorder (BED) – regularly eating a lot of food over a short period of time until a person is uncomfortably full.
- Bulimia – binge eating followed by being sick, taking laxatives or exercising to prevent weight gain.
- Avoidant restrictive food intake disorder (ARFID) – a person has a limited diet in terms of food types and quantity. AFRID is often linked to sensory differences.
- Other specified feeding or eating disorder (OSFED) – similar symptoms but not an exact match for a specific eating disorder.

Recent research further elucidates the challenges faced by Autistic individuals with eating disorders, particularly in Autistic women. While studies like those of Arcelus (2011) and Mandy and Tchanturia (2015) have highlighted the high prevalence of eating disorders among Autistic individuals, Schröder et al. (2023) emphasise that Autistic women often experience more complex eating disorders. They frequently do not benefit from conventional treatment modalities, partly due to specific Autistic characteristics like sensory sensitivities. This aligns with findings by Nielsen (2015) and Tchanturia et al. (2019), who reported that Autistic people experiencing anorexia face worse outcomes compared to neurotypical peers, including reduced recovery levels and more persistent challenges in mental health, social acceptance, and employment. This body of research underscores the need for tailored approaches in treatment and a deeper understanding of the unique experiences of Autistic individuals with eating disorders.

Why might Autistic people develop eating disorders?

Emerging research suggests that the causal factors typically associated with eating disorders, like fat phobia or the thin ideal, may be less present or significant for Autistic people who develop eating disorders. Assessments and treatments should be mindful of this.

More common reasons may include:

- Sensory differences related to food, including not recognising hunger or fullness – known as interoception (see Module 2).
- Routines and rules may be developed around eating or exercise that may then be difficult to change.
- Intense interests may focus on food, exercise or calorie counting.
- Anxiety levels may be managed through food restriction, bingeing, calorie counting or excessive exercise.
- In reaction to a world full of Uncertainty, a sense of control may be found through strictly managing food intake.
- There may be a very limited/restricted range of foods that the Autistic person is able to eat.

- Food may be used to manage emotions. Co-occurrence of alexithymia (see Module 2) may be a factor in making it more difficult for an Autistic person to register and recognise the emotions they are feeling.

- Starving oneself might be used to stop physical body changes or "growing up" occurring. A fear of change and uncertainty about getting older and wanting to remain like a child.

Autistic people experience a relationship with food that is different to neurotypical people, so while the reasons above are linked to specific eating disorders they also may be linked to disordered ways of eating in general. Sensory differences can mean that food textures, colours or smells can be unpalatable or addictive, and the broader sensory environment can impact the experience of eating. For example, adding the sensory experience of eating into an already busy sensory environment can lead to overwhelm. It can also be difficult for some Autistic people to register when they are hungry or satiated, which can lead to imbalanced eating patterns.

"I always have a craving for something I can't identify. It's like an uncomfortable fizzy feeling under my skin, I can sometimes get distracted in the day and I don't feel hunger like others and no one can explain to me what that hunger thing feels like. But I eat at night like a crazed animal, when there is no one around and nothing to distract from this unidentifiable unbearable craving, It's like sensory eating, I eat too much, too fast, I don't like food in my mouth and I don't like the sticky icky weight of food in my hands. So I eat quick and a lot. Hoping someday to quench this ache, this restlessness, this unbearable craving."

Jessica, Autistic Adult

Trauma

Post-traumatic stress disorder (PTSD) is a mental health condition that can affect anyone. It can develop after a single traumatic event or in response to repeated trauma. Complex post-traumatic stress disorder (C-PTSD) is caused by exposure to repeated traumas or long-term exposure. Research suggests that Autistic people are more likely to report symptoms of PTSD. Although research in the area is just emerging, rates of probable PTSD in Autistic people (32–45 per cent) are significantly higher than those in the general population (4–4.5 per cent) (Rumball et al., 2020; Rumball, 2021; Haruvi-Lamdan et al., 2020). This may be because Autistic people appear to be more likely to experience traumatic life events, in particular interpersonal trauma such as physical and sexual abuse and bullying (Brewin et al, 2000).

A study by the National Autistic Society in the UK (Rumball et al., 2020) found that some specific life events were reported as traumatic by Autistic people: social isolation, invalidation, gaslighting, bullying and harm from "authority figures".

Other sources of trauma may include:

- Abandonment by/loss of a loved one (for example a family member, partner, pet or support staff).
- Sensory experiences (for example prolonged periods of time spent in environments with excess uncertainty).
- Transitions and change (for example job/school transitions, housing changes, ageing changes, routine changes with the seasons, unpredictability in daily life).
- Social difficulties and confusion (for example difficulties interpreting neurotypical social cues, difficulties in neurotypical understanding Autistic social cues, misunderstandings and conflicts).
- Applied Behaviour Analysis (ABA)* and similar behavioural programs can cause trauma in autistic adults by prioritizing behavioural conformity, often at the expense of their emotional and psychological well-being, and by suppressing natural autistic behaviours, leading to long-term distress
- Events related to one's own mental health difficulties (for example medication induced loss of sense of control or altered perceptions, psychotic experiences or experiences with psychiatric services).
- Adverse childhood experiences such as financial hardship, mental illness or substance abuse within the family, institutionalisation.

→ Maltreatment due to social isolation, family stress, communication challenges, lack of Autistic Acceptance.

It's vitally important to note that trauma is "in the eye of the beholder", that is to say that what is considered traumatic may only be decided by the person experiencing it. It is not appropriate for others to determine if a person's experience has been traumatic or not. Also worth noting that the same experience may be traumatic for one person but isn't necessarily traumatic for another person.

*Many autistic adults express strong objections to "new" or "modern" Applied Behaviour Analysis (ABA) interventions, despite updates intended to make them more compassionate and person-centered. They argue that these programs still fundamentally focus on making Autistic individuals conform to neurotypical behaviours, often overlooking or undermining their natural communication styles and ways of being. Concerns also revolve around the potential psychological impact, where the emphasis on compliance and modification of inherently Autistic traits can lead to a loss of identity, increased anxiety, and emotional distress. This resistance is grounded in a desire for approaches that respect and affirm Autistic ways of experiencing the world, rather than attempting to change them.

Symptoms of PTSD:

Re-experiencing the event

Avoidance/emotional numbing

Hyperarousal

People experiencing complex PTSD encounter additional symptoms to the above list, including difficulties with emotional regulation, negative self-perception, challenges with relationships and maladaptive coping mechanisms.

Self-harm

Self-harm (or non-suicidal self-injury) is when a person inflicts deliberate pain and tissue damage on their body. There are lots of reasons why someone might self-harm, and research has shown that the reasons given by Autistic people are similar to the reasons given by neurotypical people:

- to regulate difficult feelings like agitation or numbness;
- to express or manage emotional distress;
- to feel a sense of control;
- to punish themselves;
- to relieve unbearable tension;
- to cry for help (this is not the same as attention-seeking);
- to distract from intrusive thoughts;
- in response to alexithymia;
- In response to sensory hyposensitivity or sensory seeking.

(Moseley et al., 2019)

Some Autistic people find it difficult to recognise, manage and express their emotions. This is known as alexithymia (see Module 2). Higher levels of alexithymia are linked to higher levels of self-harm in Autistic people (Moseley et al., 2019).

As with neurotypical people, self-harm may also be linked to bad experiences that are happening to a person currently or have happened in their past. Sometimes the reason is unknown.

Research has also found that many Autistic people who self-harm may not view self-injury as a problem in their lives. For some, it is viewed as a coping behaviour (Moseley et al., 2019). This highlights the variety in experiences and feelings across the community in relation to self-harm.

Research has shown that some Autistic adults who self-harm have no suicidal ideation and self-harm is not necessarily linked to a wish to die; however, research suggests it may be linked to a greater risk of suicide in future (Moseley et al., 2019). For this reason, a client who engages in self-harm should always be screened for suicidal ideation.

An HSE report (HSE, 2023) states that suicidality is exceptionally common in Autistic adults, occurring in 66 per cent of individuals, and citing increased risk factors of isolation, bullying (in-person and cyber), peer victimisation and abuse along with increased occurrences of co-occurring conditions such as anxiety, depression and Adhd.

Suicidality

Suicide rates are extremely high within the Autistic community. Research in the UK suggests that up to 11 per cent of people who die by suicide had evidence of elevated Autistic characteristics, indicating likely missed Autistic identification (Cassidy et al., 2022). Autistic people are substantially more likely to consider, attempt and die by suicide than other groups (Hirvikoski, 2016; Autistica, 2016; Balfe and Tantam, 2010; Cassidy et al. 2014; Raja, 2014; Mayes, 2013). Cassidy et al. (2014) found that the prevalence of suicidal thoughts among autistic individuals was 9 times higher than in the general population, with actual suicide attempts also being significantly higher. Further, Pelton et al. (2020) highlighted that autistic adults experience stronger feelings of perceived burden and thwarted belonging, along with more lifetime trauma than non-autistic individuals. This underlines the unique challenges faced by autistic adults and the need for mental health practitioners to be aware of these specific factors. In 2018, the National Institute for Health and Care Excellence (NICE) guidance on suicide prevention recognized Autistic people as being among those at highest risk (NICE, 2018). Autistic women are eight times more likely to attempt or die by suicide than neurotypical women (Hirvikoski, 2016; Autistica, 2016; Cassidy et al., 2014), and later-identified Autistic people are at far greater risk of suicide.

Recognising suicidality presentation in Autistic people/differences

Edey et al. (2016) contend that neurotypical people are frequently less accurate than Autistic people at interpreting the mental state of Autistic people, which often leads to misdiagnosis or underdiagnosis of suicidal ideation.

Neurotypical expectations around body language, tone of voice and facial expressions can be significantly different in Autistic people. How an Autistic person expresses distress may often not match how a neurotypical person expresses distress in terms of suicidality. Autistic expression when viewed from a neurotypical perspective may be missed, misinterpreted or underappreciated if they do not have accompanying sounds and presentations of distress that are more prevalent for neurotypical people.

According to Jager-Hyman et al. (2020) there are significant systemic and Autistic-specific barriers to accessing a range of health services generally, including mental health services, for Autistic adults. The report recommends that "all staff carrying out assessments on people with suicide related ideation and self-harm should receive training in understanding Autistic Neurology, awareness of the presentation of co-occurring psychiatric disorders, and how to best communicate with and support Autistic people who present with self-harm or suicidal ideation".

Myth: Being Autistic Is Just Another Psychiatric Disorder

An Autistic person belongs to the category of Neurodivergent because the way in which their brain perceives, thinks, feels, processes and interacts with the world is different to how neurotypical brains are connected or operate. They diverge and are different from the neurotypical. Being Autistic is not a psychiatric disorder. Both Autistic people and neurotypical people can have co-occurring psychiatric disorders but neither being Autistic nor being neurotypical is a psychiatric disorder; both are just different but equally valid types of human brains.

Physical conditions.

Neurodivergent people often face a range of challenges in obtaining appropriate support for physical conditions. Research has indicated that these challenges can result from communication challenges, misattributing physical health symptoms as a part of Neurodivergence, and a history of not being believed, which limits symptomatic reporting. (Donaghy et al., 2023) These challenges can be exacerbated by biased accusations of Fabricated or Induced Illness (FII). This bias can lead to genuine health concerns being overlooked or dismissed. Below are an example of some co-occurring physical conditions Autistic people can experience.

Epilepsy

Epilepsy is one of the most common neurological conditions. It is a brain disorder characterised by seizures that are brought on by excessive electrical activity in the brain. There are more than 40 different types of epilepsy, and it is more common in Autistic people than in the general population. Unlike the general population, symptoms in Autistic people are most likely to develop in adolescence. Epilepsy is more likely to occur if someone in the family is Autistic. Autistic neurology is also more likely in families that have cases of epilepsy.

Research shows a 12.1 per cent prevalence rate of epilepsy in Autistic people, with a higher prevalence in women and girls (Lukmanji et al., 2019; Strasser et al, 2018). While epilepsy itself is not a mental health condition, it may impact a person's mental health. They may be experiencing social isolation, lowered self-esteem, limitations on personal freedom and adapted plans for the future. In stressful times after multiple seizure episodes, mental health issues such as postictal psychosis can occur.

Ehlers-Danlos syndromes

Ehlers-Danlos syndromes (EDS) is a group of hereditary connective tissue disorders (HCTD) which include Hypermobile Ehlers-Danlos syndrome (hEDS). They are a result of heritable impairments in growth and repair of the connective tissues of the body. These include tissues such as ligaments, tendons, skin, bone and even blood and fatty tissue. Connective tissue acts as the glue that holds the body together. There is a small but growing body of evidence (and a large body of anecdotal evidence from the Autistic community) to suggest that Autistic neurology and EDS or hEDS have a significant overlap (Cederlöf et al., 2016; Kindgren et al., 2021).

Below is a small list of some of the common symptoms of EDS/hEDS:

- Joint hypermobility; loose, unstable and or painful joints that can dislocate easily. Nystagmus caused by loose eye sockets, joint pain and clicking joints,.
- Extreme tiredness;
- Skin differences either very thin and delicate to bruise or thick, velvety skin – often unlined. Varicose veins - swollen and enlarged veins, usually blue or dark purple
- Migraines, headaches,
- Digestive problems could occur when the muscles of your digestive system, that squeeze food through, weaken. This can result in the experiences such as heartburn, constipation, IBS and GORD/GERD and gastroparesis - where the stomach has difficulty emptying its contents into the small bowel, which can cause bloating and nausea
- Pelvic organ prolapse - where the organs inside the pelvis slip down from their normal position
- Dizziness and an increased heart rate after standing up, heart palpitations, a sensation of anxiety.

Severity of symptoms may vary over time for each person who has EDS. While all these symptoms are physical, they can greatly impact a person's daily mental health. Anxiety and depression are thought to affect up to 25 per cent of the general population who have a diagnosis of EDS (Hershenfeld et al., 2016). hEDs may present as either symptomtic or non-symtomatic and this can change overtime.

