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Lived Experiences of Counselors Providing Counseling to Adults With Autism Spectrum Disorder: A Qualitative Phenomenological Study

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LIVED EXPERIENCES OF COUNSELORS PROVIDING
COUNSELING TO ADULTS WITH AUTISM
SPECTRUM DISORDER: A QUALITATIVE
PHENOMENOLOGICAL STUDY

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ABSTRACT

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The purpose of this study was to examine the lived experiences of counselors providing counseling to adults with autism spectrum disorder (ASD). Eleven professional counselors participated in the study from various regions of the United States. Four themes and 10 subthemes were found. The resulting themes discuss the counselor reactions, previous experiences with ASD, approaches used in counseling, and counselor self-care. The findings exhibit new evidence in the literature such as counselors' emotional reactions to working with adults with ASD, challenges in balancing adult clients with ASD and their family members, and professional emotional boundaries used as a self-care tool. Implications are provided specific to counselor educators, counselor supervisors, and practicing counselors in the field. Recommendations include incorporating more education and exposure to individuals with ASD into counseling programs and increasing trainings and research on counseling adults with ASD.

DEDICATION

This dissertation is dedicated to my children, Weston, Ellis, and any other children that God may bless us with. You both are the lights of my life! I started this journey with myself in mind, but when you both came into the world I soon realized that almost everything I do, I do it for both of you. I want you to see how important education is and know that you can achieve your dreams no matter the obstacles. Dedication, hard work, and perseverance can help you achieve your dreams.

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CHAPTER I

INTRODUCTION

The purpose of this phenomenological study was to explore the lived experiences of counselors providing counseling to adults diagnosed with autism spectrum disorder (ASD). As the number of people diagnosed with ASD grows, multi-services attending to the whole person are needed (Roane, Fisher, & Carr, 2016). Numerous fields including medical doctors, neurologists, neuropsychologists, psychologists, psychiatrists, speech therapists, occupational therapists, behavioral therapists, special education professionals, rehabilitation therapists, social workers, and clinical counselors are continuing to learn about ASD through research and treatment. Treatments offered to neurotypical clients, or clients without ASD, are being augmented in attempts to create a treatment that fits the unique condition called ASD.

The ASD is not a modern phenomenon; people have exhibited traits of ASD for centuries. In 1943 Leo Kanner, an Austrian–American psychiatrist, published a paper that described children who exhibited social aloneness, ridged desire for sameness, and possessed cognitive potentials (Kanner, 1943). Kanner named the condition early infantile autism to describe the obsessive nature of the children's inward focus and, consequently, forged a new outlook on ASD as its own separate disorder (Baker, 2013; Wolff, 2004).

Around the same time, Hans Asperger, a Viennese pediatrician, described a group of children struggling with social and sensory difficulties, trouble adapting to new

routines, possessed a high intellect and exhibited deficits in motor skills (Wolff, 2004).

Kanner and Asperger both identified a separate set of symptoms that were unique to ASD

and suggested that ASD could no longer be categorized as schizophrenia, as it was done

previously to 1943. However, autism did not appear as a distinct category until 1980 in

the *Diagnosis and Statistical Manual* (*DSM*)–*III* (Baker, 2013).

In 2013, the *DSM–5* was published with entirely new perspectives and diagnosis

features for ASD. Previously, in the *DSM–IV* published in 1994, ASD was broken down

into a section called Pervasive Developmental Disorders, which consisted of sub

diagnoses of Asperger's disorder, autistic disorder, childhood disintegrative disorder, and

Rett's disorder. In the current edition of the *DSM–5*, all these disorders have been

combined to form ASD as a spectrum, and clients are given a severity level of one, two,

or three. Symptoms, diagnoses features, and further discussions of the changes to the

DSM–5 will be presented in Chapter II. Over the years, the understanding and

classification of ASD has changed drastically, but society and mental health professionals

continue to be baffled by what ASD is, what causes it, how to classify and quantify it,

and how to treat it (Autism Speaks, 2018).

Currently, many treatments are offered to help treat the symptoms of ASD.

Different treatment programs have diverse theories, goals, and methods to achieving

those goals. However, counseling is focused on treating multiple aspects of the client as

well as mental illness. The ASD population possesses a higher than average rate of co-

morbidity of mental health diagnoses such as anxiety and depression (Hollocks, Lerh,

Magiati, Meiser-Stedman, & Brugha, 2018; Wigham, Barton, Parr, & Rodgers, 2017) and

low self-esteem and self-efficacy (e.g., Lake, Perry, & Lunsky, 2014; Masi, DeMayo,

Glozier, & Guastella, 2017). Suicidal behaviors are also frequently observed in adults with ASD (Cassidy et al., 2014). Counseling could help provide relief for low self-esteem, self-efficacy, mental health illnesses, and decrease suicidal behaviors; however, counseling is rarely recommended as an effective treatment for adults with ASD due to lack of evidence and awareness from other professionals (Jacobsen, 2004). The results of initial studies are showing that general psychotherapy can help improve functionality in adults with ASD (Anderberg et al., 2017).

Despite the lack of awareness, counselors are working to treat clients with ASD using a variety of modalities of counseling in attempts to attend to personal experiences, emotional expression, and other mental health diagnoses (Lake et al., 2014). Unfortunately, very little information is offered to counselors in how to work with this unique population. Many clinicians reported feeling unprepared to work with individuals with ASD. Furthermore, existing trainings and resources are not meeting the needs of clinicians (Williams & Haranin, 2016). Therefore, if a clinician/counselor is seeking out training elsewhere, an investigation of what they will encounter is needed.

When the author conducted a search in PsychINFO and PsycARTICLES for trainings for professional counselors about autism, nothing appeared. On a search for counselor training autism, about 100 articles showed up; however, the articles focused on school counselors, rehabilitation counselor education, teachers, and the families of people with ASD. Only one study appeared about counselor competencies while working with children with ASD by Feather (2017). On a search for counselor experience autism and counselor preparedness autism, the same results were shown focused on school counselors, teachers, and families of people with ASD. On a search for therapeutic

relationship autism, several articles were shown focused on music therapy with children, cognitive–behavioral therapy (CBT) treatment for adolescents, and multiple studies in neuropharmacology.

On a search in Google Scholar for trainings for professional counselors about autism, articles focused on special education, impact of culture on Autism, parent–professional trainings, speech pathology, and visual cued imitation training with children with ASD. I decided to conduct a search using Google to determine what an average working counselor could potentially search for if they were seeking training on how to counsel clients with ASD. On a search in Google for trainings for professional counselors about autism, multiple trainings appeared. The first few websites were about AutPlay, a treatment for children integrating play therapy and behavioral-based techniques. The next website linked an article by Dillenburger, McKerr, Jordan, and Keenan (2016) describing the lack of autism-specific training in British professionals across numerous fields, including therapy professionals and the damaging impact on those with ASD. This study will be described in Chapter II.

The next website in Google presented by Summit Professional Education offering autism continuing education courses. Upon further investigation, payment was required for full access; however, several trainings appeared included an evidence-based approach to therapeutic intervention in the neonatal intensive care unit, differentiating sensory from behavior, pediatric neurodevelopmental disorders, preschoolers and autism, and early childhood interventions. All the trainings presented on the page were for professionals working with children. The next website was from the International Board of Credentialing and Continuing Education Standards describing the certifications for those

with applied behavioral analysis backgrounds and degrees. The only website that seemed to be providing specialized training for ASD in mental health care was a counselor located in Pennsylvania at the Center for Autism. Overall, the lack of trainings and information for counselors on working with individuals with ASD is concerning. Very little information for counselors, and all mental health care professionals, is offered. Additionally, many clinicians reported they did not receive specific training on how to counsel individuals with ASD in their graduate professional training programs (Williams & Haranin, 2016). Moreover, supervisors are also lacking the training on how to support and guide counselors-in-training with how to provide counseling to clients with ASD; therefore, counselors will continue to feel insecure and potentially unknowingly harming the client (Brookman-Frazee, Drahota, Stadnick, & Palinkas, 2012; Williams & Haranin, 2016).

Clients with ASD have been shown to struggle with many cognitive concept mechanisms, such as executive functioning, empathy, emotional regulation, social cognition, joint attention, and theory of mind among others (Booth & Happe, 2010; Caruana et al., 2018; Frith & Happe, 1999; Kiep & Spek, 2017; Mazefsky et al., 2013; Sasson, Nowlin, & Pinkham, 2012). These cognitive concepts are derived from developmental psychology research to describe the different cognitive concepts that can lead to deficits in adults with ASD. Counselors need to be aware of each cognitive concept and how they may impact the counseling process and the therapeutic relationship. Cognitive concepts create difficulties in daily life for an adult with ASD. It is how they interact with the world. Therefore, these perceptions will also influence how the client will be in the therapeutic space and therapeutic relationship.

Multiple barriers to treatment can arise during counseling that challenge the counselor both personally and professionally. Symptoms inherent in ASD, such as interpersonal disconnectedness or trouble with emotional awareness, may create a more complex counseling process and difficulty in the development of the therapeutic relationship. Hence, the therapeutic alliance must be approached differently with adults with ASD (Woods, Mahdavi, & Ryan, 2013). However, some counselors are not altering their modes of counseling when presented with a client with ASD, and they are not observing changes in the client (Brookman-Frazee et al., 2012). If this is the case, then the therapeutic relationship needs to be examined. While most counseling theories agree that a therapeutic relationship is needed for client change, interpersonal theory suggests that the relationship is the foundation for counseling, and the use of the relationship is the most effective agent of client change (Teyber & Teyber, 2018).