It can be very hard to get a diagnosis of EDS and in Ireland there are little treatment options, support or recognition. For further information and resource on hEDS and EDS connected to Neurodivergence see https://www.sedsconnective.org/.

Myth: Vaccines Cause People To Be Autistic.

A paper released in 1997 made a claim linking vaccines to Autism. This research has been completely discredited due to its serious procedural errors, undisclosed financial conflicts of interest and ethical violations. The author has had their medical licence revoked and the research removed from the records.

Life events

Relationships and sexual experiences

Some Autistic people may find developing relationships with neurotypical people challenging depending on their level of social confidence and the neurotypical person level of Autistic acceptance. At the dating stage, some Autistic people have a way of interacting that may not be perceived by others as being within neurotypical social-normative practices. They may find Autistic spaces easier to connect in and easier to communicate their needs and desires without judgement, but may sometimes not have access to such Autistic or otherwise Neurodivergent spaces.

Sensory perception can also have an impact. Autistic people with hypersensitivity can experience sexual encounters as being uncomfortable, painful or overwhelming. Others who are hyposensitive or are sensory seekers may find that neurotypical social-normative sexual experiences are not intense enough for them to experience sexual pleasure. Autistic people as well as all people can also have no desire for sexual pleasure and be asexual and/or aromantic.

Some Autistic people are highly sexualised and find comfort in expressing themselves through kink, BDSM (bondage, discipline or domination, submission or sadism and masochism), fetish and role-play as a form of escape from reality and a way to perform sexually while adopting an alter ego. According to Schöttle et al. (2017) Autistic people are often less inhibited by neurotypical social norms when it comes to sexual expression and can present with a higher prevalence of hypersexuality than neurotypical people.

Autistic people can experience enjoyment of sexual arousal that can be qualitatively different to neurotypical people. From a sensory perspective, Hartman et al. (2023) proposes that given Autistic people's ability to enter flow states, it is likely that with the right balance of sensory input, sexual experience can be a really positive experience for some Autistic people.

Autistic people are also more likely than neurotypical clients to enter polyamorous or other CNM (consensual non-monogamous) and long-distance relationships (Walsh and Stokes, 2022). They are also more likely to explore their sexuality and identity within the LGBTQIA+ community.

Hartman et al. (2023) note that Autistic people involved in polyamorous or other CNM relationships often face a lot of social stigma and are subjected to prejudice and judgement from healthcare professionals. What is usually missed are the depths of connection, intimacy and love that can be shared in polyamorous relationships.

Some Autistic individuals involved in kink and BDSM find enjoyment, connection and satisfaction. Autistic people may find safety in these spaces as there can be more of an element of predictability (role-plays, scripting, planning what will happen in advance) that may not be as present in other spaces. There can often be more control of sensory input, and it can meet the needs of those who have preference for intense or low levels of sensory input in a safe and consensual space. The rules and expectations of both parties are often set out and clear within a kink or BDSM relationship, which can be more accessible and comforting than in other relationships where a lot more of the information is left implied but not specifically said.

It's important to recognize that some autistic individuals may find the kink/BDSM scene appealing due to its clear rules and defined expectations between parties, offering a sense of comfort. Additionally, this environment allows them to explore experiences that align with their own optimum sensory balance, finding comfort and enjoyment in these unique sensory interactions. This attraction may not specifically stem from seeking out kink/BDSM elements but rather from the limited societal options for such clear communication and sensory experiences. The kink/BDSM scene might inadvertently become one of the few available spaces where autistic individuals can experience these aspects comfortably, due to a general lack of resources and opportunities in broader society.

Autistic individuals can experience discrimination and social stigma as a result of their sexual preferences (Hartman et al., 2023).

Pregnancy and parenting

Pregnancy brings with it a range of additional sensory experiences that can be immensely beautiful but also overwhelming for some Autistic parents. Interactions with healthcare professionals and navigating noisy, smelly, bright, busy medical environments can bring additional stressors. Some Autistic parents choose home births to avail of the additional privacy and control over the sensory and interpersonal environment. It’s important to note that childbirth has the potential to be an especially traumatic experience for unsupported parents working within a system ignorant to Autistic parents’ communication and sensory preferences.

Some Autistic parents seek out routine and work best when timings can be adhered to, and therefore may struggle with younger children who tend to be unpredictable and inadvertently cause routines and planned events to be thrown into turmoil through typical childhood events, accidents, illnesses and mischief. Autistic parents with sensory hypersensitivity to sound or smell may be challenged with the various smells and noises that come with the territory of parenting; however, Autistic parents may also draw upon strengths of attention to detail and problem-solving skills in resolving some of the more common parenting dilemmas.

One study highlighted the positive experiences of motherhood among nine Autistic women (Dugdale et al., 2021). The study revealed that these women found great joy and reward in being mothers, while also facing unique challenges that non-autistic mothers don't encounter. The participants emphasised the importance of self-care, self-acceptance, personal growth and strong bonds with their children, but some of their greatest challenges involved being misunderstood by others. One key finding of this study was the need for non-autistic professionals to have a better understanding of Autistic experience. This recognition can help address the often-negative consequences of insufficient support for Autistic parents.

Employment

Many workplace environments are usually set up to align with neurotypical people to the exclusion of Autistic people. Some moderate adaptations and accommodations are needed in the workplace to make them more accessible to Autistic people. The lack of understanding among employers for providing such accommodations has resulted in up to 80 per cent of Autistic people finding themselves unemployed or underemployed (AsIAm, 2023a). However, it is worth noting that unidentified Autistic adults are not counted in the above statistic, so it may be that including them could alter these results.

There is a lack of awareness and acceptance of Autistic people in many workplace settings. From a difficult and one-dimensional interview process to the sensory assault of busy office environments to expectations of constant social interaction to inflexible working hour arrangements – the odds are stacked against the Neurodivergent employee to equitably access and maintain employment.

Autistic employees can often be left unmotivated, unsupported and unrecognised because they may internalise the challenges in the workplace as being their fault, whereas the fault lies with employers who fail to offer the correct environment to help their Autistic employees reach their potential, which would benefit all parties. Camouflaging and masking can lead to burnout, illness and job loss.

According to Praslova (2021), "Like many neurodivergent people, I could not find an accurate reflection of myself in the media, in my workplace, or in the world at large. I lacked the language to defend myself from my internalised exclusion". Autistic people are regularly bullied, infantilised, portrayed as unemotional, exploited and underpaid in the workplace, despite being on average 140 per cent more productive than their neurotypical colleagues when matched with the correct type of employment. "You deserve better, and it is not disloyal to challenge or leave an abusive situation. That is you being loyal to the person who very much needs your allyship: yourself" (Praslova, 2021).

Therapists can encourage Autistic clients towards self-advocacy when seeking to bring a fair and balanced solution to their employment situation; to seek the appropriate accommodations, to seek appropriate recognition, meaningful work, accurate pay and appropriate responsibilities to gain equitable status in their field in line with their capabilities and qualifications.

Menopause

It is believed that Autistic people generally have a heightened sense of hormonal fluctuations.

Going through menopause can be difficult for everyone, Autistic or not, with individuals experiencing physiological and psychological changes during this time. Menopause symptoms can include increased anxiety and depression, hot flushes, mood swings, difficulty sleeping, problems with memory and concentration, and headaches and migraines.

Due to the physical and emotional assault on the body, menopause can result in some people being unable to access their usual coping mechanisms. Many Autistic people have had negative experiences with the healthcare system and struggle to access proper support. Because a lot of Autistic people already struggle with existing cognitive, social, emotional and sensory differences, the onset of menopause can exacerbate these problems, leaving them feeling intensely overwhelmed. The changes associated with menopause, such as a change in routine, changes in menstrual cycle, change in body, age related changes, changes in libido can be a source of immense distress for some Autistic people. In studies run by Rachel Moseley, some Autistic women put their Autistic diagnosis down to menopause because they struggled so much with the extra difficulties that it brought, that their ability to cope with life that had gotten them through 40 plus years no longer worked, and in seeking help they were diagnosed (Grebbin, 2022; Groenman, 2022; Moseley et al., 2020).

Death, grief and bereavement

Impact of bereavement

Someone dying can upset the routine and life of an Autistic person. At the very least, the people around them will be acting differently, both emotionally and in terms of routine – taking time off work to attend a funeral, for example. If the Autistic person was close to the deceased, then their absence can have a larger impact felt by them not being where they should, whether that's at a regular social event, at home or as part of their care.

There are also the social situations that come from bereavement and the lead up to it – hospital visits, funerals, visits to others also grieving, all of which adhere to a strict neurotypical social code that might be new, unknown, confusing and distressing to the Autistic person, as well as just the general stress that can go with neuortypical social interaction (NAS – UK, 2023a).

Experiencing grief

Autistic people may understand the concept of grief in a different way to neurotypical people and it can be difficult for some Autistic people to process the finality of it, while other Autistic people may seem unfazed by it. Autistic people may not show the same reactions to death as neurotypicals do, and this can affect them getting support if their communication around it is different and not understood.

This will impact how they experience grief, or if they do experience grief at that time. Grief can be delayed and triggered by something quite innocuous. Like with anyone who is grieving, don't assume that just because someone doesn't physically demonstrate the signs of grief you expect, they aren't feeling it. As a result of Autistic perception that requires more processing, it may be that an Autistic person might not start the grief process till other are nearing the end of their grieving process.

"When I was in school a friend of mine died quite suddenly, I remember there being lots of support for a few weeks afterwards but then all of a sudden that was it and we were just supposed to get back to work, it was like there was some agreed secret timeframe allowed to process and grieve his death, but I felt like I hadn't even started by the time that agreed time limit was up, I thought first there was something wrong with me that I didn't feel grief but it did come later, just there were no supports by that time"

Autistic Adult

Some Autistic people may have a unique way of processing their grief that may look different to a typical grief reaction. Anger, mistrust, increased dependence on others and an increase in visible Autistic traits are some of the ways that Autistic people might show their grief. For some, there is also concern that the way they appear to others doesn't match how they feel grief should look (for example, not crying at any point, wanting to be alone rather than surrounded by other people), and this can lead to anxiety around other people's opinions and concern over their own emotional state, especially for those not yet identified.

Autistic people can be very connected to animals, and a pet dying can be similarly if not more upsetting or traumatising than losing a human friend. This process can be even harder for Autistic people if other people who do not understand this connection, do not show the same amount of compassion and understanding for the Autistic person grieving for a lost animal (NAS – UK, 2023a).

Retirement and later years: ageing

There is a huge gap in research when it comes to understanding Autistic elders. Research into this area is nearly non-existent. What we know comes from lived-experience accounts, and what we know about the Autistic neurotype and neurotypical experience is that as Autistic people grow older and face retirement, they may have some concerns that make this transition particularly challenging for them.

1. **Social isolation**: Autistic individuals may find it difficult to make social connections, and when they retire they may lose the social interactions they had at work. This may lead to social isolation and loneliness, which can impact their mental health and well-being. Mason et al. (2019) found that normative outcomes connected with quality of life for neurotypical elders, such as socialisation and employment, may not have the same value for later year Autistic individuals.

2. **Sensory issues**: Autistic individuals may have sensory sensitivities that can make it challenging to adapt to changes in their environment. In retirement they may face new sensory challenges, such as spending more time at home. Home adaptations can bring new sensory benefits but also challenges that can be overwhelming. Downsizing or moving into retirement homes can be extremely distressing and even traumatising as there may be less individual control of the sensory environment and new routines and changes to adapt to.

3. **Body changes**: As all humans age our bodies change, Autistic people may find aspects of these changes distressing, such as loss of physical strength, loss of hair or greying of hair, changing skin.

4. **Anticipation of death:** Death for some Autistic people could be a source of uncertainty and distress whether death of self or death of friends and family and questions of what happens next.

5. **Routine disruption**: Many Autistic individuals thrive on routine and predictability. Retirement may disrupt their daily routine and they may struggle to adjust to the changes.

6. **Financial concerns**: Retirement can bring financial challenges, such as reduced income, reduced savings and increased healthcare costs. Individuals may have difficulty adjusting to a change in their financial situation.

7. **Healthcare needs**: Autistic individuals may have unique healthcare needs, such as access to support services for co-occurring conditions, and a change in income may affect their ability to access these supports.

8. **Lack of structure**: Work often provides structure and a sense of purpose for individuals. Retirement can mean the loss of that structure and purpose, which can be challenging for Autistic individuals who may struggle with changes in routine.

9. **Housing**: As Autistic individuals age, they may need to consider their housing needs, such as living in a more sensory-friendly environment with accommodations to support their unique needs.

It's important to note that every Autistic individual is unique, and their concerns and needs may vary.

Myth: Autistic People Don't Have A Sense Of Humour And Can't Understand Sarcasm.

Autistic people can be found on stage in stand-up comedy and some are comedic actors. Most Autistic people generally have a good sense of humour and most enjoy a joke and a laugh.

Understanding your Autistic client

Assumptions and appearances

As mentioned in Module 2, how your Autistic client experiences and expresses emotions might differ from what you are used to with other clients. This means that it can be harder for a neurotypical individual to "read" an Autistic person through their body language, tone and expression.

Stimming and self-regulation

The world can be a chaotic and unpredictable place for anyone, but even more so for Autistic people given the mechanisms of Autistic perception (see module 2). Autistic people may also be dealing with challenging and uncomfortable sensory experiences and difficulties in feeling understood and understanding communication from neurotypical people (see double empathy in Module 2). To manage this chaos, an Autistic person may prefer to have routines so that they know what is going to happen and in order to reduce uncertainty. Some may wear variations of the same outfit, take a very particular route to work or eat a restricted diet of foods that feel safe and comforting. Change in these routines can be difficult if they are being used to maintain calm and avoid anxiety.

Hyperfocusing on passions and engaging in monotropic focus can also be a beautiful, exciting and fulfilling way of focusing for Autistic people to reduce uncertainty and learn (see Module 2 and below, monotropism).