Interpersonal theory, as originally created by Harry Stack Sullivan and further developed by contemporary interpersonal theorists, Kiesler and Teyber, was used as the theoretical foundation and as the lens that this researcher viewed counseling with adults with ASD. A brief description of interpersonal theory will be discussed, and a more in-depth examination of interpersonal theory will be provided in Chapter II. Harry Stack Sullivan was a Neo-Freudian American psychiatrist whose work was published in the 1950s in a series of seminal papers and books discussing his ideas about personality development and psychiatry. Sullivan believed that all humankind is more alike than we are different, which he termed one-genus hypothesis. For Sullivan, sensations, also called experiences, and the interpersonal interaction with others plays a major role in the development of the person (Sullivan, 1953).

According to Sullivan, the self-system, or the development of the personality, is created through the repetitive interactions initially with parents and then others. The child develops perspectives about self and others, termed self-other relational patterns, through these interactions, and these patterns are carried out in future interactions with others (Teyber & Teyber, 2018). Over time, people develop interpersonal coping styles based on those experiences and the ways they attempt to avoid and minimize anxiety (Evans, 1996). According to Sullivan, anxiety was the "experience of interpersonal insecurity, was the primary cause of inadequate or inappropriate patterns of interpersonal relations" (Evans, 1996, p. 141). Anxiety will cause a person to be developmentally halted. They will not progress until the anxiety has passed (Sullivan, 1953). Sullivan believed loneliness was an exceedingly important emotion and highly misunderstood and undervalued emotion. Prolonged anxiety and loneliness together disrupt the individual's sense of interpersonal security and damages the individual's ability to create positive self-image leading to mental illness (Evans, 1996). Sullivan (1953) stated, "loneliness in itself is more terrible than anxiety" (p. 262). Loneliness can damage a person's sense of self and how one relates to others.

A plethora of research exists that suggests loneliness and social support have substantial influence on an individual's well-being. Loneliness was associated with higher rates of mental illness in adults with ASD (Mazurek, 2014). Feelings of loneliness can develop into anxiety and depressive symptoms (Woods et al., 2013). Anxiety disorders and other mental illnesses are prevalent in adults with ASD (Hollocks et al., 2018). From an interpersonal theory perspective, it is important to connect clients,

especially adults with ASD, with people in their lives and help them maintain and deepen their social ties (Teyber & Teyber, 2018).

The purpose of this research was to investigate the lived experiences of counselors who work with adults diagnosed with ASD. It is important to gather this information, so we may better understand what the counselor believes has been working and what is not working in helping adults with ASD relieve emotional distress and increase functionality. It is hoped that the findings of this study may not only help practicing counselors, but also aid in helping counselor educators and counselor supervisors as well.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is the governing body that accredits master's and doctoral degree programs in counseling and similar programs and assures programs will uphold high and consistent standards set forth by the counseling profession. Those standards require counseling programs to teach courses in social and cultural diversity including "diversity . . . of physical, emotional and mental abilities" (CACREP, 2016, section 2, para. 2). An ASD is considered a mental and emotional disability as evidenced by emotional deficits and by its very presence in the *DSM-5*. Nevertheless, very few university counseling programs provide training and knowledge about disability problems (Smart & Smart, 2006; Smith, Foley, & Chaney, 2008). Regrettably, disabilities have not been perceived as a multicultural concern by counselor educators and counseling professionals (Smith et al., 2008). If counseling programs are neglecting content about disabilities, then they might also neglect teaching about the complexity of ASD.

It is hoped that the findings of this study may fill a hole in the descriptions of counselors' experiences and indirectly impact counselor education by providing information for the development of improved curriculum for teaching about disabilities and ASD as multicultural concerns. The findings can aid in helping counselor educators and counselor supervisors provide improved education, training, and support to new counselors before they provide services to clients with ASD. Therefore, new counselors will be better prepared and possess skills and techniques necessary to offer counseling to clients with ASD

Problem Statement

In this study several dimensions of the counselor's experiences working with adults with ASD were addressed. First, the number of individuals diagnosed with ASD is rising; therefore, more and more clients who come into a counselor's door seeking services are also increasing (Gillis & Beights, 2012). Given this information, the importance of competency and understanding of the unique requirements of working with a client with ASD is also growing. Few counselors are trained and possess the knowledge on how to provide treatment to adults with ASD (Maddox, Kang-Yi, Brodkin, & Mandell, 2018). According to Gillis and Beights (2012), counselors, and all mental health professionals, need more thorough specialized training on how to alter counseling to fit the needs of this population. Counselor proficiencies on how to treat clients with ASD are not addressed in the current literature (Feather, 2017).

The second dimension is how ASD can be commonly comorbid with other mental health illnesses (Kohane et al., 2012; Masi et al., 2017; White, Oswald, Ollendick, & Scahill, 2009; Wigham et al., 2017). Mood and anxiety disorders have significantly high

prevalence rates in this population. Furthermore, suicidal ideation is the most common depressive symptom in the ASD population (Richa, Fahed, Khoury, & Mishara, 2014). Adults with ASD are at a higher risk of suicide ideation, attempts, and mortality by suicide than the general population (Hedley, Uljarevic, Wilmot, Richdale, & Dissanayake, 2018; Hirvikoski et al., 2016; Zahid & Upthegrove, 2017). With these serious concerns, the literature does not present what general counselors are doing to attend to these problems within counseling adults with ASD.

Clients with ASD have shown to have trouble with emotional regulation, or the intentional adjustments to one's emotional state, and this could possibly lead to the development of other mental illnesses such as depression (Mazefsky et al., 2013). The most popular method of treatment used with adults with ASD is a type of psychotherapy called CBT. The CBT has shown success rates for children and adolescents in decreasing anxiety symptoms; however, research examining CBT with adults with ASD is severely lacking (Gaus, 2011). Initial studies with CBT and adults with ASD are showing similar success rates with anxiety; however, modifications are needed in order to make the treatment more appropriate for ASD. Furthermore, research on CBT in decreasing depression and suicidal behaviors in adults with ASD is missing (White et al., 2018). Another promising form of treatment used with adults with ASD is mindfulness-based therapy (MBT). This form of treatment is also showing success rates in decreasing a range of mental illnesses, including depression; however, modifications are also required when offering the treatment to adults with ASD. Information about where counselors learn about and how to apply CBT and MBT modifications with adults with ASD is unknown.

Third, numerous challenges to treatment exist when working with a client with ASD (Woods et al., 2013). Cognitive concepts such as theory of mind, empathy, and central coherence can describe how complex the therapeutic alliance and counseling process can become. Counselors need to be aware and understand the barriers in counseling and know what methods to use to work past them. Lastly, while there is an abundance of information about the perspectives of clients with ASD, the counselor's voice is missing in the literature (Vulcan, 2016). Very little information exists about the current practices and in what way treatment is offered to adults with ASD. Identifying what occurs in the treatment process is important so it can be replicated and more adults with ASD can have access to better mental health care (Maddox et al., 2018).

Only three studies have been found in the literature focused on the counselors who work with individuals with ASD. These studies examined the counselors who work with child clients with ASD. No studies exist focused on the counselors working with adults with ASD. In a study done by Williams and Haranin (2016) surveying 64 mental health clinicians working in 21 mental health agencies, it was found that half of participants reported they lack skills to work with children with ASD. Furthermore, Brookman-Frazee, Taylor, and Garland (2010) found that counselors reported feeling unprepared to work with clients with ASD, and they do not augment their interventions with this population. If counselors are feeling unprepared while working with children with ASD, then counselors who work with adults with ASD might be feeling likewise. Counselors need to have appropriate knowledge and awareness of their own feelings of being unprepared when working with clients with ASD (Harris, Durodoye, & Ceballos, 2010).

This phenomenological study examined the lived experiences of practicing counselors in the United States when working with adults with ASD. This study examined what it means to be a counselor who works with individuals with ASD. It would benefit the counseling profession to have a greater understanding of the counselor's challenges, what they would need to better work with this population, and how they can be better prepared for challenges in treatment. Additionally, only 15.6 % of counselors reported having a supervisor who had expertise in working with clients with ASD, and 22% reported that their agency offered group supervision for working with clients with ASD (Williams & Haranin, 2016). This suggested that the percentage of supervisors who have knowledge and skills in providing counseling to people with ASD is greatly lacking. This study may be able to offer insight and knowledge about the counselor's experiences and how counselor supervisors can better guide and advise counselors-in-training on how to work with adults with ASD.

Once we understand what counselors need to feel comfortable working with adults with ASD, then the field of counselor education will benefit in three ways. First, this study can provide counselor educators with awareness that people with ASD, especially adults, require a different set of skills from their counselor such as having knowledge of and appropriately applying counseling modifications (Gaus, 2019). Secondly, this study can aid in helping counselor educators know what counselors need to learn in order to feel competent providing counseling to adults with ASD. Furthermore, this study's findings might illuminate the gaps in education on how counselors are currently trained to address adults with ASD. Third, the findings can also aid in how to strengthen the foundational knowledge of social and cultural diversity in the

CACREP 2016 standards under section two, counseling curriculum, by providing ideas on how to better train students in multicultural counseling skills including awareness of and developing relevant skills to address disability issues related to ASD.