Autistic people may also repeat physical movements such as hand flapping, pacing, rocking, finger tapping or the repetitive use of an object such as clicking a pen or turning a switch on and off. This physical repetition is known as stimming and it is used to self-regulate when someone is feeling stressed, anxious, hyper or give needed input in times of boredom or depression. Many Autistic people also stim when feeling happy and it can be a way to express pure joy.

Stimming is a natural, healthy expression and should never be discouraged except in extreme cases when the person is harming themselves or others. This does not include stims which simply do not make sense to neurotypical people, are inconvenient or go against neuro-normative standards or expectations. In these cases the dangerous stims should be worked on respectfully with the person to help them to find a more healthy yet as reregulating stim to replace the dangerous stim. To read more about the function of stimming see Module 2, Autistic perception and sensory cognition.

Focused interests (monotropism)

Many Autistic people have highly focused, intense interests. They can be enduring and lifelong interests or they may change over time. Many members of the Autistc Community and Autistic researchers agree that this ability to hyperfocus is a core cognitive style of Autistic neurology (Murray et al., 2005). Like everyone, pursuing interests and passions can create a sense of happiness, well-being and joy.

Monotropism is the term used to describe such highly focused interests, and allows the Autistic person to feel a sense of stability in a polytropic world. According to Murray (2018), "Never pathologise 'special interests', and don't assume that Autistic interests are 'restricted'– there are plenty of ways to get us interested in new things, it's just that they mostly involve taking existing interests and building on them".

Many Autistic adults build careers from their passions and interests. When feeling anxious or uncomfortable, focusing on an interest can be a useful tool to restore balance.

"My interests and passions can be a fantastic way to help build a connection with the client. This is something that makes me happy to talk about and can act as both a comfort tool but also as an icebreaker."

Autistic Adult

Myth: All Autistic People Are Savants (Have Superior Intelligence).

Across the autistic population, there is as wide a variety of cognitive capabilities and academic skills, just as there is among neurotypical people. Autistic individuals collectively form a distribution of cognitive skills that is distinct yet comparable to the distribution seen in the neurotypical population. Both the Autistic population and the neurotypical population have a similar spread of cognitive abilities, with many individuals clustering around an average and fewer individuals at the extremes.

Connecting

All clients bring their own experiences and expectations to a therapy session, with their individual life events and motivations helping shape the therapeutic process. This applies to both neurotypical and Autistic clients. The Autistic community is as varied as any other community and a one-size-fits-all approach is never appropriate. There will likely be Autistic specific aspects of life that impact members of the Autistic community that neurotypical clients may not have brought to your therapy practice before. It is important to remain open to whatever the Autistic client brings to the therapy session, and to embrace new ideas, new circumstances, new situations and new experiences that the Autistic client may introduce a therapist to.

Cultural considerations for therapists working with Autistic clients

Clients from cultures that differ to the therapist's culture offer a rich opportunity to explore new and alternative philosophies and ways of operating. Clients may present with issues and concerns that are specific to their culture, beliefs or ethnicity, and therapists should inform themselves when dealing with cultural diversity. This includes the differences found in Autistic culture.

Different cultures have different levels of acceptance of Autistic neurology, and clients may be facing challenges from within their community that can be difficult and hurtful. Therapists can support their client through normalising Autistic neurology and building self-assurance in their client through acceptance and compassion techniques.

Involving a trusted friend, relative or advocate

Some Autistic clients may wish to involve an advocate in the therapeutic process. This is often a partner, friend or family member but could also include a professional advocate or a support worker from an adult autism service. Therapists should ensure that their client consents to the involvement as soon as this can be established.

The option for supportive assistance during therapy may come in the following forms:

1. To assist with arranging appointments. The therapist may need to let the chosen person know of days and times of appointments.

2. To assist with travel arrangements.

3. The chosen person may help the client adjust to the environment, assist with meeting someone new, act as a microphone (not a voice) for the client and relate the process of the therapeutic process to the client. They could stay for the initial meeting and then reduce the time of their presence as the client gets comfortable and confident to stay on their own. The advocate may, under certain circumstances, be required to remain for the full process.

Not all Autistic clients will require this additional support, and some may only require it for a while or may require it at different times throughout therapy. For some it will assist them to begin the process and without it they may not be able to attend. This can be discussed in pre-therapy preparations, and the therapist can check with the client throughout their time in therapy if they would like to adjust their supports. It is important to receive consent from the client before connecting with any other party, and to have clear understanding and boundaries as to what the client needs from this.

Autistic experiences with counselling

Engaging with counselling

There are many reasons why an Autistic person might be interested in counselling. They might have just gone through a traumatic experience and need support, they might be looking to learn coping skills for life in an often alienating environment and ways to help them navigate the world around them, or this might be a step they are taking to help make sense of their life so far. For many, being diagnosed as Autistic (especially if diagnosed as an adult) can take a while to sink in and leads to looking back over their life so far and reprocessing everything through this new lens of understanding.

"From the very beginning of sessions [it was] important for me to have explained kind of literally what was expected during the session; so there might be silences at points ... and how might they feel about that? Or the general way that it's going to work is that the client is going to be doing quite a bit of the talking and I will be asking questions to kind of deepen my understanding of where they're at; to be really quite explicit about literally what's going on in the session"

Participant, AMASE report, Hallett and Kerr, 2020

In this AMASE report there were a number of comments around the theme of welcoming, which respondents valued, and which helped them feel safer and better able to express themselves. These included the counsellor being "warm and inviting", "speaking in a soft, calm voice", "getting a sense that the counsellor wanted to help", "finding the counsellor caring and kind" and "feeling accepted and validated". These qualities or attitudes helped build trust and rapport, particularly in making the new situation of counselling less anxiety-inducing, but also in helping the client ask clarifying questions, advocate for themselves and mask less.

Clients want counsellors to check frequently around sensory needs and comfort levels during sessions, and to offer options around modalities to engage with. They may need counsellors to explore accommodations that clients may require in the counselling process and to identify, encourage or suggest other self-advocacy opportunities in their daily lives.

Previous experiences with counselling

"From the few years I have been involved with counsellors and therapists, many include 'Neuro-Affirmative approach' on their website, and list it as a specialisation, but in my experience it has not translated into an environment that actually listens to the autistic voice and supports their experience."
Autistic Adult

The AMASE report (Hallett and Kerr, 2020) found that 36 per cent of Autistic people surveyed said practitioners did not have enough understanding of Autistic Neurology and Autistic experience. Forty per cent felt there was nothing out there to help them: "I'm told that depression and anxiety is normal for me", "They always treat me like I'm a bit stressed ... I was suicidal", "As soon as I mentioned my autism diagnosis, I was kicked off the mental health waiting list".

Some late-diagnosed Autistic people might have experienced counselling or therapy before their diagnosis and so may have had a bad or even traumatic relationship with this.

"Late-diagnosed autistic adults can have had very negative experiences of health and other professional services over their lifetime for a variety of reasons. This can cause trepidation when engaging with another health professional."
Autistic Adult

Previous therapists may not have been Neuro-Affirmative and Autistic clients may be sceptical about entering a new therapy process. Module 4 outlines practical steps that therapists can do to ensure they operate in a Neuro-Affirmative manner. An open and frank discussion with a client at the start may help explore any concerns and reservations a client may have about beginning this process with a new therapist.

"I had intense CBT when I was at university for depression and social anxiety. This was before I knew that I was Autistic, or even particularly what autism was (other than Mark Haddon's version of it). Rather than helping, I just repeatedly didn't quite fit into the categories and examples and came away feeling a bit more broken each time. In the end I ended up just making up my GAD and PHQ scores to reflect a progress I felt that I should be making through the weeks."
Autistic Adult Client

"I've been in counselling for almost a year now. For me the most important part of finding a counsellor was to find someone who was flexible in approach and 'laid back'. I didn't want someone who would be focused on improving or fixing me, but just a space where I could talk, somewhere I felt safe and accepted and could put into words, thoughts and feelings that I didn't have words for."
Autistic Adult Client

Autistic clients may require therapists to be flexible in the therapy process. This can extend to the approaches and modalities employed, the need to set a regular time and day for sessions or to leave it flexible, the practicalities round the space and seating options, the structure of the sessions, the need to stim or pace during sessions, processing time for responses and clarity around therapy goals and expectations.

Some therapists may need to consider alternatives to talk therapies to facilitate emotional exploration and could offer options such as art, play therapy, music, writing, poetry, animation or story-making as options for therapeutic processing.

Therapists should work collaboratively with clients to create the best environment for a positive outcome in therapy. Therapists need to avoid engaging in any stereotyping of Autistic neurology based on limited knowledge and validate the lived experience of their clients.

"I need my therapist to be Neuro-Affirmative. I don't want to pay for the privilege of educating my therapist about autism."
Autistic Adult Client

Autistic clients particularly need therapists to be well versed in intersectional identities and co-occurring conditions so that they can approach each client in a unique and bespoke manner.

Some clients might find a one-hour session too long and may require options around shorter sessions and may also benefit from having options around in-person or video/audio alternatives on days that they may not be able to travel to sessions.

Barriers to accessing counselling

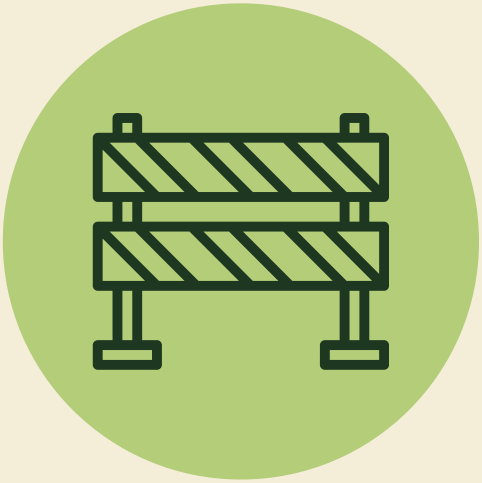
Autistic clients may find the prospect of therapy too stressful and may find the level of uncertainty a barrier to access.

A submission to the Autism Innovation Strategy from a disabled person organisation stated that "Most therapeutic interventions offered to Autistic people ... place significant emphasis on the use of verbal speech and forms of communication viewed as atypical are discouraged. This denies Autistic people agency and ignores the specific importance of non-spoken and non-traditional communication in Autistic culture" (Department of Children, Disability, Equality, Integration and Youth (2023)).

They may not be able to make the journey required or have access to the equipment required for teletherapy.

They may lack the funding/finances to access private counselling and may find the prospect of long waiting lists in the public system to be too anxiety-inducing.
They may lack the support of an advocate to find a therapist and they may feel disengaged to try due to the lack of resources available to find a Neuro-Affirmative therapist.

They may have had previously negative experiences of therapy and may have lost their confidence in therapy and the therapist being able to help them or understand them in a Neuro-Affirmative way.



Quality of life and emotional well-being

Historically a "good outcome" for an Autistic person has been to have a "normal" life. There is a risk for neurotypical professionals working with Autistic people of taking a colonising position in relation to Autistic people and their lives. Rober and Seltzer (2010) described how psychotherapy practices that were aimed at helping others can mirror colonial practices in that similar to particular colonial powers, known for robbing people of their natural resources, psychotherapy practices can rob Autistic people of confidence in their own strength and resources. This was done from a high-minded view of helping others (by liberating, protecting and educating) and was carried out by benevolent missionaries, teachers and social workers. Psychotherapy practice can mirror this by focusing too much on change, undermining a person's self-determination and focusing on particular ideas of what is normal or preferable in life. This can be done with positive intentions of care and help yet can also be harmful to people's lives (Rober and Seltzer, 2010).

From a neurotypical perspective, this idea of a normal life can mean having friends, living independently (alone or with a partner) and being employed or in higher education. Neurotypical professionals can then end up taking up a colonising position in relation to their Neurodivergent clients. Research has indicated that the level of support a person receives has not been found to correlate with quality of life, and the amount of perceived support and the discrepancy between needed and received support did not correlate with quality of life either. Khanna and Tosh (2014) and Vermeulen (2014a) argue that there has been too much of a focus on addressing perceived deficits when supporting Autistic people rather than how to improve emotional well-being and quality of life. As with the positive psychology movement, Vermeulen argues that instead of treating stress and mental health problems, there should be a focus upon improving emotional well-being. He has developed a questionnaire – the Good Feeling Questionnaire (Vermeulen, 2014b), and other methodologies for use with people with different communication preferences to explore positive emotional well-being for Autistic people.

The PERMA Model of Well-being developed by Martin Seligman has been applied to counter the focus on "deficits" and autism. The PERMA elements are: positive emotions, engagement, relationships, meaning and achievement (Seligman, 2018).

Positive emotions include experiences, people and things that elicit emotions such as joy, gratitude, pride, excitement and love among others. Questions to elicit information about positive emotions may include, "When do you feel proud/joyful?", "When have you felt most excitement?", "What were you doing?", "Who was there?" "Where were you?".

Engagement is the experience of being fully immersed in an activity and is often also described as "flow". This could be through cooking, baking, playing a video game, sport or monologuing on passions. Questions to elicit information relating to engagement may include, "When do you have a sense of being most engaged?", "Where were you?", "Who were you with?", "What were you doing?".

Relationships: Our wellbeing is closely tied to the quality of our relationships. Positive interactions with those around us foster feelings of being heard and supported, enhancing our happiness. Actively participating in these relationships by offering support in return also increases how positive emotions relate to the quality of relationships that a person has in their lives. Questions to elicit information relating to relationships may include, "How would you describe your relationships with other people?", "Which are your most important relationships, and why?"

Meaning relates to the sense a person has that their actions are worthwhile and of value. Questions to elicit this kind of information may include, "When have you had a sense of meaning in your life?", "Where were you?", "Who were you with?", "What were you doing?". This information could also be elicited through exploring values.

Achievement is the experience of setting goals and achieving them. Questions to elicit information relating to achievement may include, "When have you had a sense of achievement?", "What were you doing?", "Where were you?", "Who were you with?", "How did you go about this?".