Gaps in the Literature

Currently, one in every 59 people is diagnosed with ASD and it occurs in all racial, ethnic, and socioeconomic groups (Centers for Disease Control and Prevention, 2019). Therefore, counselors see many clients coming into their office diagnosed with ASD and struggling with an array of issues (Gillis & Beights, 2012). Numbers are growing because professionals and the general public are becoming more knowledgeable about ASD, so the need for better mental health services is increasing. However, several gaps in the literature are present.

First, while there is a large amount of research focusing on children and adolescents with ASD, research on adults with ASD is minimal. This may be due to several factors: the unfamiliarity of ASD while the adult was younger and, therefore, no diagnosis was made, a misdiagnosis was given, and/or due to the difficulty in current diagnosis because of the lack of information (Barnhill, 2007; Lai & Baron-Cohen, 2015). Currently it is estimated that 5.3 million adults over the age of 20 are diagnosed with ASD and little mental health support is provided (Turcotte, Mathews, Shea, Brusilovskiy, & Nonnemacher, 2016). With these estimations, it is important that we learn what interventions are needed so we can provide better treatment for adults with ASD. This research hoped to understand what interventions counselors are currently employing that are helping adults with ASD and fill a small gap in the research on adults.

Secondly, a gap exists in research on counseling with adults with ASD. Maddox et al. (2018) stated, "we know very little about the current practices and patterns of treatment delivery for adults with ASD and co-occurring anxiety and depression in community settings" (p. 33). While it may be assumed many adults with ASD are seeking treatment through counseling, what happens in the process and what methods are used is bare (Anderberg et al., 2017). Adults with ASD are less likely to receive counseling and when they do, they average more visits than the general population (Maddox et al., 2018). Maddox et al. suggested the reasons for this is unknown; however, it seems reasonable to infer that counseling may not be working as well so the clients need more time in counseling to achieve their goals. Traditional counseling may be less effective with this population according to Maddox et al. Third, while we are still learnings how counseling can benefit clients with ASD, a tremendous gap exists on the perspectives and experiences of practicing counselors who are providing counseling to clients with ASD (Vulcan, 2016). I hope to give a voice to the counselor's experiences and reflections on their work.

Statement of Purpose and Research Question

Giving voice to the counselors requires an openness to understanding how they experience working with adults with ASD and how they interpret those experiences. Qualitative design is focused on the understanding of experiences, how people think and feel about experiences, and what meaning they derive (Merriam & Tisdell, 2016). Counseling's power is in the relationship between the counselor and client and the meaning that is created during that process. Similarly, qualitative design has the goal of the construction of meaning (Krauss, 2005). This study hoped to discover the meaning

that the counselors are experiencing when working with their adult clients with ASD. Furthermore, phenomenological research illustrates the common meaning a group of people experience while living with a shared phenomenon. Phenomenology attempts to describe a universal essence of experience (Creswell & Poth, 2018). In this case, it is the essence is the experiences, meanings, and emotions the counselors experience while working with adults with ASD.

The purpose of this research was to understand the lived experiences of clinical counselors while working with clients with ASD. This study aimed to discover counselors' perspectives, created meaning and emotions while working with adults with ASD. The principle question for this study is as follows:

Q1   What are the lived experiences of counselors providing counseling to adults diagnosed with autism spectrum disorder?

Significance

The rationale for this study is best described through five tiers of needs. First, is the discovery of counselors' lived experiences. This study's main goal was to understand the counselors' perspectives, thoughts, feelings, and experiences while providing counseling to individuals with ASD. I sought to understand how counselors experience unique symptoms of ASD both in the counseling room and personally. When we understand what practicing counselors are using to treat clients in the room and how they are personally coping with their experiences, then we can better teach other counselors what to expect and how to prepare to work with clients with ASD.

Secondly, as counselors our duties lie in the best care for the client. One of the aims of this study was to better understand what counselors believe to be helping clients with ASD and what interventions they are utilizing. I aimed to understand how

counselors attend to mental health needs and how they approach the challenges to treatment. When counselors are aware of more effective methods, then they are better able to serve the unique needs of adult clients with ASD.

The third tier is how to enhance counselor preparedness before they initiate sessions with adults with ASD through training and education. I hoped to better understand and discuss what is and is not effective and how to personally prepare one's self. If this is understood, then counselors entering the field will be better equipped on how to work with individuals with ASD. The fourth tier is supervisors need to know how to support and guide counselors-in-training through challenging experiences during counseling with adults with ASD. Lastly, counselor educators need to know how to train and provide teaching that fits the needs of counselors and clients. If understanding and knowledge is acquired through the five tiers of needs, then this may strengthen counselor educator's ability to provide an optimal educational foundation for counselors-in-training when working with adults with ASD.

Researcher Stance

In phenomenological research it is common for the researcher to write about one's experiences with the phenomenon (Merriam & Tisdell, 2016). To keep the findings of the study pure of judgement and preconceptions, I was transparent about my personal assumptions and experiences with this subject matter. Therefore, a discussion of my experiences of the phenomenon is needed and will be presented (Creswell & Poth, 2018). The development of these assumptions was created over numerous years of working in the counseling field in two different roles: as a counselor and, later, as a counselor supervisor.

The central assumption of this study was that most counselors do not have training with how to provide counseling to clients with ASD. I initially had this problem myself and over the years working as a counselor, I have heard similar predicaments from discussions with my colleagues. All my initial experiences with working with a person with ASD, initially as a preschool teacher and later as a counselor, I felt anxious, uncertain, and lost. I noticed quickly that traditional talk therapy methods did not work, and I realized I needed more in-depth training. Over the years, I have discussed these experiences and many colleagues have echoed comparable feelings when it came to working with clients with ASD. Most, if not all, agreed they did not know what methods or interventions to use or how to counsel people with ASD, and consequently did not accept clients diagnosed with ASD. I was struck that with the number of peopled diagnosed with ASD climbing, more and more counselors may be denying clients with ASD seeking counseling because of their own insecurities. This breaks my heart!

I started working as a counselor in an inpatient mental health hospital in the child and adolescent units, and my experiences there lead me to return to school for a doctorate degree and prompted the beginning to this research, unbeknownst to me. Repeatedly I saw children come into the unit who were just different than the other children. They were admitted for an array of different behaviors and diagnoses; however, they all exhibited social awkwardness, displayed repetitive behaviors, and possessed an intense focus of interest in something. Through word of mouth and discussions with other counselors and staff in the hospital, no one knew what to do or how to help these children. Many of them considered these children just a problem. I was at a loss. Before I performed a family session with one such child and the family, I researched symptoms

and it dawned on me, Autism! I was astounded that this child was not diagnosed with ASD previously and he was a teenager! I explained these findings to my supervisor, she agreed with me, and said, "that makes it more difficult because I have no referrals for them." This was the birth of my interest in clients with ASD and a first of many similar experiences.

Currently I work with numerous clients with ASD in my private counseling practice. I am amazed how clients would struggle with the cognitive concepts in different ways. I am challenged both personally and professionally with each client on how I have to change my methods, the way I speak, or how I describe something so it is understood by each person. I do notice that the thread of profound loneliness is present in most of my clients with ASD. So many of them deeply desire connection and closeness with someone, yet the means to get there is lost on them. Most of my work with them is finding ways to reconnect with others and themselves.

Furthermore, I am a licensed counselor supervisor in Texas and have provided supervision to numerous counselors-in-training who have stated they do not have any previous ASD training. All my supervisees reported knowing symptoms, but not knowing how to provide specialized counseling to this population. Several supervisees work in agency settings where clients with ASD come into the office regularly, usually with severe behavioral problems. These supervisees all have reported feelings of fear, intimidation, worry, and feeling stuck when approaching therapy with a client with ASD. A couple of counselors have gone as far as telling their agency supervisors that they do not want to work with clients with ASD.

The second assumption based off the literature and personal experience is the common belief that although ASD is a mental health diagnosis, it is not a diagnosis that can be treated with counseling. In my experience, physical and mental symptoms are intertwined. Although counseling may not treat repetitive behaviors directly, we can treat the underlying emotions, such as anxiety and loneliness, which could increase the frequency and intensity of repetitive behaviors. I believe that working within a treatment team of professionals is the best practice when approaching a multifaceted mental illness like ASD. The treatment team must treat all the aspects to the person including comorbid illnesses and the emotional experiences. Counselors should be included in treatment teams; however at the moment, this is often not the case.

The third assumption is that qualitative research is greatly undervalued. I believe qualitative research is the best method that corresponds to the values and goals of counseling. I think of qualitative design as a method to elicit story telling. Story telling has been at the core of my heart for as long as I can recall. I have been an avid reader most of my life and began writing as a young child. In high school, I used to write poems all over my notes and homework. In college, I received a minor in creative writing. Writing is in my blood. When I learned about qualitative design, I knew it was the best fit for me.