This framework can be used for considering what can be explored and developed when working with Autistic people to move away from "treating" or addressing perceived deficits and building emotional well-being and quality of life from the perspective of the person. It can be used in tandem with approaches that focus on the person's own aspirations and strengths. This kind of focus can help professionals avoid taking up a coloniser position in working with their clients.

Strategies for building resilience and eliciting aspirations and strengths

Historically, the experience of being Autistic has been framed in relation to impairments and deficits. The language used when people discuss Autistic people still often reflects this lack of understanding – sometimes even when they are attempting to use a positive approach.

Spiky profile: It is important to remember that many Autistic people have "spiky profiles". This means they have significant strengths in some areas, but face significant challenges in others; they may struggle in some contexts but not in others. The risk in focusing upon strengths is missing out on particular challenges that may impact the person's life. For example, someone may perform very well academically, while finding it difficult to order a coffee in a busy canteen (Urbanowicz, 2019). From a neurodiversity point of view, all neurotypes have strengths and challenges in particular environments or situations: no neurotype has only strengths or only weaknesses.

Daily life: From a social perspective it is important to take into account that strengths and challenges depend upon the environment, context or culture the person is in. For example, if a person does not engage in social interactions typical to a particular situation, this does not necessarily make that person's way of responding a weakness. It is important to consider a person's particular strengths and abilities *and also* the particular contexts (physical, interpersonal and otherwise) that facilitate that person in making use of those strengths and abilities.

Savant skills: Some people associate Autistic experience with having an exceptional ability of some kind. Many Autistic people have talents, but as with the general population exceptional ability is rare. Around 10 per cent of Autistic people have these savant skills. There is a risk that Autistic people who have savant skills become defined by that particular skill. People may try to pressure them to "perform" their skill set and patronise them for their "amazing ability". They may be labelled as "inspiring" for their skill despite facing other challenges. A person who has savant skills must be respected for their whole being and not just for their unique skill.

It is important to have an awareness of stereotypes relating to Autistic experience, whether they are negative or positive. People may have strengths or weaknesses in areas that do not fit stereotypes.

Intersectional identities

Many Autistic people hold multiple marginalised identities. This can mean that they face further barriers to support and stigma based on the added identities they hold. Awareness of these identities and the lack of understanding that community members may have faced can help build a supportive relationship from the very start.

Gender

Autistic people are four times more likely to identify as gender-divergent in comparison to neurotypical people (George and Stokes, 2018; Twenge et al., 2017, Hisle-Gorman et al, 2019). It can be challenging to deal with a developing identity if unsupported and navigating narrow societal expectations. Research has found that Autistic people who identify as gender-divergent more often deal with severe mental health challenges as compared to Autistic people without gender diversity (George and Stokes, 2018). Access to gender-related supports may not be available to all Autistic people. Barriers such as inaccessible medical or psychological care, as well as stigma and a lack of understanding from familial and clinical supports may mean that community members are not given the support they need.

Therapists are encouraged to embark on some specific LGBTQIA+ training to address any personal conscious or unconscious bias that may exist and to be aware of all the elements of challenge that Autistic and LGBTQIA+ clients might present with. Therapists need to ensure that they address clients by their preferred pronouns and familiarise themselves with the services available to their trans clients, and remain abreast of the laws around gender identity. There is a lot of information on the Transgender Equality Network Ireland website (www.teni.ie).

According to Warrier et al (2019), Autistic transgender people regularly face discrimination, abuse and harassment. In many places their identity is questioned with little legal safeguarding of their rights. Anyone, regardless of their gender, who has faced such adversities is more likely to have poor mental health.

"A lot of us autistic people don't really fit in socially, and I think this extends to ideas around gender." Madge Woollard, Autistic pianist

(National Autistic Society, 2023c)

"The non-autistic world is governed by social and traditional expectations, but we may not notice these or fail to see them as important. This frees us up to connect more readily with our true gender." Dr Wenn Lawson, Autistic advocate, researcher and psychologist

(National Autistic Society, 2023c)

"Denying transgender and gender non-conforming autistic people the respect, dignity and equal access to services that they need can worsen the social marginalisation that many of them face. And it can have serious health impacts – and, sometimes, result in tragedy."

Autistic Self-Advocacy Network (ASAN)

Sexual identities

Studies focusing on Autistic people living in the Western world have found that relatively more Autistic adults report non-heterosexual identities and interest – this is particularly the case for Autistic women (Twenge et al., 2017). Autistic people are more likely to identify as sexually diverse (such as gay, lesbian, bisexual or asexual) as compared to neurotypical people (Twenge et al., 2017; Byers et al., 2013; George and Stokes, 2018). If not supported, these intersectional identities can be linked to personal challenges (such as feeling different), social dynamics (such as stigmatisation or exclusion) and a greater risk of mental health challenges.

Some Autistic people sometimes fear that their sexual identity will be dismissed as a phase or as a copying behaviour. It is important for therapists to accept the sexual identity of their clients without question, and everyone is entitled to identify with whatever sexuality they feel. Sexual orientation may not always be clear for a client, and they reserve the right to redefine their sexual identity with time, as each person goes through a period of discovery in their lives.

Autistic people who are closely connected to their family of origin may have additional challenges in relation to sexual identity expression, depending on the religious or cultural ethos of their family. Their therapist may provide the only safe place for them to openly discuss their sexual identity. They will need time to build trust prior to a disclosure outside of their faith or family systems.

Ethnic minorities

There is still a lack of research around the experiences of Autistic people from ethnic minorities. This, in turn, impacts on the availability of diagnostic services and broader supports. The National Autistic Society (2023b) found that five areas particularly impacted the experiences of Autistic people from minority cultures:

- Identification – levels of understanding around Autistic neurology may be lacking in particular ethnic communities, leading to a delay in seeking an assessment. Equally, school staff may not notice Autistic characteristics due to their assumptions about a child's behaviour or language abilities.
- Barriers to support – information relating to the diagnostic process and available supports is often available only in English and written using complex medical terms and professional jargon. This can make it difficult for people to access the information that may be most useful to them.
- Communication challenges – families don't always feel confident dealing with professionals who may lack cultural understanding. Others within minority communities may be suspicious of professionals if past personal or broader community experience has not been positive and supportive.
- Awareness and understanding – supports within an individual community may not always be available. Neurodivergent people may be stigmatised and blame may be placed on the parents (see Autistic history in Module 1 for how this misconception might have come about).
- Denial and isolation – some families believed that a Neurodivergent diagnosis should remain private and not be discussed outside the home. Some even refuse to acknowledge a diagnosis.

Each of these barriers may impact how an individual feels about themselves as well as the supports they may have accessed.

Some families may be reluctant to trust healthcare professionals outside of their culture. Some Western practices are unfamiliar to them and the terminology used may differ greatly from culture to culture. The processes, boundaries, assessments, waiting times, services, recommendations and job titles may be very different to what they are accustomed to and they may require support to navigate and understand the local system.

Therapists are encouraged to access training around diversity of cultures and religions to address any conscious or unconscious bias that may exist. It is prudent to be aware of the diversity of attitudes and levels of acceptance among the cultures and ethnicities of their clients. Clients (and their families) may experience racism as well as discrimination and marginalisation and these added aspects of challenge will inevitably present in the therapeutic process.

AslAm supports members of minority communities through its work on intersectionality (see references).

Autistic Travelling Community

Members of the Autistic Travelling Community face disadvantage and prejudice both from their status as an ethnic minority and from their neurotype being different to the predominant type. Their lived experience is qualitatively different from those in the settled neurotypical community. It's important to reflect on your own positionality as a practitioner and embody cultural humility when working with any intersectional community such as the Travelling Community (Gray and Donnelly, 2013; Minceir Beoir, 2021).

Members of the Travelling Community may face discrimination based on their ethnicity, as mentioned above, and may also struggle with challenges around embracing and accepting all their intersectional identities because they may face misunderstanding or lack of acceptance from within their own community and from society in general.

"As a Traveller mother who recently learned her son is autistic, what I would say to other Travellers who have autistic children is don't be ashamed, there is nothing to be ashamed of; talk about it with other Travellers because if we don't, how will they ever learn? Reach out to, and listen to, the autistic community ... The hardest part of our journey together is the fight for services, the lack of understanding and acceptance within my community and society in general ... It is vital that we as the Traveller community and the autistic community support the rising of the Traveller autistic voice as it is missing within both our communities at present ... I set up a blog with a plan of inviting autistic writers to educate us as a Traveller community; and a Facebook group with an Autistic activist friend, 'Travellers in solidarity with the autistic community', to support building relationships and bridges between our communities." Rose Marie Maughan, "The Rise of the Traveller Autistic Voice"

Maughan, 2019

Myth: Autistic People Are Oppositional

At times of extreme overwhelm, some Autistic people may experience what is known as "meltdowns", which it's important to know are outside the person's control. When in meltdown, some Autistic people might become oppositional in times of intense frustration; however, this is the exception rather than the rule.

Module 3 summary

In Module 3, the discovery of an Autistic identity in adults is framed as a significant and enlightening journey. It aids in understanding various life experiences and paves the way for self-awareness and individualised support approaches. Regrettably, many Autistic adults have not received formal recognition due to a variety of systemic issues, including outdated perceptions and diagnostic overshadowing.

It's important to note that co-occurring identities like Adhd, dyslexia and dyspraxia are prevalent among Autistic individuals. Additionally, this community faces higher mental health challenges with a spectrum of conditions ranging from depression to OCD to bipolar. Therapists must recognise that behaviours like stimming, which may resemble symptoms of other conditions, are crucial emotional regulation strategies for Autistic individuals.

Autistic individuals also experience a higher incidence of eating disorders, influenced by factors like sensory differences and interoception variations. Moreover, they may face distinct forms of trauma, including sensory-based traumas, social misunderstandings or disruptive life transitions.

Physical conditions like epilepsy and Ehlers-Danlos syndrome are more common among Autistic individuals. Personal experiences, whether in relationships, employment or life transitions like menopause, can differ significantly from neurotypical narratives, calling for a compassionate understanding. In employment, many Autistic individuals face workplace discrimination.

Grief, retirement and the later years bring unique challenges, and therapists should remain attuned to these individual experiences, respecting each person's coping strategies. When initially engaging with Autistic clients, therapists should create a welcoming environment, encouraging clients to self-regulate and communicate their needs. Some may find comfort in being accompanied by a trusted person in initial sessions.

It's crucial for therapists to respect cultural, religious, gender and ethnic identities, recognising the additional challenges clients might have faced before accessing therapy. The PERMA Model of Well-being offers a positive framework for understanding, emphasising strengths over challenges. Given that many Autistic individuals may also navigate other marginalised identities, therapists should actively challenge their biases and engage in continual learning to ensure an inclusive and understanding approach.

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Module 4 – The therapeutic process with an Autistic client

"I don't feel like I have had enough training in terms of understanding the lived experience of an Autistic client. Very little is covered in general counsellor training and each therapist is left to their own devices to skill-up in the area. This is unfair on the client and the therapist."

Psychotherapist

"Most therapists' understanding is based on the white male brain. They need to understand culture and gender differences."

Autistic Client

Introduction

The focus of this module is on the therapeutic process with an Autistic client. This process begins with the initial contact between the therapist and client – preparation for the initial sessions – and continues throughout the therapeutic engagement between the therapist and client. There are several areas for therapists to be mindful of as part of this process. This includes the physical space, the person's previous experience of therapy and therapists and the expectations for therapy. A key concept for therapists is collaboration and facilitating a collaborative relationship with Autistic clients.

"Learning about how my autistic self experienced the world opened a new version of the world to me. It hasn't 'fixed' anything – I don't want it to – but it has helped so much."

Autistic Adult

Before the initial session

It is important for therapists to begin thinking about the development of a collaborative therapeutic relationship from the initial contact with the client, even prior to the first session. This can include considering the best forms of contact, providing instructions for finding the location of the therapy session, preparation for an online session, communication options and payment. The level of preparation will differ from person to person. The detail and amount of attention necessary for each topic can be adapted depending on the person.

Prior to the initial session The therapist can begin setting the context for collaboration prior to meeting in-person
or online for the first time through email or phone contact depending on the person's preferred communication style (refer to Appendix A for an example of a letter). This contact can include providing some information of what to expect beforehand, i.e. directions to the location, a description of the therapy setting and the format of the initial meeting (including video and photos), as well as requesting important information for the initial meeting such as sensory aversions and preferences and communication preferences (refer to Appendix B for more on information that can be collected). Having a conversation about how they will be getting to the session can be helpful for some clients.

It can be beneficial to have a list of routine procedures for all clients (including neurotypical clients). This can include guidelines regarding phone calls, financial obligations, when to arrive for a session, options of where to wait if they are early (e.g. car, waiting room, coffee shop) and when and where to knock or ring the bell. Therapists can have a conversation with the person about the level of information they would find helpful. This could be discussed with the person or written down physically or in an online document depending on the person's preference (see sample in Appendix A). Changes and transitions can be challenging for some people and it is important for therapists to outline how changes could be managed. These procedures can take the guesswork out of therapy and could reduce the client's uncertainty. These key issues can be discussed and reviewed with clients as part of the ongoing collaborative process of therapy.

You could consider sending prospective clients a short video that may outline the physical space where the therapy will take place so that they have an idea of what to expect in advance of their first session (see Ryan, 2023).

Preparing for the initial session

On initial contact the therapist may ask the person if there are any sensory adaptations that may be required for the space or spaces the person will be accessing. This can be done verbally or with a written request for such information (see Appendix B). This information can then be used to adapt the environment for the person prior to their arrival. Clients may not have a full understanding of sensory adaptations they require; however, they may develop this awareness throughout the process of conversations about sensory adaptations and developing self-awareness and learning more about what makes an optimum sensory balance for them. Some people may benefit from a photo or video of the room prior to their arrival.