The last assumption is that ASD is not thoroughly discussed in counseling programs. In my experience, ASD was briefly discussed during a diagnoses course during my master's counseling program. I remember reading about the symptoms criteria and never hearing about it again. I never gave it much thought during the course and did not recognize the impact of social and emotional factors that accompany ASD. I do not

remember discussing it in a multicultural course, as it probably should be. I have asked

several colleagues to see what they learned about ASD during their counseling program,

and to my surprise it was a very similar experience. The ASD is discussed as a diagnosis

and then forgotten. I believe as counselor educators, it is our duty to equip our students

with the most knowledge that we can, so they are prepared for the world of counseling

and that includes teaching about ASD. These four assumptions have guided me towards

the creation of this research, however now that they have been acknowledged and

presented, this researcher will stay open and accepting of all facets of the phenomenon.

Definitions or Key Terminology

In this research study, cognitive concepts were collected from research in the field

of developmental psychology to describe the deficits commonly observed in clients with

ASD and the impact they can have on clinical work. These concepts are not common

knowledge in the counseling community; however, they are clinically relevant and

require a basic understanding of how they impact the person with ASD. How they are

experienced in the context of the counseling process will be discussed further in Chapter

II. Each cognitive concept listed below has a plethora of research examining multiple

aspects. For the brevity of this research, only a few key research studies relevant to the

topic will be examined and included.

Autism spectrum disorder. An ASD refers to the diagnosable mental illness in the *DSM–5*
    called autism spectrum disorder. Clinical diagnosis and symptoms will be
    described in Chapter II.

Asperger's syndrome. Asperger's disorder was a clinical diagnosis in the previous edition
    of the *DSM–IV-TR* (text revision). Asperger's disorder is commonly called

Asperger's syndrome, Asperger's, or AS in the literature and is no longer a

clinical diagnosis according to the *DSM–5* published in 2013. High-functioning

autism (HFA) is the current term used to describe Asperger's syndrome.

Broad autism phenotype. Broad autism phenotype, commonly referred to as the BAP, is

the range of ASD behaviors and symptoms that are not considered clinically

diagnosable but are noticeable and can become problematic. Symptoms are

described as a milder form of ASD (Sasson et al., 2012). Studies have suggested

that the broad autism phenotype is not limited to family members, but ASD-like

behaviors are normally distributed in the general population (Ingersoll, 2010).

Central coherence. Central coherence is the cognitive ability to put various pieces of

information together to form a greater picture or meaning. Clients with ASD

exhibit weak central coherence and focus only on the details at the expense of

understanding the global meaning (Booth & Happe, 2010).

Emotional regulation. Emotional regulation is described as follows:

> ER (Emotional Regulation) defined as the automatic or intentional modification
> of a person's emotional state that promotes adaptive or goal-directed behavior.
> Individuals with ASD may fail to use adaptive ER strategies and instead react
> impulsively to emotional stimuli with tantrums, aggression or self-injury. Such
> behaviors are often interpreted as deliberate or defiant but may be due to
> inadequate management of emotion. (Mazefsky et al., 2013, p. 679)

Emotional regulation is the person's ability to experience, tolerate, identify, and

express emotions (Laurent & Rubin, 2004).

Empathy. Empathy has been described in many ways. In this study it is best described by

Szalavitz and Perry (2010) as "the essence of empathy is the ability to stand in

another's shoes, to feel what it's like there and to care about making it better if it

hurts" (p. 12). In her 2013 TED talk, Dr. Brene Brown described empathy as:

"empathy fuels connection. Sympathy drives disconnection" and "empathy is feeling with people" (Brene Brown RSA Shorts, 2013). Wiseman (1996) described empathy in four attributes: to be able to see the world as others see it, to be nonjudgmental, to understand another person's feelings, and to communicate your understanding of that person's feelings.

Executive functioning. Executive functioning is our ability to decide where we place our attention and how we multitask multiple different stimuli at once. Executive functioning also includes how we generalize learning from one situation to another (Jacobsen, 2004), plan, working memory, impulsiveness, monitor behaviors, and shift focus (e.g., Kiep & Spek, 2017). Executive functioning impairments have been observed in some people with ASD and some have exhibited weak mental regulation. Executive functioning is theorized to describe inflexibility, preference for sameness, and hyper focus on specialized interests that characterize behaviors in ASD (e.g., Kiep & Spek, 2017).

Heterogeneity. Heterogeneity refers to the broad spectrum of diversity under the diagnosis ASD. Two people may have the same diagnosis of ASD, but symptoms may look drastically different. This creates difficulty in diagnosis and in the development of interventions and treatments (Masi et al., 2017). Heterogeneity is best described as,

> diversity or variability; it describes dissimilar parts that are somehow connected. We think of Autism as a disorder that causes deficits in patterns of cognition, emotional, behavioral and social functioning that are manifested differently across groups. (Georgiades, Szatmari, & Boyle, 2013, p., 123)

Joint attention. Joint attention refers to the ability to shift one's attention based on the attention and eye gaze of another person or group of people. Joint attention

involves the mental process of recognizing another person is mutually

experiencing the same stimuli. Individuals with ASD struggle with joint attention

and may lead to trouble with social cognition (Caruana et al., 2018).

Social cognition. Social cognition is defined as the mental processes that facilitate

understanding of social knowledge, skills, perceptions, awareness, and

interpretations including theory of mind (Brothers, 1990). Research has suggested

those with ASD have deficits in social cognition (Sasson et al., 2012).

Theory of mind. Theory of mind has been described in many ways: the ability to

recognize mental states in others and calculate future behavior (Frith & Happe,

1999; Scheeren, Rosnay, Koot, & Begeer, 2012), mindblindness (Baron-Cohen &

Hammer, 1997), and unaware of self and others' thoughts, feelings, and

experiences (Senju, Southgate, White, & Frith, 2009). Theory of mind is the

ability to know that others are thinking, feeling, and experiencing the world at the

same time one's self perceives the world. Some research has proposed that

individuals with ASD have an absence of theory of mind and some research is

suggesting otherwise (Scheeren et al., 2012).

Summary of Research Study

As the prevalence rates of the diagnosis of ASD increases, the demand for

specialized care is on the rise. Mental health professionals need to be aware and

understand the unique condition of ASD and how to best develop interventions that

attend to the wholeness of the client. Qualitative research methodology was used by

means of the phenomenological approach. An in-depth look at the perceptions, emotions,

and the meaning that is created by the counselor's experiences while working with adults

with ASD was examined using semi-structured interviews. A counselor's perspective and experiences not only give voice to the stories of the clients, but just as important, the story of the counselor. This study hoped to discover the person of the counselor. This study also hoped to discover what counselors need to feel prepared and confident when working with adults with ASD so counselor educators will have a better understanding what needs to be taught in counseling master's programs.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this chapter is to thoroughly explore autism spectrum disorder (ASD) and counseling with adults diagnosed with ASD. I will present the literature that is salient to understanding the need for a phenomenological study of counselors who work with adults with ASD. First, the evolution of ASD and the pertinent history of the *Diagnostic and Statistical Manual* (*DSM*) in how it relates to ASD will be examined. Next, a presentation of the literature on comorbid mental illnesses with ASD will be presented. Third, types of treatment for ASD and barriers to treatment will be discussed including the literature about using psychotherapy with adults with ASD. Last, Interpersonal Theory will be reviewed and will serve as the theoretical background for this study.

**The Historical Development of
Autism Spectrum Disorder**

For 75 years, scientists and professionals have been fascinated with ASD. It has taken numerous years for ASD to be viewed as its own condition. Only a few known cases before 1943 were documented that described ASD symptoms. It was not until 1943 when Kanner began the initial studies with children whom he believed had early infantile autism that started the focus on a new disorder as its own unique cluster of symptoms. I will briefly lay out the beginnings of ASD and how it has developed through time into what we know today. I have excluded many important individuals and historical events in

the development of modern day ASD for the brevity of this study. I have focused on what I believe to be the most important and pertinent historical information about ASD to show the connections to what perspectives we carry today. The myths and preconceptions surrounding ASD are rooted in the historical development and provide understanding of how society perceives people with ASD. Those misconceptions influence how people understand, treat, and diagnose clients with ASD at the present moment.

Early Accounts

The first case believed to exhibit ASD involved a 39-year-old man, Hugh Blair, who in 1747 appeared before a Scottish court for evaluation of his mental state so he could get married. Blair had symptoms that could be now classified as ASD such as echolalia (repeating verbalizations), obsessive and repetitive behaviors, odd collection of feathers and sticks, abnormal gaze, and deficits in social behaviors (Wolff, 2004).

In the late 18th century and 19th century, children with disabilities were often abandoned and some were later found in the wild. They were believed to be raised by wolves or other animals and were called wolf children. In 1798, Victor, estimated age at about 11 or 12 years old, was one such child found near Aveyron, France (Wolff, 2004). A French physician, Dr. Jean Itard, attempted to provide education and cultivate Victor with the hopes to develop social attachments and language skills. Victor exhibited sensory indifferences; he did not speak but made grunting noises, did not imitate others, and rocked. Over the course of five years, Victor showed great improvements in many areas; however, his language never progressed past basic syllables (Wolff, 2004).

In 1911, Eugen Bleuler, a Swiss psychiatrist, coined the term autistic and could be described as thoughts that distort reality, are fictional, are wishful thinking, and are

considered fantasy (Haswell Todd, 2015). Autistic thinking was when a person had infantile wishes to evade the unpleasant reality and replace them with fantasy (Evans, 2013). To think autistically is an act all people engage in, not just those who are mentally ill. Bleuler also created the term schizophrenia; the two terms were confused with each other often and while schizophrenia was accepted by the medical community, autistic was not (Haswell Todd, 2015). This researcher is assuming the reason for the acceptance of schizophrenia is because it described an abnormal mental state and autistic described a mental state that all people engage in, although those with schizophrenia engage with it more often and for longer periods of time.

In 1908, Dr. John Haslam wrote a chapter called "Cases of Insane Children" in his book *Observations on Madness and Melancholy* that described a 7-year-old boy who was inattentive, curious, and had a poor estimation of distance. When Dr. Haslam evaluated the boy again at 13 years old, he noticed the boy had numerous obsessions, preferred to spend time alone, and spoke only about his preoccupations (Wolff, 2004). At the time, symptoms of ASD would be classified with the mental illness, schizophrenia. People with ASD were described as feebleminded, defective, and many spent their lives in psychiatric asylums (Baker, 2013).

Kanner. In 1943, the seminal work and theories published by Dr. Leo Kanner changed the beliefs and fate of ASD as its own unique disorder. Our modern description of ASD is credited to Dr. Kanner and Dr. Asperger. They were the first pioneers to identify and describe autism as its own distinct disorder separate from schizophrenia and mental retardation. Strangely, although both doctors were researching and published their work about ASD around the same time period, Kanner in 1943 and Asperger in 1944,

neither referenced each other in publications nor exhibited any understanding about the other. During World War II, Asperger lived in Vienna, Austria, and Kanner lived in Baltimore, so it is possible the chaos of war made it difficult to communicate. However, much confusion and theory of their involvement still exists today (Haswell Todd, 2015). Controversy about who came up with the term autism to describe their condition first, either Kanner or Asperger, is still under speculation. Many historians believe Asperger was the first with some of his papers dating back to 1938, and a diary entry dated 1930; however, Kanner received more attention due to his location in the United States and his work written in English (Feinstein, 2010). Both doctors' work will be examined and what they believed their disorder encompassed will be described. Kanner's work will be discussed first followed by Asperger's work.

Dr. Leo Kanner, an Austrian–American psychiatrist, was a well-known and respected doctor and social activist. He was passionate about working with children and opened the first child psychiatry clinic in the country (Feinstein, 2010). In his 1943 seminal work, *Autistic Disturbances of Affective Contact*, he described 11 cases of peculiar behaviors in children, which later he called early infantile autism (Haswell Todd, 2015). He had 11 children in his study, including eight boys and three girls. Eight of the children were verbal and three were nonverbal. Kanner's (1943) study consisted of several visits to his clinic and the parents' descriptions of the child's early childhood and current problems through correspondence. This study appeared to have started in 1938 with initial check-ups and follow-ups by correspondence with parents.

Kanner (1943) defined several common symptoms between the children. I have grouped the symptoms Kanner described into five clusters: social, language, sensory,

inflexibility, and physical. The first cluster, social difficulties, encompasses the ability to relate to others. The most important crucial symptom Kanner noted that was connected to all the clusters was the desire for aloneness. Kanner wrote several passages to describe symptoms: "there is from the start an extreme autistic aloneness that, whenever possible, disregards, ignores, shuts out anything that comes to the child from the outside" (p. 242), followed by "profound aloneness dominates all the behavior" (p. 247), and "there is an all-powerful need for being left undisturbed. Everything that is brought to the child from the outside, everything that changes his external or even internal environment, represents a dreadful intrusion" (p. 244). Kanner defined many of the outside world interference as intrusions into the child's world and, therefore, interrupting their aloneness. These intrusions were usually ensued by major panic and tantrums. When the intrusion was gone, the child would resume as if nothing happened, and their emotional state would return to neutral.

The first cluster of symptoms is social difficulties. Starting as very young children, Kanner (1943) described the children's inability to respond or adjust themselves in a socially appropriate manner. The children potentially saw the person as the intrusion and did not respond verbally or physically as other children naturally would. The children would not seem to notice if a person was present in the room nor acknowledge interest in people conversing or talking to them. The children were more interested in the objects of the room. Kanner wrote,

> but he never looked into anyone's face. If an adult forcibly intruded himself by taking a block away or stepping on an object that the child needed, the child struggled and became angry with the hand or the foot, which was dealt with per se and not as a part of a person. He never addressed a word or a look to the owner of the hand or foot. When the object was retrieved, the child's mood changed

abruptly to one of placidity. When pricked, he showed fear of the pin but not of the persons who pricked him. (p. 247)

Clearly, Kanner (1943) noticed the children's lack of connection between objects and people. The children regarded the hand or foot simply as another object, a detached part rather than looking at the whole. Kanner described what we now know as central coherence. Central coherence is the cognitive ability to put various pieces of information together to form a greater picture or meaning (Booth & Happe, 2010). The children did not see the greater picture, the whole person, and focused only on the hand or foot that interfered with their focused activity. Kanner also noted that the children did not play with other children and did not seem to notice the presence of other children. The children can recite physical characteristics or the names of the other children but had no relationship to them. The children were more interested in the pictures of people rather than the actual person.

The second cluster of symptoms Kanner (1943) described was related to language. He noted that all the children struggled with language, and eight of the 11 children had delayed speech and three were mute. Although, one of the children labeled mute was seen mouthing words in a repetitive style by peers at school. Similarly, the verbal children did not use language to convey meaning but used it to recite sentences and identify objects usually in a repetitive nature. Kanner also noted that the children showed echolalia, or repeating words or sentences the child heard. Many of the children were originally believed to be deaf due to their lack of responsiveness and lack of verbalizations. However, the verbal children had excellent role memory, where they could recite enormous amounts of information such as zoological names, botanical names, or the titles and composers of Victrola records. Furthermore, the children

exhibited literalness and inflexibility in word meanings. If weather means the state of the atmosphere, then it cannot mean whether, the decision between options.

The third cluster of symptoms was related to sensory input. Kanner (1943) noted food was the earliest form of intrusion into the child's world. Many of the children struggled with eating, and one of them had to use a feeding tube as an infant. But, over time they gave up and would eat normally. Another intrusion was loud noises and moving objects. Kanner wrote, "yet, it is not the noise or motion that intrudes itself that is dreaded. The disturbance comes from the noise or motion that intrudes itself, or threatens to intrude itself, upon the child's aloneness" (p. 245). A major panic would occur before an anticipated loud noise, such as the vacuum cleaner, or ensue after a noise occurred, such as loud wind.

The fourth cluster of symptoms Kanner (1943) described was inflexibility. Kanner described this as,

> the child's noises and motions and all of his performances are as monotonously repetitious as are his verbal utterances. There is a marked limitation in the variety of his spontaneous activities. The child's behavior is governed by an anxiously obsessive desire for the maintenance of sameness that nobody but the child himself may disrupt on rare occasions. (p. 245)

Kanner wrote that the children became anxious if their environment was changed, and they possessed an extraordinary ability to remember the placement of each object in great detail. The children insisted on the same sequences of events, words, and daily activities. If any of these were altered, intense anxiety and anger would arise. With this demand for sameness, the children lacked the ability to cope with spontaneous activities and responded to spontaneity with panic. The children were drawn to objects that were consistent in appearance and function. Many of the children enjoyed toys that would spin.

Kanner wrote that the children felt control and power over the toys that were consistent.

They felt the same power over their body's ritualistic motor movements as well.

The last cluster Kanner (1943) described was physical characteristics. Kanner

wrote that the children were all physically normal. Kanner wrote that the children were

regarded as feebleminded; however, he perceived them as highly intelligent. His opinion

of the children was far different from the common viewpoint during the 1940s. Several of

the children lived in state schools for the feebleminded, and many of them were

considered schizophrenic. Several children were introduced to Kanner as idiots or

imbeciles. Kanner did not share these viewpoints; he viewed them as possessing great

cognitive abilities. Possibly one of the most influential pieces of knowledge from his

study was when he delineated the difference between people diagnosed with

schizophrenia and these children,

> while the schizophrenic tries to solve his problem by stepping out of a world of
> which he has been a part and with which he has been in touch, our children
> gradually compromise by extending cautious feelers into a world in which they
> have been total strangers from the beginning. (p. 249)

Kanner noted that while some of the symptoms were similar, those with schizophrenia

became more disconnected from the world over time, while the children in his study were

different from the beginning of life. The children attempted to interact with the world, but

only on their own accord as their anxiety decreased. Kanner wrote that the children did

interact with people and the outer world more fluidly as they got older. They continued

with their desire for sameness and aloneness, but would respond and comply more

willingly than they did when they were younger. Kanner concluded,

> we must, then, assume that these children have come into the world with innate
> inability to form the usual, biologically provided affective contact with people,

just as other children come into the world with innate physical or intellectual handicaps. (p. 250)

This statement was pivotal in the development of ASD as its own condition. Kanner insinuated that the children were born different, and it was possibly due to a biological cause.