Key considerations

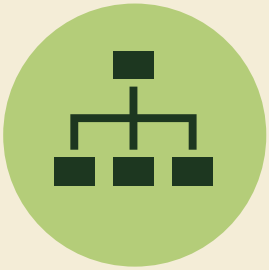
a) **Timekeeping:** Timekeeping may be a difficulty for both Autistic and neurotypical clients, particularly for the first session because they will not be familiar with the location. For face-to-face sessions, location, logistics, directions and public transport may be a challenge for some Autistic clients. This is due to the potential for sensory overload and increased uncertainty as they navigate unfamiliar sounds, lights, smells and movements while simultaneously following new directions. Being flexible and available should the client need you regarding directions or reassurance before the session can be helpful. It would be supportive to be available to greet the client on their arrival to reduce the waiting time before the initial session.

b) **Waiting rooms:** It would be helpful to review with the client the procedures for access to the building where the session will be hosted. Therapists can review the sensory considerations relating to their waiting room – lighting, sound, smells, textures (see Module 2). This can ensure that waiting rooms are less likely to be sensory averse for clients. You might check with the client if they need some time before the session starts. This may be helpful for them to adjust to their new environment.

c) **Including others:** Before the initial session, the therapist can ask the client if they would like to bring someone they trust along with them. It may be helpful for them to have someone present who is aware of their needs to assist them with their journey to a new environment. It may also ease their anxiety, help them communicate, process the new environment and help them after the session. It is important that the focus of this inclusion is on facilitating communication with the client. As such, it would be important for the therapist to be conscious of this not becoming a conversation with the support person *about* the client rather than *with* the client through the inclusion of the support person. This process of

communication may be something the client encounters in their daily life and there may be a risk of this being replicated in the therapy room. Therefore it is important for the therapist to be conscious of avoiding this particular way of interacting. Explicitly discussing this risk and how best to avoid it with the client and support person may be helpful.

d) **Online sessions:** Provide information on the video communication platform (e.g. Zoom/Teams/Meet) to be used and outline the steps for using the platform in advance of a session. This can be helpful for clients and can include information on how to log in and test that it is working, how to turn the video and mic on and off, what to expect from online waiting rooms, how to use the text chat box and how to hide their image if they wish so they are not distracted seeing themselves on camera.



e) **Structure of the session:** A brief outline of the length of the first and subsequent sessions can be shared with clients. It can be supportive to provide an outline of what might be involved in the first session.

f) **Arrival and departure:** Some information on what is expected upon arrival at the location of therapy and upon departure can be helpful for the client. It is good practice to explain such procedures as they relate to online sessions also; for example, how long a client might have to wait in an online waiting room before a session starts, and whether they will be seen or heard in an online waiting room.

g) **What to do if ...:** It can be helpful to provide guidelines on what to do if planned arrangements need to be changed. This could include a plan if the therapist is unable to see the client due to illness or for another reason, if the therapist is delayed or if the therapist is required to spend extra time with the previous client. For online sessions it can be helpful to provide information on what will happen if the therapist and client are disconnected during the session or if there are Wi-Fi/data issues, e.g. if there are delays and whether or not a client should just stay waiting in an online room. Note: online can be just as unpredictable as in-person and online waiting rooms do not have receptionists to answer questions.

h) **Payment:** It is important to inform clients clearly about the procedures for the payment of therapy sessions (when, how and the amount to be paid). It can be helpful for the client to know that they can have a conversation with the therapist if there are any difficulties regarding payment. Information on methods of payment should also be outlined, for example if card, cash, bank transfer or payment app transfer are accepted.

i) **Communication before and between sessions (planned and unplanned):** It can be helpful to be clear about the therapist's preferred means of communication (phone/email/message app) and the boundaries around contact, including topics of communication (maybe questions about homework), whether contact is appropriate between therapy sessions and the times the therapist is available for contact. A conversation around contact if there is an emergency can also be important.

Conclusion

Prior to meeting with the client, the therapist can begin forming a collaborative and supportive relationship by clarifying key topics relating to the therapeutic space and to the therapy.

The physical space

The physical space relates to the therapy room and its physical qualities – size, colours, lighting, smells, textures, type of chair and sound – as well as other spaces that will be accessed by the client, such as the reception area, waiting room, toilet and parking area. It is important for therapists to have a space that can accommodate and be adapted for people with a diversity of sensory perceptions and also to provide people with information on the space.

There are aspects of the space – the building, reception, toilets and the counselling room itself, that are important to be adaptable for clients. The sensory elements mentioned above can be aspects of the environment that may require adaptation in assisting the client to feel more comfortable. The sensory requirements of the space will be different for each person as everyone will have their own needs around sensory balance. Referring to the principles of universal design would be helpful when designing the layout of your practice. Universal design refers to the creation of products, environments and systems that are inherently accessible and usable by people of all abilities, ages and backgrounds. It aims to eliminate barriers and accommodate diverse needs without requiring adaptations and modifications. The goal of universal design is to ensure inclusivity, enhance user experience and promote equal participation for everyone, regardless of their physical, sensory or cognitive characteristics. It emphasises simplicity, flexibility and consideration of a wide range of users, ultimately fostering a more equitable and user-friendly world (Rose, 1997). It shares a common goal with neurodiversity of creating inclusive environments that embrace the uniqueness of individuals, creating equitable opportunities for everyone to thrive.

Having a space that can be adapted for a diversity of clients is important. For example, this might include having curtains that can be pulled and using lamps and soft lighting that facilitate different intensities of light output. Stay away from harsh lighting such as fluorescent tubes and other sources of fluorescent lights that have little control options because they can be perceptually overloading. Reduce clutter and use soft, calming colours. Pops of colour that can be moved if they are too overloading, e.g. cushions or blankets, are a sensible option. The ability to close windows if there is noise outside or to reduce the likelihood of unpredictable flying insects coming in can be helpful. So too the use of different texture and seating options such as beanbags, a chair or a rug in case the client would prefer to sit on the ground. Try to avoid a ticking clock because it can be distracting for some people.

It is important for the client and the therapist to share control of the space in the session, and it is important for neurotypical therapists to be aware of the unique mechanisms of Autistic sensory perception (see Module 2) that means Autistic clients may experience a therapy room vastly different to a neurotypical client or therapist.

In the first session, exploring the client's level of comfortableness in the room could be discussed to ease uncertainty, anxiety overload and to work towards attaining an optimum sensory balance for each client.

The client may need to assess the room in advance for sensory triggers, and their needs may change from session to session and as their self-awareness grows.

- Check with the client their needs around their own optimum sensory balance. This may include the sensory input that assists them and the sensory inputs that create barriers, as well as their general sensory preferences. These can include but are in no way limited to body contact – for example they may prefer no handshaking, preferred distance in personal space, unexpected sensory input, unexpected smells, texture, sound, preferred temperature and hard or soft furnishings.

- Avoid overloading an Autistic client with questions when they enter the room. Each time, at the start of a session, initial instructions should be kept to a minimum, giving the client time to process the environment, how it's the same and how it might have changed from last time, and what might be possible in terms of adaptations to make the space more accessible for them. For some it may be difficult to assess the room and process questions at the same time. It is important to remember that the optimum sensory balance is different for each client, so always communicate with your client about what they think might work best for them.

- Have fidget or comfort aids available in the room and invite the client to bring their own if preferred to assist in regulation and concentration.

- Try to maintain the room as the client has experienced it before and notify them of any changes in advance of the session to alleviate uncertainty. Neurotypical therapists should be aware of differences in Autistic perception (see Module 2), and while the room may look the same to you, it could be perceived as vastly different to your Autistic client.

- Therapists may consider having some assistive technology available for clients who may need to use specific equipment for communicating. Your client (or through the assistance of their advocate or by consulting with other Autistic advocates) will be best placed to advise what equipment might suit best. Being familiar with assistive technology and Augmentative and Alternative Communication methods (AAC) and having an openness to using the various pieces of equipment demonstrates inclusiveness and provides equity of opportunity to those who need to use this equipment. The use of AAC should always be welcomed and respected.

The client may or may not be aware of the mechanism of their own perception and optimum sensory balance. This is a process that can continue throughout therapy. It is important that this process is collaborative and meets the unique needs of each person. Developing sensory awareness and understanding what their optimum sensory balance looks like can also assist a client in their therapy, e.g moving during a session may help a client concentrate. Auditory monologuing of their emotions and thoughts and talking at someone may help them to best process, tapping their feet might help them think, using their hand to draw or colour what they are feeling might assist them in understanding their emotions better. Having an open conversation with the client about the structure of the session, emphasising the importance of their comfort and being open to any suggestions that would help the client settle in the room are key to providing the optimal setting for therapy.

Considerations and possible adaptations

It is important to remember that Autistic people do not habituate and get used to and filter out sensory input over time in the same way that neurotypical people do, so it is unlikely that repeated exposure will result in decreased effect. Therefore, when considering the sensory environment from an Autistic person's point of view, you should consider how you experienced it the first time and be aware that for many Autistic people, every time they experience something it's like a new first time (Jamal et al., 2021). (See Module 2 to learn more about Autistic perception.)

- Smells within the room (e.g. air freshener, incense or perfume). It may be helpful to remove any sources of smells or open a window. Conversely, a person may prefer particular smells and these could be integrated into the space and session, such as a scented vaporiser during relaxation exercises.

- Intrusive and unexpected sounds (e.g. a ticking clock, noise from pipework in the walls, traffic sounds from open windows, people in other rooms, fire alarms, phone notifications, water features, flickering or dying light bulbs). It may be helpful to remove items that make particular sounds, close windows, check bulbs regularly or have conversations with other people in the building about sounds during the time of the session. Talk to your client about what has helped in the past and whether they can adapt anything for the current issue, for example wearing noise-cancelling headphones that block out background noise but that still filter in the sound of talking.

- Light (e.g. harsh or fluorescent lighting or lighting that creates visual distortion such as natural light coming through Venetian blinds). It can be helpful to have options that adapt to fit with the diversity of client needs. For example, using dimmer lamps that can control light intensity and other kinds of soft lighting (rather than all-or-nothing overhead fluorescent lights), heavy or blackout curtains that can be opened to let in or closed to block out natural light, and that can also be used to muffle outdoor sounds while still allowing open windows for ventilation (screened if possible to avoid bugs).

- Temperature (e.g. is the room too cold or too warm?). Everyone experiences temperature differently. A cold room to one person might be refreshing to another; a room that is too hot for one person might be perfectly cosy and comfortable for another. One person's temperature perception can change over time depending on emotions, hormones and health. It can be helpful to be able to control the temperature of the room, but in cases where this is not possible, making available blankets or cushions, making sure clients know they can leave on or take off their jacket and making clients aware of the freedom to open or close windows can help them make adaptations to suit their optimum sensory balance.

- Visual noise or clutter (e.g. a shelf of books or a number of different items in the room). This can be distracting for some people. Adaptations can include having a clutter-free space, having doors to cover shelves or adjusting seating positions so the person is not looking at the visual noise. For some, visual noise may be helpful. In this case having visual noise in the form of an object or busy art piece might suffice – one that can also be easily hidden or put out of sight for other clients.

- Facilitation of movement (e.g. does the space facilitate movement?).Can the person pace? Would it be helpful to go on a walk for the session? Can the client take their shoes off?

- Seating and how supportive it is. It is a good idea to have different options for seating. This could be as simple as a sturdy chair and a soft fluffy rug, and letting people know they can sit on the floor or on the chair. Other options for seating would be a couch, a rocking/movable chair (but don't go for a rocking/movable chair if this is the only sitting option available because while some might find this helpful, it could make others feel agitated or anxious or nauseous). Another good option is a beanbag for those who feel more grounded closer to the floor. It is important also to think about the texture of seating – it's better to go for soft textures, avoiding anything that might be itchy or scratchy as this can be highly uncomfortable or painful and distracting for some. Avoid silk or velvet textures, and for those who like that type of texture, you can have textures they can pick up and put down or bring along themselves, e.g. a small textured plant or a sample book of different textures from a decorating store that they can explore but that can be removed easily for other clients who may find such items distracting or overloading.

- Access to weighted blankets, fidget aids and freedom to stim are important for self-regulation. There are aids that they may choose to bring with them such as weighted blankets, lap pad, a weighted hat or teddy or ankle weights that might help them feel grounded, energised or relaxed.

- There are stims that they can engage in, such as vocal stims or body movement, that they may need to do to assist them better in a therapy space. An Autistic client may not have heard of some of these things before and suggesting they try some out and explore their sensory system more could open up new avenues towards better self-awareness and understanding. Note: there is vast diversity, and what works for one may be a major barrier for another. There is no one size or even one category of stims and regulatory aids that fits all.

Conversations about the physical space

It can be helpful to check in with the client to see if the physical space is supportive or not. The therapist can ask if there are any changes that would be helpful to the space. As a way of encouraging feedback, the therapist could ask the person what they do not like about the environment. This is important because it could be really difficult for the client to bring up these topics themselves. If making a change to the room or furniture, it may be helpful to signal this to the client because this may be disorienting for them.

Building a relationship that empowers the person to advocate for themselves and feel in a position to take the lead is important. Taking feedback into account and making adjustments where possible and necessary will demonstrate that the client was heard and respected. It can be helpful to identify what kinds of supports and accommodations might be needed. Be open to exploration of this and recognise that this collaborative approach is something they might not be used to or may not have been afforded before.

Outside-the-box/Eco-Systemic therapy settings

When considering therapy options for your clients, it's important to think creatively and explore alternative settings where they may feel most comfortable and able to communicate effectively.

Therapy can take place in a variety of locations outside the traditional therapy room, and there are many great options to consider. For example, some clients may find it easier to communicate while on the move – during a walk or a car ride, which can reduce the pressure of making eye contact or maintaining direct visual contact. Other clients may feel more relaxed in water or in the presence of animals, which could make activities such as swimming or visiting a pet farm helpful alternatives. Parks, trampolines and light-exercise activities are also possibilities to explore. By thinking creatively and being open-minded, while working within best practice and ethical guidelines, you can identify alternative therapy settings that will work best for each individual client's unique needs.