Another physical description Kanner (1943) provided was that the children in his study came from highly intelligent families. Most of the children's parents were highly educated and worked in respectable fields such as medicine, law, and science. Eight families were published in the *Who's Who in America* magazine and *American Men of Science* magazines, which were popular magazines at the time. These families were prominent and financially stable families. Another influential comment Kanner made in this study was,

> in the whole group, there are very few really warmhearted fathers and mothers. For the most part, the parents, grandparents and collaterals are persons strongly preoccupied with abstractions of a scientific, literary, or artistic nature, and limited in genuine interest in people. Even some of the happiest marriages are rather cold and formal affairs. Three of the marriages were dismal failures. The question arises whether or to what extent this fact has contributed to the condition of the children. (p. 250)

Kanner brought up the question of the child's environment and relationships with the child's parents. These questions brought about much discord in the psychoanalysts' community. After Kanner's work, doctors at the time argued that ASD symptoms were an infant's response to an emotionally distant and disconnected mother (Baker, 2013). Kanner published another paper, *Problems of Nosology and Psychodynamics of Early Infantile Autism,* in 1949 describing autistic children being reared in emotional refrigerators (Cohmer, 2014).

Kanner later became focused on genetics, and in a paper published in 1954 he stated that it is possible the etiology of ASD is biological. Through many papers and statements Kanner gave over the years, it is evident he changed his mind back and forth between an organic cause and the cold and detached parents (Feinstein, 2010). However, Kanner continued to believe and voice that the cause of ASD was rooted in parental nurturing all the way until his death in 1981 (Cohmer, 2014). Kanner spent his life advocating for infantile autism to be separate from mental retardation and schizophrenia (Baker, 2013). The culture of parent blame as the cause of ASD continued for decades and some may argue, it continues to the present day.

Asperger. Hans Asperger is another pioneer believed to describe the initial symptoms of ASD and carve the pathway for ASD as a separate disorder. Asperger was a Viennese pediatrician and unfortunately little information about him in known. He lived in Nazi-era Vienna and wrote his publications in German. His work was seldomly translated into English, and his main work outlining his study of children with ASD published in 1944 was not translated into English until 1991 by Uta Frith. It was believed at first that all his original work was destroyed by a bomb during World War II; however, a new study published in 2018 dispels this belief by analyzing the patient cases written by Asperger from 1928 to 1944 (Czech, 2018). These findings provide some knowledge in understanding the gap in Asperger's history, but it also opens more controversy surrounding Asperger, his political alliances, and his work.

Asperger called the condition he found as autistic psychopathy and had written several papers about the condition dating back to 1938. Asperger published his seminal

work titled *Autistic Psychopaths' in Childhood* in 1944 giving an account of four cases of

male children that exhibited symptoms of,

> Solitariness, abnormalities of gaze, expression and gestures impeding emotional
> contact with other people, insensitivity to social cues, lack of feeling for others
> sometimes amounting to callousness, oversensitivity and insensitivity, "autistic
> intelligence" inventive rather than imitative with specific interests in restricted
> fields such as chemistry, poisons, mathematics, or art which could lead to creative
> achievements, educational delays of all kinds, and rage or tears in the face of
> pressure to conform. (Wolff, 1991, p. 178)

Asperger wrote that although the children were highly gifted, they lacked in social

reciprocity and had poor relationships sometimes to the point of being cruel to others.

Asperger unknowingly was writing about the children's deficits in empathy. The children

showed no understanding of placing themselves in other's shoes, and therefore Asperger

was unknowingly discussing theory of mind. Theory of mind is a modern cognitive

concept that describes the ability to know that other people are experiencing the world at

the same time, but in their own perspective (Senju et al., 2009).

Asperger (1944) noted that the autistic psychopath condition was recognized in

early childhood and persisted throughout the lifespan. Like Kanner, Asperger also

discussed the implication of the family on the creation or the maintenance of the illness

(Wolff, 2004). Asperger stated many of the parents had similar personalities as the

children. Asperger was describing what we now know as the broad autism phenotype.

The broad autism phenotype is the range of ASD behaviors present that are not clinical or

diagnosable. The broad autism phenotype is currently highly studied in family members

of a person with ASD and considered a mild form of ASD (Sasson et al., 2012).

Asperger was focused on the children's ability to be useful members of society

and emphasized how brilliant the children were in the study (Czech, 2018). Similarly to

Kanner, this perspective was different than the prevalent viewpoint of people with ASD during the 1940s. Asperger advocated to give the best care possible so that people with severe mental disabilities could develop their potential (Czech, 2018). Recently, Czech (2018) published a detailed account of Asperger's background, and researchers are postulating that during World War II Asperger joined several parties that had ties to the Nazi Regime and held strong professional ties with numerous ardent Nazis. What is more troubling is that the documents showed that Asperger may have actively complied with sending severely disabled children to the Nazi euthanasia program in a clinic called Spiegelgrund (Czech, 2018). It is unknown if this was done with the knowledge of the euthanasia program, but Czech described a thorough account of the widespread knowledge of these killings at Spiegelgrund in the Viennese population and Asperger's close professional affiliations with the doctors and the founding director of the Spiegelgrund clinic. It is possible Asperger did not know or had reasons to send children to this clinic whether it was personal beliefs or something else; it is more than likely he did know about the killings. Before this study, historians theorized that Asperger was not affiliated with the Nazi Regime and presented a facade of compliance with the Nazis, so he could protect his patients (Feinstein, 2010). The truth behind Asperger's intentions and decisions will never be truly known, but controversy about Asperger will persist.

Lost and Found Again

The 1950s brought about interest and more studies about Kanner's infantile autism; however, professionals claimed it was a rare disorder. Kanner and his colleagues continued to write about the emotional frigidity of the parents of children with infantile autism (Feinstein, 2010). For the most part, the perceptions of ASD during the 1950s

were mostly unchanged. Professionals argued about how to classify ASD and classified those who exhibited ASD symptoms with schizophrenia (Baker, 2013). The first *DSM-I* published in 1952 stated autism-like behaviors were considered childhood schizophrenia. Arguments about the etiology of ASD increased and many did not know how to treat ASD.

Many children diagnosed with schizophrenia, including those on the higher functioning level of ASD, were locked up in mental hospital where they were given appalling treatments such as electric shock and what they believed to be medication at the time, a drug called lysergic acid diethylamide or LSD (Feinstein, 2010). The 1950s was marked with more attention given to how to treat infantile autism but most continued to be baffled by ASD. Recognition of ASD in adults was nonexistent. During this time, ASD was considered a childhood illness, and adults with ASD were completely ignored.

In 1955, Jeanne Simons, a social worker and counselor, founded the first clinic devoted to treating ASD, the Linwood Center for autistic children in Ellicott City, Maryland. In this clinic, ground-breaking treatments were offered called the Linwood method, provided education where they gave early, rigorous, and long-term treatment. The Linwood method is like what we know today to be behavior therapy. This was the first time a professional did not blame the parents and believed children with an array of mental and physical disorders deserved to be given treatment instead of locking them away in an institution (Feinstein, 2010). Simons had great success with her patients and went on to write many articles and a book describing her method.

The 1960s showed a great shift in the perspectives of mental health care. State psychiatric asylums were closed in response to the 1959 Mental Health Act, and children

were integrated back into main stream education and social surroundings. With these children back into daily life, there was a greater need for diagnoses that fit their experiences; therefore, better treatment needed to be developed (Evans, 2013). More attention was starting to be focused on where to place this group of lost children in society.

In 1967, Austrian Bruno Bettelheim wrote a book entitled *The Empty Fortress: Infantile Autism and the Birth of Self* that blamed the parents as the cause of ASD. Bettelheim's book became a bestseller and the first book discussing ASD to be translated into Spanish. This book greatly influenced and damaged the perspectives on ASD for decades to come in many countries. Bettelheim was a Dachau Nazi concentration camp survivor and equated inmates of the Nazi concentration camps to children with ASD and camp commandants to their mothers. Feinstein (2010) wrote about Bettelheim,

> children with autism, he believed, had an inner reality comparable to the external reality of the prisoners and, like them, directed all their energy into a defensive withdrawal. Their absence of language, he claimed, should be recognized as a "defense against emotional pain or any further depletion of the self," and infantile autism, concluded, was "a state of mind that develops in reaction to feeling oneself in an extreme situation, entirely without hope." (p. 55)

Bettelheim used the emotional refrigerator statement from Kanner and created the refrigerator mother theory, which became an internationally known theory. The refrigerator mother theory is the idea that the cold and emotionally disconnected mother is the cause for ASD.

While Kanner believed a predisposition biologically and influenced by nurturing caused ASD, Bettelheim believed ASD was a disease caused by extreme parenting. Therefore, ASD could be cured by a parentectomy or removing the child from the family (Feinstein, 2010). Bettelheim became a professor at the University of Chicago and

became the director for the orthogenic school for emotionally disturbed children from 1944 to 1973. His position at this university caused much controversy and fame for the university. Bettelheim's lectures drew hundreds of students, and his papers created controversies (Feinstein, 2010).

Bettelheim was an authoritative man, some said sadistic and cruel while others said caring, but he did physically hit the children and taught others to do so as well (Feinstein, 2010). Although Bettelheim's methods and beliefs were extreme, he created an awareness in the general public about ASD. Many professionals followed Bettelheim's lead by blaming mothers including psychologists and doctors (Feinstein, 2010). In response to Bettelheim's famous book, American parents of children with ASD were outraged and came together to form the National Society for Autistic Children, later called the Autism Society of America (Feinstein, 2010). Parents all over the world converged to create societies for the betterment of children with ASD.

By the end of the 1960s, ASD continued to be misunderstood and the refrigerator mother theory continued to have a powerful influence. Bettelheim's book was required reading for all incoming psychologists even into the late 1980s (Feinstein, 2010). The *DSM-II* published in 1968 did not have any mention of ASD (American Psychiatric Association, 1968). People with ASD symptoms would be diagnosed with 295.8, schizophrenia, childhood type. In 1971, Lorna Wing, a British psychiatrist, published a book named *Autistic Children: A Guide for Parents and Professionals*, which many would argue was a counter argument to Bettelheim's book. In 1972, a well-known child psychiatric researcher, Michael Rutter, conducted the first study of genetics of ASD. He changed the meaning of the word autism to mean someone who lives in fantasies into

someone who does not daydream at all (Evans, 2013). The 1970s was marked by research focused on the study of the genetic etiology of ASD.

Transformations in the *Diagnostic*
and Statistical Manual

In 1980, the *DSM-III* appeared and transformed mental health care and perspectives. Unlike the past *DSM*s, *DSM-III* was based on research and created the term pervasive developmental disorder (Feinstein, 2010). It had a specific diagnosis for infantile autism with these criteria: (a) Onset before 30 months of age; (b) pervasive lack of responsiveness to other people; (c) gross deficits in language development; (d) if speech is present, peculiar speech patterns such as immediate and delayed echolalia, metaphorical language, and pronominal reversal; (e) bizarre responses to various aspects of the environment, for example, resistance to change, peculiar interest in/or attachments to animate or inanimate objects; and (f) an absence of delusions, hallucinations, loosening of associations, and incoherence as in schizophrenia (American Psychiatric Association, 1980). This is the first time ASD was recognized as a separate disorder.

Recognition that adults can also suffer with ASD was unheard of until 1981. The introduction of a subset diagnosis, Asperger's syndrome, appeared in 1981 by Lorna Wing. She believed her condition was not entirely a different condition than ASD, but not as severe as what they generally considered autistic during the time (Feinstein, 2010). In her paper "Asperger's Syndrome: A clinical account" she called for a unique diagnosis she called, Asperger's syndrome, based on the work by Asperger. In her paper, Wing (1981) described six cases of children and young adults who were physically normal, however, exhibit trouble in speech, communication skills, social interaction, extreme focused interests, and were overall eccentric. However, Wing did note that the adult

participants did exhibit "inappropriate gait, posture and facial expression produce an impression of oddness" (p. 119). Lorna's paper was the first paper that examined adults and stated that adults could suffer with similar symptoms as the children.

Unfortunately, Wing's work was not given much heed in the revision of the *DSM-III-R* in 1987. The revised *DSM* continued to classify ASD by three deficits: social interaction, verbal and nonverbal communication, and restricted activities and interests. However, the revised *DSM* did include a new understanding that symptoms could vary in severity and show up in many ways. The biggest feature of the change was the change in the name: previously called infantile autism and now called autistic disorder. This change was accepting because of the new realization that ASD could also affect adolescents and adults. It was no longer viewed as a childhood disorder, but now a lifelong disorder (Feinstein, 2010).

Two very important diagnostic tools were developed in the late 1980s that allowed clinicians to formally diagnose ASD based on the *DSM* criteria: the autism diagnostic interview and the autism diagnostic observation schedule. These tools are relied on currently to diagnose ASD. Also, during the late 1980s and early 1990s, many studies were conducted in the developmental psychology field looking at cognitive concepts in ASD, such as theory of mind, central coherence, executive dysfunction, and trouble in joint attention (Feinstein, 2010). A few years later in 1994, the new *DSM-IV* was published and included several categories of similar disorders including childhood disintegrative disorder, Asperger's syndrome, pervasive development disorder, autistic disorder, Rett's disorder, and a catch all category, pervasive development disorder–not

otherwise specified (American Psychiatric Association, 2000). This was the first time ASD was given thorough symptom descriptions based on empirical research.

Over the next few decades, *DSM-IV* was updated twice, yet most of the diagnostic criteria stayed the same. However, in 2013 when the newest *DSM-5* emerged, the ASD criteria were transformed. All the separate categories from the *DSM-IV-TR* (text revision) were combined to form autism spectrum disorder. The new *DSM-5* (American Psychiatric Association, 2013) described ASD in two domains: social communication impairment and restrictive/repetitive behaviors. Each domain has several diagnostic criteria included and a severity level is recorded depending on severity of impairment and the support that is required. The first domain is social communication impairment and is described as "persistent deficits in social communication and social interaction across multiple contexts" (p. 50). This domain's diagnostic criteria comprise of problems with social-emotional reciprocity, inability to comprehend and display nonverbal communicative behaviors, and an inability to initiate, retain, and understand relationships. This domain includes behaviors such as lack of eye contact, constricted facial expressions and body movements, misreading nonverbal language, lack of initiating or responding to social connections, misinterpretation of literal or implied meaning, and displaying socially inappropriate behaviors such as discussing bathroom behavior in a job interview.

The second domain described in the *DSM-5*, restrictive/repetitive behaviors, are described as "restricted, repetitive patterns of behavior, interests or activities" (p. 50). This domain includes repetitive motor movements, demanding strict routines, preoccupied with special interests, and sensory integration issues. This domain covers

behaviors such as echolalia, stereotyped behavior such as rocking, spinning or hand flapping, extreme upset when change occurs, imposition of and adherence to routines and rituals, formalized pedantic language, and difficulty transitioning. Through the *DSM-5*, individuals are given a severity rating based on how much support is needed with a rating of one (need some support), two (needs substantial support), or three (needs very substantial support). This new spectrum system allows for more flexibility in diagnosis and recognizes the heterogeneity of ASD symptoms. A person may be given different ratings that reflect the support they need in the two main domains. Some people may have more trouble with communication and needs more assistance than the restrictive/repetitive behaviors domain.

Although the new *DSM-5* provides a broader sense of ASD and has included many of the symptoms noted as core deficits in ASD, many symptoms commonly observed in people with ASD are not included in the general description (Mazefsky, 2015). The research is showing many other deficits that make daily life challenging. Several of those deficits in ASD, also called cognitive concepts in the developmental psychology field, will be discussed.

Diagnostic and Statistical Manual –5: Other perspectives

Other deficits have been found that expand on the symptoms listed in the *DSM–5*. The ASD is an information processing disorder (Gaus, 2011). Troubles with processing emotional regulation, social cognition, theory of mind, central coherence, and executive functioning are common in ASD. While these cognitive concepts are highly researched, I will explain briefly what they are and then focus on how they impair the person with ASD in their daily functioning.

Emotional dysregulation is commonly observed in those suffering from ASD.

Mazefsky (2015) described emotional regulation as a potential core deficit in ASD even

though it is not described in the *DSM–5* as part of the ASD symptoms. Emotional

regulation is the adjustments of a person's emotional processes that aid in maintaining

emotional stability. Individuals with ASD may struggle with identifying coping skills

when distressed and react with aggression, heightened anger, and/or fear, self-injury and

intense reactions to stress such as tantrums or meltdowns (Laurent & Rubin, 2004;

Mazefsky et al., 2013). It is frequently observed that individuals with ASD have

explosive, erratic, sometimes violent displays of anger that include self-injury or

destroying property; however, these episodes do not usually include physical aggression

towards others (Gaus, 2011). Laurent and Rubin (2004) stated,

> in fact, it becomes evident that the process of emotional regulation encompasses
> an individual's ability to experience, recognize, express, and regulate all
> emotional effectively and fluidly during social transactions with respect to
> environmental constrains. (p. 287)

Individuals with ASD struggle to express emotions in socially appropriate ways, how to

read and respond to others' emotions, and alexithymia, or the difficulty in labeling

emotions (Hollocks et al., 2018; Laurent & Rubin, 2004).

Problems with emotional regulation bleed into deficits in social cognition. Social

cognition is the cognitive mechanisms underlying social behaviors (Senju, 2013).

Individuals with ASD tend to have idiosyncratic way of processing and expressing

thoughts and emotions (Anderson & Morris, 2006). They have limited understanding of

social behaviors, trouble reading facial expressions and nonverbal language, pedantic and

formal language, misunderstand social situations and motivations of others, then also lack

the social skills to respond accordingly (Gaus, 2011; Senju, 2013). Furthermore,

individuals with ASD struggle with creating accurate hypotheses about what others are feeling and thinking, which connects to the deficits in theory of mind. Theory of mind is "the ability to attribute independent mental states to self and others in order to predict and explain behavior. This ability appears to be a prerequisite for normal social interactions" (Frith & Happe, 1999, p. 1). Theory of mind is the ability to reflect on one's own mental states and the mental states of others. Theory of mind has also been called mindblindness. Mindblindness is a state in which a person is blind to all mental states such as thoughts, beliefs, knowledge, desires, and intentions of others. In this state, they must rely on scripts to explain others' behavior (Baron-Cohen, 1995). Therefore, they struggle with what is socially acceptable behavior, come off as socially awkward, and lack the skills to form and maintain relationships (Woods et al., 2013). Persons with ASD also struggle with perspective-taking and not recognize their behavior's effects on others, so they may come off as brash or harsh (Jacobsen, 2003).