Also, suggest if a therapy session might be more beneficial after they go for a walk or have some form of exercise. Or would this perhaps benefit them more effectively after the therapy session?

Conclusion

The physical therapeutic space is an important context within which the therapeutic encounter takes place. As such, ensuring that the space is adapted to meet the needs of the person is central to facilitating this encounter and developing a helpful therapeutic relationship. Furthermore, conversations about sensory adaptations with an openness to feedback and collaboration are also key for facilitating the therapeutic relationship. These conversations can take place throughout the therapeutic process and can be important for making the person feel understood and respected.

Virtual therapeutic space

Like physical spaces, virtual therapeutic spaces have contexts that can either promote connection or disconnection between the therapist and client. Some clients may prefer online therapeutic sessions at all times or at particular times during the therapeutic process. It is helpful to establish, in a collaborative manner, how the therapist and client will navigate the virtual space in a way that enables a helpful context for therapeutic experiences. Conversations relating to key considerations in the virtual therapeutic space to establish shared expectations can be helpful.

Key considerations

a) **Backgrounds*:*** The therapist can have a conversation about the background they use for the online session and whether this is distracting for the client or not.

b) **Video*:*** Some clients may prefer to have their camera off during the session or have the camera off during particular times during the session. It is best practice to have the device (for the client and therapist) set on a solid surface and not handheld or sitting on a movable surface or on their lap.

c) **Sound/headphones*:*** It can be helpful to have conversations with clients about the sound quality of the online session and whether adjustments need to be made. Some people prefer to wear headphones to eliminate sounds from their environment.

d) **Environmental distractions in your physical space:** It is important to check your environment for any auditory or visual distractions that may impact the session.

e) **The client's physical space*:*** There may be aspects of the client's environment that can interfere with the interactions between the therapist and client. It could be helpful to have a conversation about this.

f) **Walking/movement breaks*:*** Clients may find it helpful to move or walk during the session. This may be for a short break or may be for longer periods during the session depending on their needs.

g) **Checking in:** The client may or may not find online sessions draining. Therapists can establish whether this is the case or not and it may be helpful to check in with them during online sessions.

h) **Whiteboards/other tools:** For some clients, visual means of interacting and communicating can be especially helpful. Virtual whiteboards, text chat and similar tools can be useful for online therapeutic sessions.

i) **Back-up plan:** It can be helpful to have a conversation ahead of time about what both therapist and client can do if there are Wi-Fi or data issues or a disconnection during the session. This may be to move to an alternative video source, to a phone call, messaging or email options.

Conclusion

Online therapeutic spaces can lead to difficulties if there are distractions in the client's or the therapist's environment, if there are connectivity issues or if there are unclear ideas about what is expected during online sessions. The advantage of flexibility around virtual sessions offers the option for the therapeutic process to continue if the client prefers not to or can't tolerate an in-person session, or because of distance between the therapist and client or if one or other moves away. Online sessions can also provide opportunities for adapted or creative therapeutic interactions through the use of whiteboards, other forms of assistive technology and other creative online tools.

Beginning the therapeutic process: initial appointments

Initial meetings are important as they set the stage for the development of the therapeutic relationship for the rest of the therapy. It is also the point in which the client will make a decision about the fit of the therapist and whether to continue with them or not. Engaging with the client about the physical or virtual therapeutic space has been described above. Other parts of setting the stage for therapy involve considering the procedures and routines outside of the therapeutic interaction (such as travel, financial arrangements, phone calls and language used) and in the therapy session. Setting the expectations of the client in a collaborative way relating to these areas can be important for assisting the therapeutic relationship.

"Something that is crucially important for me is consistency – my therapist always starts sessions on time, avoids rescheduling too often and gives me notice in advance when they're taking time off. Without those basic elements in place, I wouldn't be able to work with them."

Autistic Adult

Providing an introduction

For the initial meeting, introduce yourself, introduce the setting and provide an outline of intent for the meeting or online interaction.
Provide and request important information if you have not been able to do this previously (refer to Appendix B).

This may include:

a) **Routine procedures:** Outline what happens during the process of therapy, including routine procedures, e.g. regarding phone calls, financial obligations, when to arrive for a session, where to wait if they are early, when to knock and not to knock. Also inform the client about the way notes are taken and stored and how future sessions are going to be arranged. This takes the guesswork out of therapy and could reduce the client's uncertainty. Change and transition can be difficult, so take this into account.

b) **Boundaries:** Boundaries include what is and what might not be appropriate or expected, e.g. communication between sessions and pre-empting difficulties rather than dealing with them only as they come up.

c) **Length of the therapy:** Have a conversation with the client about the possible length of the therapy. What are the therapist's and clients' ideas about the number of sessions they may meet for? How might you both know that the therapy should end? Can the number of sessions be adapted to the needs of the person?

d) **Previous experience of professionals and seeking the client's preferred use of language:** Conduct a discussion of the client's previous experiences of professionals. This can provide important information on what has worked or not worked for them in the past and can identify to the therapist potential pitfalls and opportunities in developing a relationship with the person. It is also important to check how the person would like to be referred to in terms of identity-first language (see Module 1) or otherwise and what pronouns they use.

Examples of questions include:

- What (if any) mistakes have professionals made before?
- What would I need to do to not mess up?
- What's important for me to do/not do?
- Would you prefer more structure (a plan or agenda for the session) and input (information or ideas from the therapist) or less of this?
- What language would you prefer we use? Would you prefer that I use identity-first language or not or other language?
- What pronouns would you prefer I used?

e) **Continuing collaboration:** These discussions can continue throughout the therapeutic process and be revised and adjusted as the process continues. A conversation about how to facilitate these discussions should take place.

"The collaborative identification assessment process was the most powerful, healing, non-judgemental, respectful, safe, trusting and transformative journey I have ever experienced in my whole life."

Autistic client

Conclusion

The initial session is important for setting the stage for the therapeutic relationship, creating a context for safety and comfort and developing a collaborative process for working with the client. Conversations about the therapeutic space, routine procedures, boundaries, language and their previous experience of professionals can be important here. This collaborative process can continue throughout the therapy.

"I think more emphasis should be placed on listening to the actual words of the autistic person. I frequently encounter issues with people placing more emphasis on my body language and facial expressions, and particularly what they think I should be feeling/saying, rather than what I actually am."

Autistic Adult

Communicating with your client

Being flexible in your communication approach during a therapy session is important. Communication with the Autistic client is key and the therapist may need to adapt their way of communicating, which lets the client know that you are both learning how to work together towards the best outcome for the client. The therapeutic process begins with gathering information and often an assessment session about the client's life experiences, what brings them to therapy and their goals. Clients may also be curious about the process of therapy and it can be helpful to provide them with some ideas about the therapeutic process and answer any questions they may have about it. This helps set their expectations for the process and reduces the chances of unexpected therapeutic ruptures due to misunderstandings.

"Some Autistic people don't have a lot of language around emotionality and introspection and metacognition. They just don't have words sometimes. I'm a big fan of the psychodynamic approach, the one step removed. So, you know ... being able to use tools that allow the person to navigate their process or their emotionality or their challenge at that moment, that isn't just around verbal skills."

Psychotherapist

Autistic communication

A. Autistic clients can process verbal and nonverbal communication including gestures and tone of voice differently to neurotypical clients. Sarcasm and tone of voice may be taken literally, so it's best to consider your use of sarcasm and idioms to ensure they are appropriate. It is important that you get to know each client individually and their preference around this. For example, some Autistic people may find understanding metaphors difficult or confusing – or they may have metaphors of their own that they like to use to explain things. Similarly, some Autistic people enjoy using sarcasm and they may or may not have issues understanding others' use of sarcasm. Listen to your client's language to help understand how they communicate, and check with them to see if how you are responding to them is appropriate for them.

B. Understanding their own feelings and reading other people's feelings may be challenging especially when the double empathy is a factor (see Module 2) and there may be a mismatch of communication style between Autistic and neurotypical people. Each client may have different language skills in articulation. Give practical examples of what you are communicating and extra time for processing. Make accommodations for individual processing needs such as including time for the client to repeat what is said. The term for this is "echolalia" and it assists with processing. You may consider using art, visual imagery, dance, movement, colour, interests, puppets or teddies to facilitate communication and an exploration of internal cognition and feelings.

The term "alexithymia" (see Module 2) relates to challenges recognising one's own feelings and emotions and those of others. This is important to consider when you are discussing goals for therapy and as therapy continues. The therapist must check that the client understands the feelings and emotions that are being discussed. Be mindful that Autistic people may understand and explain their emotions and feeling states in different ways to neurotypical clients. These are not wrong ways, just different ways of understanding – for example, explaining how they feel through colours or diagrams and naming and characterising different states they feel. It might be hard to translate these experiences into words and can be confusing for the client.

While many Autistic people can experience alexithymia, this is not a universal Autistic experience, so it is important not to assume alexithymia. You could consider alternative mechanisms for eliciting thoughts and ways of feeling and experiencing emotions. For some, using alternative methods to just talking can help.

Examples of tools to assist the client are as follows:

- The use of visual cards like "feeling emoji cards" and a "feelings wheel" may assist the Autistic client to understand and relate to expressions and sensations associated with feelings and emotions. For clients with synesthesia (see Module 2), colour cards may need to be adapted to sync with their colour preference. Some Autistic people may find emoji cards confusing if they are not pictures of actual people.

- Drawing or writing down how they feel and where they feel it can also be useful for some Autistic clients. The client may build on this and keep a feelings diary/journal between sessions.

- Clients may prefer to express themselves through visual/auditory media forms, e.g. through filmmaking, music or the production of anime/animation or other art forms.

It is important to be aware that like all clients, not all Autistic clients present the same, and while a client may appear confident in their communication, you need to remain aware that they may be masking/camouflaging (see Module 2). Checking in with the client often, presenting questions short and to the point, being more specific, giving them time to process and offering them choices are essential. Consideration can be given to the use of irony, idioms, sarcasm, metaphors and rhetorical questions. Some clients may find this useful in therapy and others may need more explanation or a change in your communication with them. Avoid infantilising talk.

Without checking in, an Autistic client may reach overload because too much may be going on at any one time. They may become overwhelmed, can't process any more and may not be able to communicate. It's important for the therapist to create awareness on how best to communicate and check in with the client respectfully that they are understanding what is being discussed. Seeking clarity around your understanding of their unique needs will help build confidence in the relationship between therapist and client.

Information sharing

It can be helpful to begin by giving clear information about your role as a therapist and the importance of understanding the client's needs and goals. Clearly explain the process of therapy and its likely/potential outcomes. As with all clients, the formulation and structure of the sessions will depend on the client's individual needs.

Information gathering

If questionnaires are used to assess the client, an adaptation of the assessment process may be needed – for example, the adjustment of language. One option may be a suggestion of sending the form before the session so that the client has time to process the questions. Recollecting how they felt over the past month (or a week or two ago) may be difficult and overwhelming, which would not make an accurate assessment of the client's needs. Adapting the questions by breaking them down and making them less abstract may help the client process. Questionnaire wording and limited choice can also cause issues for some Autistic clients. To counteract this, letting them know they can make amendments to the questions or add further clarification on some details can help. On completion of the assessment, summarise the key needs that arise and ask the client if they would like a written copy.

Options for supporting communication with clients

The following can assist the client to process and express themselves through the assessment, information sharing and also during therapy sessions:

1. The use of visual cards may assist some clients and using emoji/feelings cards as visual aids to express feelings and emotions.

2. Be aware of and understand the double empathy problem (see Module 2).

3. The availability of stim/fidget aids for clients.

4. The use of pen and paper or whiteboard for clients to draw or write questions and answers.

5. Allow time between questions to help the client process and answer.
   Check with any issues that are hindering their ability to process and answer – sensory, visual, auditory or verbal.

6. Invite clients to pace the room, stim or use fidget aids.

7. Respect Autistic communication and clarity around not having to engage in eye contact.

8. Invite the client to let the therapist know if they need to use the bathroom.

9. Invite the client to pause the process and take breaks if they feel uncomfortable.

10. It is important not to assume that the client can easily express their feelings or that they will express their feelings in the same way you do. Their preferred way of communication should be respected.

Structure of sessions and ending sessions with your client Sessions may need to be shorter or longer than usual or the periods between each session may vary depending on the client's capacity.

As with pre-therapy preparations, the structure of the sessions going forward will help reduce uncertainty. A clear plan and setting an agenda for the next session can be helpful.

Any reading or exercises before the next session should be communicated in an appropriate way that the client can work with. Following a structure with the sessions helps with boundaries and the client will understand the process: the beginning, the ending and the in between.

When the process of therapy is coming to an end, it would be helpful to have open discussions around how the client might like to finish up. For example, some may prefer to know that the process is finished and complete, while others may like to have the option to re-engage if they need to connect again in the future. A closing-off session for any therapeutic process is always best practice.

t

"Understand that autistic people may need a longer time or shorter time in therapy than neurotypicals as it can be hard to communicate. If a therapist cannot commit to long-term sessions with a client, this should be made clear from the start as it can be hard to build a relationship, and being autistic and the challenges that presents in a neurotypical world are constant. It is very disconcerting if one has to find another therapist because the person they have been seeing doesn't see clients long-term (more than a year). Clear information from the start regarding this."

Autistic Adult

Conclusion Considering the communication strategies and approaches that fit with your client is central to developing and continuing the therapeutic process. Clarity around communication between client and therapist allows for more accurate gathering of information as part of the assessment process and for arranging sessions or exchanging necessary messages between sessions.

Developing a collaborative therapeutic relationship

A central aspect of working with any client group is developing a positive and collaborative therapeutic relationship and this is of particular importance when working with Autistic clients. It is important for the therapist and client to have a relationship that involves connection and negotiation. It is important to follow the pace of the client and be curious about what is important to them. It may take a significant amount of time to build this relationship.

The therapeutic relationship in psychotherapy

Research has indicated that it is the effect of the relationship between the therapist and client, rather than the modality, that makes a more significant difference to the outcome of therapy. The Contextual Model of Psychotherapy (Wampold, 2015) indicates that the pathways influencing outcome involve the following common factors:

1. A real relationship.

2. The creation of an expectation through an explanation of the difficulties and the process involved.

3. The enactment of health-promoting actions.

The real relationship is defined as "the personal relationship between therapist and client marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that benefit the other". Expectations are set with collaborative understanding of what the problems are, what will help address them and agreeing the goals and tasks of therapy. Well-developed models of therapy involve promoting healthy actions, which may include improving difficult relationships, challenging maladaptive thinking patterns or expressing difficult emotions.

When working with Autistic clients, developing a good therapeutic relationship and collaboratively developing an understanding of what is causing difficulty for the person as well as how best to address those difficulties are key. The modules have described the many different aspects of interacting with the client that impact the development and maintenance of this relationship. This includes the initial contact with the client, the initial session, navigating the therapeutic space and communicating with the client. All of these interactions influence the development of the therapeutic relationship.

Focusing on interests

Some Autistic clients have intense interests from a young age and have accumulated immense knowledge. Connecting by being inquisitive, respectful and getting to know about your client's specialised area of interest will create a good therapeutic relationship with your client and help them build confidence and engagement. As they are so attached to this specific interest it can be incorporated in the therapy to assist the client's understanding.

"I think therapists/counsellors should bear in mind that what they/society may perceive as difficulties/problem areas may differ from the client's perception. For example, I find social situations difficult for various reasons, but as I have no desire to socialise more, I do not perceive this as an issue. On the other hand, someone who knows of my need for routine and anxiety around uncertainty might conclude that I would not wish to travel. However, I have a desire to travel more and my difficulty doing so is probably the only area where I perceive being Autistic as having a negative impact on my life at present."

Autistic Adult

Conclusion

The therapeutic relationship is key to effecting change. This involves a real relationship where there is a collaborative understanding of the problem, expectations are set for the process of change and health-promoting actions are developed. Key aspects of this include collaborative communication based on the individual needs in each interaction with the person. An important tool to develop this relationship includes requesting and receiving feedback. This will be discussed in more detail in the next section.

The importance of feedback

Integrating feedback into therapy can be a helpful way to adapt therapy to Autistic clients. Feedback informed treatment (FIT) provides guidelines on how this can be achieved. This involves developing a culture of feedback with the person and encourages collaboration. The session rating scale (SRS) form can be used to elicit feedback to support this process. The outcome rating scale (ORS) can be used with this to assess outcomes (Miller et al., 2016). In this section we will set the context for developing the collaborative relationship and the use of feedback to continue its development.

Seeking feedback in therapy

Key to achieving this is adapting the therapeutic approach and methods of interacting and relating to the client in the context of their neurotype as well as other differences. The FIT approach (see Appendix C), developed by Scott D. Miller (Miller et al., 2016), provides a framework for seeking feedback and adapting treatments to individual clients. Evidence indicates that seeking feedback improves treatment outcomes overall through addressing the therapeutic common factors: the real relationship, the creation of expectation and the enactment of health-promoting actions.

How to seek feedback

It is important to seek feedback in a task-specific way. When seeking feedback it is helpful to avoid inquiring generally about how the session went. Instead, frame questions to elicit concrete, specific suggestions for altering the type, course and delivery of services. The SRS and ORS are dialogue tools that improve the way the therapist focuses on the outcome and the alliance of the service provided. These are written documents completed by the client at the end of the session. The therapist can discuss the feedback with the client at the end of the session or at the beginning of the next session. Some clients may prefer to expand on feedback between sessions and questions can be put to them over email (within agreed boundaries).

Some specific questions that can be asked are:

- Did we talk about the right topics today?
- What was the least helpful thing that happened today?
- Did my questions make sense to you?
- Did I fail to ask you about something you consider important or wanted to talk about but didn't?
- Was the session too short/long/just right for you?
- Did my response to your story make you feel like I understood what you were telling me or do you need me to respond differently?
- Is there anything that happened (or did not happen) today that would cause you not to return next time?
- Did my way of communicating make sense to you?
- Did the whiteboard/drawing I used help or hinder the session today?
- Were there any sounds/smells/lighting/visual/comfort issues during our session today?
- I used a metaphor today. Did that work/make sense to you or was it too abstract?

Such feedback tools can be useful, but it is important to always remember that each Autistic person is different, and while this may work well for some, it may become a chore for others and a barrier to engaging with therapy if there is an expectation of homework or having to lose some of the end of their session for feedback. So it is important to be directed by what suits best for each individual client and to make sure it is clear that such feedback tools are optional not mandatory. Explaining the value of feedback and keeping the doors open to other methods of feedback, such as open writing or artwork for clients to give feedback, will enhance the process. Some clients may not wish to give feedback initially but may be more comfortable to do so after the relationship is established.

The importance of continuous learning and a position of "not knowing"

Developing self-awareness and a "learning from" approach using feedback

A cultural humility framework to adapting therapy is a helpful way of thinking about adaptations to therapy when working in a Neurodivergent context. This approach is "self-first" in that it involves understanding one's own implicit biases and ableist beliefs, and is about developing self-awareness and reflection and engaging in conversations in an open and curious manner. An important part of the process is to identify mistakes and to learn from those mistakes. This is different from a "cultural tourism" approach in which a preferred view or method is used for working with a particular group with no self-reflection or willingness to understand the experiences of people living in the margins. This is a significant trap in working with Autistic people where the person is viewed in terms of a particular idea of what it means to be Autistic without consideration of other aspects of their identity. In the context of psychotherapy practice this involves engaging in critical self-examination and self-awareness, building the therapeutic alliance, repairing cultural ruptures and navigating value differences (Mosher et al., 2017). This framework can be useful for therapists adapting their approaches to working with Autistic clients.

Navigating value differences, repairing ruptures, developing self-awareness and building the alliance can all be supported through the process of seeking feedback. Feedback also helps therapists be more responsive and address ruptures quickly and effectively. It involves moving from a "learning about" mindset to a "learning from" mindset with a focus on learning from the person and their particular context. Nick Walker (2021) describes the privilege of neurotypical therapists as "not having to learn".

Autistic people are typically put in a position of having to learn to interact, understand and communicate in a particular way, whereas neurotypical people are put in a position of not having to empathise, understand or learn. Walker outlines that it is central to working with Autistic clients to "check" that privilege by taking up a position of learning, humility and openness to correction, and developing a real understanding and compassion towards Autistic experience. This involves seeing clients as experts on their own lives and experience as well as learning from Autistic experts and curricula designed by Autistic experts.

Self-awareness can also be developed through this process and continued through other methods. This can include journaling, discussions in the context of supervision or with colleagues and through reading Neurodivergent literature. Take into account the Zen Buddhist phrase "Empty your cup". This is also described as a "beginner's mind" position – approaching a situation from a position of "not knowing" and of curiosity. This process is a continuous journey for therapists.

Supervision

Supervision from someone who is Autistic or otherwise Neurodivergent or who works alongside or under the mentorship of Autistic or otherwise Neurodivergent professionals working in the area of Autistic understanding can be a vital part of developing a full understanding of Autistic neurology and culture. In choosing a supervisor it is important to take into account their experience with understanding Autistic experience, Autistic perception, Autistic values and culture and whether they engage in continuous professional and personal development around Autistic people and neurodivergence. Linking in with a Neuro-Affirmative therapist group can also be helpful.

Conclusion

Evidence indicates that seeking feedback has significant positive therapeutic outcomes. The SRS and ORS are tools that can be used to elicit conversations around feedback. Seeking feedback can help repair ruptures, navigate value differences, build the alliance and adapt one's approach or methods to the needs of Autistic clients. Specific and concrete questions about the therapy are important for eliciting helpful feedback. A "learning from" approach that involves learning from the other person and developing self-awareness around one's biases is an important part of developing collaborative relationships with Autistic clients for neurotypical therapists.

Inclusive practices for Psychotherapy

It is important to note that these practices can be applied to all clients a therapist meets. Firstly, there may be clients who are Neurodivergent and who have not shared this or who are not aware of their neurodivergence. Secondly, a person who may not be considered to be Neurodivergent may have particular sensory and communication preferences or other needs that may benefit from discussion and adaptation with the therapist. Thirdly, focusing on feedback can be an important way to address core therapeutic factors for any client. Finally, and most importantly, implementing these practices fits with the principles of universal design discussed in this section. This involves making therapeutic spaces as accessible and inclusive as possible for all people by being cognisant of all potential differences in interacting with clients. Engaging in these practices with all clients helps make therapeutic spaces and relationships more inclusive in a less stigmatising way than only using these practices with people who are identified as Neurodivergent.

There should be a roll-out of comprehensive Autism awareness training for all adult mental health services nationwide. This should focus specifically on clinical issues frequently seen in adult mental health services, such as mood disorders, eating disorders and gender diversity. The training should outline how Autism intersects with these co-occurring conditions, impacting their clinical Autism presentation with practice considerations for assessment and intervention processes.

The Autism Innovation Strategy should ensure a public pathway for adult Autism diagnosis and the development of a comprehensive post-diagnosis support, including needs assessment around communication aids, sensory needs, organisational skills, support for community groups, strategies for self-help and Neuro-Affirmative counselling support.

(Submissions from the survey platform of the Autism Innovation Strategy, Government of Ireland – Department of Children, 2023)

Module 4: Summary

In Module 4 therapists are guided on how to cultivate an inclusive space for Neurodivergent clients. Accessibility begins with a user-friendly website and straightforward documents detailing processes and procedures. Clients benefit from visual insights into the therapy setting and a preview of their therapist. Engaging Autistic professionals in sensory audits ensures that the environment caters to the nuanced needs of the Autistic perception, capturing subtleties that might be overlooked otherwise.

Before sessions, determining accommodations, ensuring timely interactions, creating a sensory-friendly environment and clarifying procedures like payments enhance the client's comfort. Within the session, pacing, availability of regulation aids and flexible seating options can make a significant difference. The space should also be adaptable to each client's needs and outside-the-box therapy settings should be considered.

For online sessions, factors like background visuals, camera permissions and contingency plans for tech issues are all important. Confidentiality must be assured, and distractions minimised.

Effective therapy is built on flexible communication, respecting the concept of the double-empathy problem. The therapist and client should collaboratively identify issues, set expectations and develop strategies for well-being. Tools like SRS and ORS can facilitate ongoing feedback, allowing for adjustments and reducing biases.

Continual professional development is essential to stay updated with best practices. Supervision from, or in collaboration with, Autistic or Neurodivergent professionals offers valuable insights, grounding therapists in a genuine understanding of Autistic culture and perception, promoting respect for diverse worldviews. This comprehensive training ensures that the therapist is equipped to honour and validate each client's unique way of interacting with the world.

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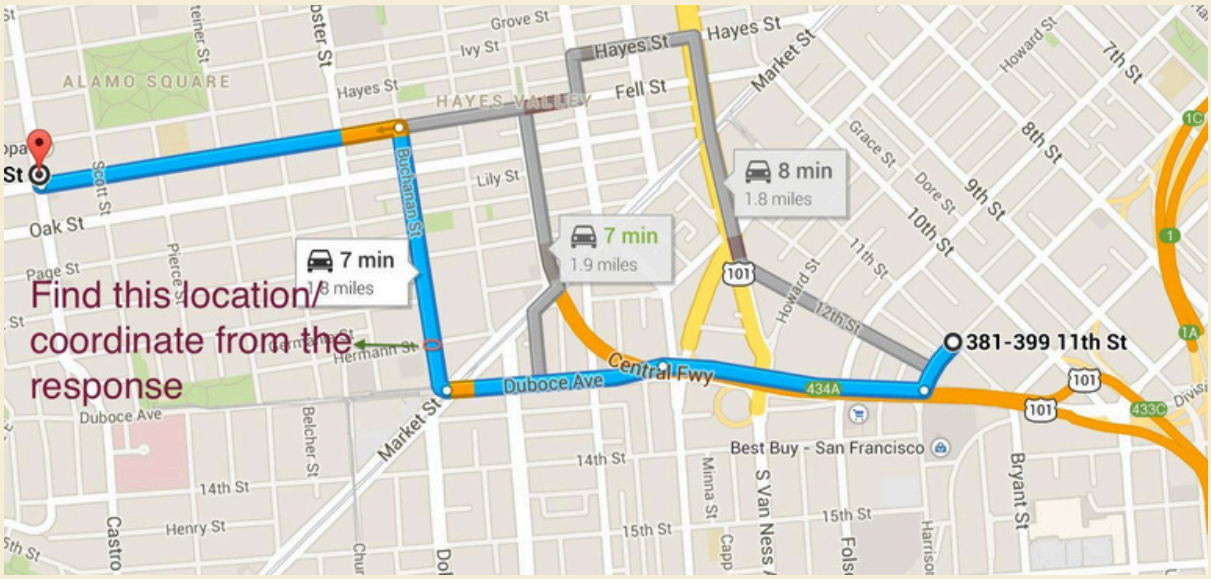
Appendices

Appendix A: initial meeting letter

Dear client, I am contacting you to gather and share some information before our initial meeting.

Firstly, I have included some directions and information on getting to the practice. Here is the eircode (D15 WT54) and a Google Maps link: (https://goo.gl/maps/Nog2TeptBaZiQbkF7). There is parking at the King Street Car Park or on Queen Street. There is a machine for parking that takes coins. Tara Street train station is a five-minute walk away or the 46A and 75A bus stop is outside. The office is located on King Street, across from the coffee shop (Starbucks).



Here is a picture of what the building looks like. You will see a yellow door. Ring the bell marked “reception” and when answered you will hear a long buzz sound. Push the door to open. The door to the reception is the white door at the top of the steps.

When you enter, please tell the receptionist your name and wait in the waiting room in the picture below. I will come down to meet you.

This is the reception room. Mary or Jessica will be at reception.
Here is a photo of the room where we will meet. I sit on the left chair and you can sit on the right chair.

If there is any other information that would be helpful for you, please let me know. On the day, if you have any issues finding the office, please send me a text or phone me on: 087-000-0000.

For our initial meeting we will meet for 50 minutes. I will ask you some questions about what you would like to focus on in therapy and we can discuss the information I sent you prior to the session around confidentiality, payment, the therapy process and any questions you might have around this.

It is very important to me that we have a good connection for both of us to feel comfortable. I have included below some questions that would help me make sure that I adapt how I work to best fit with what works best for you. Providing this information beforehand would help me prepare for our initial meeting together. Please send me whatever information you feel is appropriate via whatever form of communication is best for you, e.g. email, text or voicemail. This information is optional as we can establish your needs for therapy when we meet.

Our initial appointment is set for 5 August at 11 a.m. I look forward to seeing you then.

Kind regards,
Kevin

Questions:

- Are there any sensory inputs that would help you or any sensory inputs that would make it more difficult for you in the room that I should be aware of for our meeting?
- Do you like/dislike any particular types of sounds/smells/lights/textures?
- Are there any sensory experiences you have that you think would be helpful for me to know?
- Are there any communication preferences that you have that you think would be helpful for me to understand?
- Do you prefer communicating verbally, through writing, texting, drawing or through voice note at any particular time?
- If I am sharing information with you, would you prefer if I explain it verbally to you, draw a picture, use examples, explain it in a certain way, write it out or use an information sheet?
- What would be helpful for me to understand about how you prefer others to share information?

Appendix B: initial meeting checklist

- Exploration of sensory considerations for the person for therapy (aversions and preferences). Questions may include: are there any sensory experiences that I should be aware of for our meeting? Do you like/dislike any particular types of sounds/smells/lights/textures? What would be helpful for me to know about any sensory experiences you have?

- Exploration of the person's communication preferences (e.g. speaking, writing, texting, emailing or voice notes). Questions may include: What would be helpful for me to understand about how you like to communicate? Do you prefer communicating through speaking, writing, texting, voice notes or drawing at any particular time?

- Exploration of the person's preferred methods of understanding/information processing (e.g. spoken, visual or information sheets). Questions may include: if I am sharing information with you, would you prefer if I explained it to you, drew a picture, used examples, explained it in a certain way, wrote it out or used an information sheet? What would be helpful for me to understand about how you prefer others to share information?

- Explicit conversation about the therapy process. This may include your therapeutic approach, how the number of sessions is decided and how reviews are conducted, what each session may look like and any relevant ideas about therapeutic change.

- Explicit conversation about confidentiality – what this means and examples of situations when it may come into play.

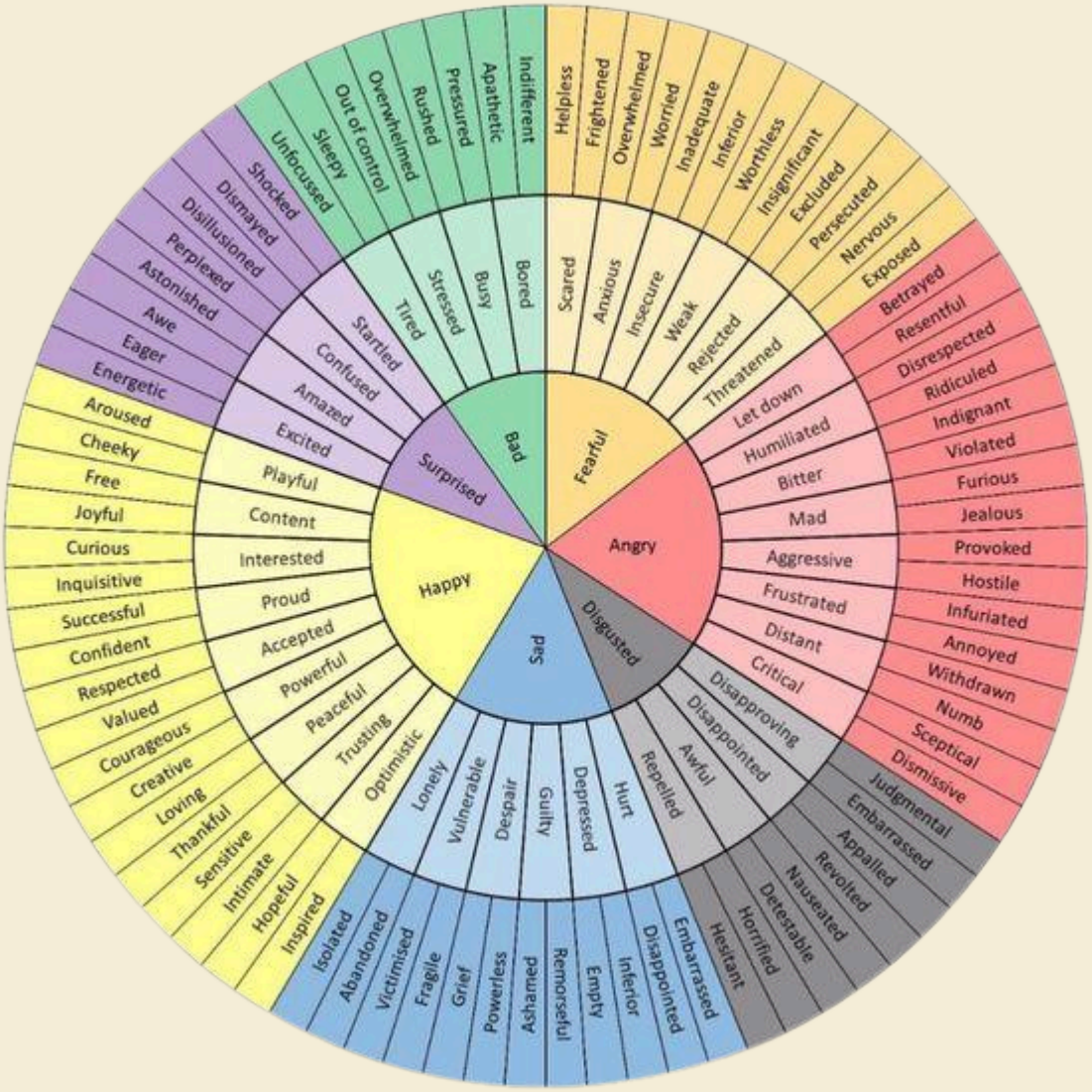
- Explicit conversation about payment if relevant.

- Conversation about involving others, who could be included and how they could be included if relevant.

Appendix C: FIT documents and resources

A free licence for individual practitioners to use FIT documents (the SRS and ORS) as well as a guide for implementing FIT and articles on FIT are available at: https://www.scottdmiller.com/.

Scales may be overloading for some Autistic clients. Being aware of this and communicating with your client about this possibility is important. Having the option of viewing it with pie- or ring-size cutout to cover some and show other information can be useful to reduce information overload.



Appendix D: common initialisms (that may appear in clients' reports and related paperwork/communications)

Note: some of the same initialisms can have different meanings, so it is always good to check in different contexts.

A

AA Actually Autistic

AAC Augmentative and Alternative Communication

ABA Applied Behaviour Analysis

ACE Adverse Childhood Experience

ACT Acceptance and Commitment Therapy

ADD Attention Deficit Disorder

Adhd Attention Deficit Hyperactivity Disorder

ADI-R Autism Diagnostic Interview – Revised

ADOS Autism Diagnostic Observation Schedule

AEDS Adult Eating Disorders Inpatient Service

AuDHD Autistic and Adhd

AIS Autism Innovation Strategy

AMHS Adult Mental Health Service

AON Assessment of Need

APA American Psychological Association

APD Auditory Processing Disorder

AQ Autism Spectrum Quotient

ARFID Avoidant Restrictive Food Intake Disorder

AS Autism Spectrum/Autistic Spectrum/Asperger's Syndrome

ASC Autism Spectrum Condition

ASD Autism Spectrum Disorder

ASIAM Ireland's National Autism Organisation

AT Assistive Technology

AWN The Autistic Women and Nonbinary Network

B

BED Binge Eating Disorder

BDD Body Dysmorphic Disorder

BPD Borderline Personality Disorder

BPD Bipolar Disorder

C

CAMHS Child and Adolescent Mental Health Services

CARS Childhood Autism Rating Scale

CBT Cognitive Behavioural Therapy

CDC Center for Disease Control and Prevention

CDNT Children's Disability Network Team

CFT Compassion Focused Therapy

CHO Community Healthcare Organisation

CMHT Community Mental Health Team

CNS Clinical Nurse Specialist

CPD Continuing Professional Development

CPI College of Psychiatrists of Ireland

C-PTSD Complex Post-Traumatic Stress Disorder

CRR Community Rehabilitation Residence

CRSD Circadian Rhythm Sleep Disorders

CRT Crisis Resolution Team

CVPD Central Vision Processing Disorder

CWO Community Welfare Officer

D

DA Disability Allowance

DARE Disability Access Route to Education

DAS Developmental Apraxia of Speech

DBT Dialectical Behaviour Therapy

DEASP Department of Employment Affairs and Social Protection

DES Department of Education and Skills

DISCO Diagnostic Interview for Social and Communication Disorders

DOH Department of Health

DSM Diagnostic and Statistical Manual of Mental Disorders (published by the American Psychiatric Association)

DX Diagnosis (or Diagnosed)

E

EBD Emotional/Behavioural Disturbance

EBP Evidence-Based Practice

ECT Electroconvulsive Therapy

EDNOS Eating Disorder not Otherwise Specified

EF Executive Function

EFD Executive Function Disorder

EFT Emotionally Focused Therapy

EFT Emotional Freedom Technique

EIBI Early Intensive Behavioural Intervention

EMDR Eye Movement Desensitisation and Reprocessing

ERP Exposure and Response Prevention

ESL English as a Second Language

ETB Education and Training Board

EUPD Emotionally Unstable Personality Disorder

EWO Education Welfare Officer

F

FC Facilitated Communication

FCAMHS Forensic Child and Adolescent Mental Health Services

FCT Functional Communication Training

FMHS Forensic Mental Health Service

FMRI Functional MRI (examines the brain's functional anatomy)

FSP Family Support Plan

FSS Family Support Services

FXS Fragile X Syndrome

G

GAD Generalised Anxiety Disorder

GARS Gilliam Autism Rating Scale

GI Gastrointestinal

H

HIQA Health Information and Quality Authority

HSE Health Service Executive

I

IACP Irish Association for Counselling and Psychotherapy

IAN Irish Advocacy Network

IASLT Irish Association of Speech and Language Therapists

ICD International Classification of Diseases

ID Intellectual Disability

IEP Individual Education Plan

IFL Identity-First Language

IFS Internal Family Systems Model

IHREC Irish Human Rights and Equality Commission

IPLP Individual Profile and Learning Programme

L

LÁMH A Manual Sign System used by Children and Adults with Intellectual Disability and Communication Needs in Ireland

LGBTQIA+ Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, Plus

LMHS Liaison Mental Health Service

LOC Level of Care

M

MBCT Mindfulness-Based Cognitive Therapy

MBSR Mindfulness-Based Stress Reduction

M-CHAT Modified Checklist for Autism in Toddlers

MDD Major Depressive Disorder

MDT Multidisciplinary Team

MGLD Mild General Learning Disability

MHC Mental Health Commission

MHIDT Mental Health Intellectual Disability Teams

MHR Mental Health Reform

MHSOP Mental Health Services for Older People

MOC Model of Care

MOCEIP Model of Care Early Intervention Psychosis

MRI Magnetic Resonance Imaging

N

NBSS National Behaviour Support Service

NCGE National Centre for Guidance in Education

NCSE National Council for Special Education

ND Neurodivergent

NDA National Disability Authority

NEPS National Educational Psychological Service

NES Night Eating Syndrome

NGO Non-Governmental Organisation

NICE National Institute for Health and Care Excellence

NOSP National Office for Suicide Prevention

NT Neurotypical

O

OCD Obsessive Compulsive Disorder

ODD Oppositional Defiant Disorder

ON Orthorexia

OSFED Other Specified Feeding or Eating Disorder

OT Occupational Therapist

P

PANDAS Paediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections

PCCC Primary Community and Continuing Care

PCT Primary Care Team

PCT Person-Centred Therapy

PDD-NOS Pervasive Developmental Disorder – Not Otherwise Specified

PE Prolonged Exposure

PECS Picture Exchange Communication System

PFL People-First Language

PHQ-9 Patient Health Questionnaire (Standardised Well-being Tool)

PICU Psychiatric Intensive Care Unit

POA Power of Attorney

POLL Psychiatry of Later Life

PSI Psychological Society of Ireland

PT Physical Therapist

PT Physical Therapy

PTSD Post-Traumatic Stress Disorder

R

RPP Relapse Prevention Plan

RTC Residential Treatment Centre

S

SAD Seasonal Affective Disorder

SAD Separation Anxiety Disorder

SAD Social Anxiety Disorder

SEN Special Educational Needs

SENO Special Educational Needs Organiser/Officer

SET Special Education Teacher

SIB Self-Injurious Behaviour

SLT Speech And Language Therapist

SNA Special Needs Assistant

SM Selective Mutism

SPD Sensory Processing Disorder

SPD Schizoid Personality Disorder

SpLD Specific Learning Disability

SSLD Specific Speech and Language Disorder/Difficulty

SSRI Selective Serotonin Reuptake Inhibitors

SZA Schizoaffective Disorder

T

TBI Traumatic Brain Injury

TENI Transgender Equality Network Ireland

THP Transitional Housing Programme

TOM Theory of Mind

U

UNCRPD UN Convention on the Rights of Persons with Disabilities

V

VOCED Vocational Education

VQ Verbal IQ

VR Vocational Rehabilitation

W

WAIS Wechsler Adult Intelligence Scale

WHO World Health Organization

WISC Wechsler Intelligence Scale for Children