Individuals with ASD struggle with issues related to executive functioning. Executive functioning is the mental processes needed to work towards personal goals in an ever-changing environment. It is the ability to control what one is focused on at a time and decide what is relevant so we can shift focus (Jacobsen, 2003). Executive functioning includes planning, organizing, goal-setting, task management, cognitive flexibility, working memory, impulse control, and monitoring of own actions (Gaus, 2011; Kiep & Spek, 2017). Persons with ASD may have difficulties in everyday tasks such as procrastination, poor self-direction, poor basic problem solving, and deficits in generalizing learned information and skills on a greater level (Gaus, 2011; Jacobsen, 2003). This also is connected to deficits in central coherence. Central coherence is the

ability to create a higher meaning from various pieces of information, such as generalizing skills from one situation to another. Strong central coherence is the ability to look at the greater whole without looking at the details. However, individuals with ASD struggle to see the larger picture; therefore, they focus on the small details and sometimes have impeccable memories for small detailed information, such as the objects of their obsessions (Jacobsen, 2003). A person with ASD might be able to verbatim recite difficult poems or know most details of extensive road maps.

Overall, great strides in the development of ASD have occurred since Kanner and Asperger initially wrote about ASD. Clinicians and researchers continue to be baffled by ASD and the more knowledge is learned about ASD, the more we realize we do not know about it. Controversy, opposing theories and ideas, and heated debates are littered throughout the history of ASD and continue as more studies are completed and as more clinicians work with those with ASD. It is important that counselors are aware of the impact of the history of ASD has on ourselves, society, and our clients with ASD. Perspectives on what ASD is and how is it portrayed in everyday life and what we see in the media influences where we focus our research and treatments. As the diagnosis rates increase, it becomes more and more important on a professional's ability to provide information and services fitting for those with ASD.

Comorbidity

Adults with ASD are at a heightened risk for comorbid mental health disorders with anxiety and depression as the most common disorder in adults (Hollocks et al., 2018). Comorbidity is defined as two or more disorders occurring at the same time (Matson & Williams, 2013). According to Gillberg and Billstedt (2000),

> problems/disorders comorbid with a given condition could be (a) coincidental, (b) casually directly related, one condition leading to the other, or (c) casually indirectly related, another underlying condition/impairment leading both to the core problem and the comorbid disorder(s). (p. 321)

In the case with ASD, it seems (b) casually directly related is plausible. High rates of comorbidity are exhibited in the research; however, the answer as to the relationship between ASD and another disorder is complex and blurred. Diagnostic over-lapping of symptoms, called over-shadowing, occur within ASD and other mental illnesses such as obsessive–compulsive disorder (OCD), attention deficit/hyperactivity disorder (ADHD), depression, and social phobia which makes it difficult to correctly diagnose or determine if ASD leads to another disorder (Hollocks et al., 2018). Repetitive behaviors common in ASD can often be mistaken for behaviors common in OCD. Social disinterest or unusual social communication and limited facial expressions may be hard to distinguish from withdrawal seen in depression or social anxiety disorder (Helverschou, Bakken, & Martinsen, 2011). In children, it is not uncommon for a child to be diagnosed with ADHD before a diagnosis of ASD. Problems with internal distraction (ASD) versus external distraction (ADHD) can make the difference in an ADHD or ASD diagnosis (Matson, & Williams, 2013). Diagnostic over-shadowing creates a convoluted and difficult diagnosis.

Furthermore, debate exists about whether to diagnose anxiety concurrently with ASD. Weisbrot, Gradow, DeVincent, and Pomeroy (2005) stated that anxiety and ASD are so entwined that anxiety is a natural part of ASD. Many have suggested that anxiety is so prevalent in ASD that anxiety disorders should not be diagnosed alongside ASD. Anxiety disorders should be assumed with ASD (Bellini, 2006; Ghaziuddin, 2005; Gillott & Stranden, 2007). Gillberg and Billstedt (2000) stated,

the implications are that: (a) comorbidity is to be expected whenever a diagnosis of autism or Asperger syndrome is made, and (b) the exclusion criteria of the *DSM* and ICD [international classification of diseases], i.e. those that rule out a diagnosis of autism in another disorder and a diagnosis of another disorder in autism may have to be disregarded. (p. 327)

However, others have suggested that it is possible with careful assessment one can dependably differentiate ASD and anxiety disorders (Kerns & Kendall, 2012). Wood and Gadow (2010) argued that ASD alters typically known anxiety symptoms and could be considered a unique syndrome. Furthermore, psychiatric disorders may present differently, such as self-injury, aggression, eccentric behavior, or odd movements (Bakken et al., 2010). These diverse symptoms make it incredibly difficult to determine the true nature of comorbidity.

In the past, it was believed by scientists and psychologists that people with intellectual disabilities or ASD could not also have another disorder and concerning symptoms were credited to intellectual impairment (Matson & Williams, 2013). This belief prevented researchers from identifying underlying mental disorders in adults, and, therefore, little research exists before the year 2000. Most ASD research focused only on children because ASD was once believed to be a childhood disorder initially called Kanner's syndrome (Gillberg & Billstedt, 2000). At first, scientists and psychologists thought that adults could not have ASD. Over time they realized that this was false, and researchers began to look at the impact and rates of ASD in adults. According to Tantam (1991), the first large scale descriptive study with adults who were considered able autistic people did not occur until 1982 by Newson, Dawson, and Everard. The first study examining comorbidity in children and adults combined did not happen until 1998 by Ghaziuddin, Weidmer-Mikhail, and Ghaziuddin. Research is still in the beginning stages

of understanding comorbidity in adults. However, signs of other disorders are evident in the historical studies of ASD.

Ghaziuddin, Ghaziuddin, and Greden (2002) noted that Kanner's participant children exhibiting anxiety, fear, and depression in his 1943 study. Helverschou et al. (2011) also commented that anxiety disorders are so integrated with ASD that Kanner described them in almost each child in his study. Kanner (1943) described a child who was fearful of a closet simply because the vacuum cleaner was kept there. The child was anxious about the potential sensory overload and was fearful of the room the sensory overload (vacuum cleaner) was kept in. These children were not formally diagnosed with other disorders, but other symptoms are clear.

In a recent meta-analysis done by Hollocks et al. (2018) looking at 36 comorbidity studies with adults with ASD, they found rates of 42% of participants diagnosed in their lifetime with an anxiety disorder and 37% of participants diagnosed in their lifetime with depression. The rates of anxiety disorders and depression in the general population are about 1% to 12%. This suggests that adults with ASD are diagnosed in far greater numbers with anxiety and depression than the average population. Furthermore, these numbers are only representative of the adults with ASD who have been diagnosed. Many adults go undiagnosed with ASD because of numerous reasons including complexity of diagnosis, developmental reasons, and high frequency of comorbid disorders, which creates difficulty in diagnosis and missing the symptoms of ASD (Lai & Baron-Cohen, 2015).

Studies examining comorbidity will be described in categories starting with anxiety disorders. Many anxiety disorders have been found comorbid with ASD;

however, the literature focuses on two primary disorders: social anxiety/phobia and OCD

because of the overlapping symptoms and problems with misdiagnosis. So, these two

diagnoses will be examined followed by mood disorders and problems with suicide.

Other disorders have been found comorbid with ASD, but this researcher will focus on

the most prominent illnesses.

Anxiety Disorders

Anxiety disorders are a group of mental illnesses that are the most prevalent

mental illness comorbid in adults with ASD (Hollocks et al., 2018). In the *DSM–5*

(American Psychiatric Association, 2013) anxiety disorders are described as,

> disorders that share features of excessive fear and anxiety and related behavioral
> disturbances . . . anxiety disorders differ from one another in the types of objects
> or situations that induce fear, anxiety, or avoidance behavior, and the associated
> cognitive ideation. (p. 189)

This grouping of disorders includes separation anxiety disorder, selective mutism,

specific phobia, social anxiety disorder or social phobia, panic disorder, panic attack

specifier, agoraphobia, generalized anxiety disorder, and anxiety disorders due to

substance use or medical condition. The OCD previously was included in anxiety

disorders in the *DSM–IV*; however, in the *DSM–5* it has been moved into another cluster

of disorders called obsessive-compulsive and related disorders. The OCD will be

included in this anxiety disorders section due to the historical ties OCD shares with

anxiety disorders in the literature and previous *DSM*s in order to keep clarity and

consistency.

Although the recognition of comorbidity in adults with ASD is a relatively new

research focus as evidenced by the lack of published research before the year 1981, in

1943 Kanner noted throughout his study the fearful nature and anxiousness of the

children. He described the odd fears the children had including tricycles, egg beater, vacuum cleaner, elevators and spinning tops, changing things such as wind and large animals, running water, gas burners, putting bread into the toaster to make toast, when someone covered their face, street cars, trains, grinders, and mechanical toys. Many of these were potentially linked to sensory-type fears; nonetheless, they clearly interfered in the children's daily lives.

In the past several years, interest in comorbidity in ASD has become more apparent. Although there is still much to learn, anxiety disorders, most of the time, go hand in hand with ASD. Recently, Hollocks et al. (2018) completed a systematic review and meta-analysis collected from the literature from the years 2000 through 2017 examining comorbidity in adults with ASD. They collected 35 studies focused on anxiety and depression in adults with ASD. In total, the combined studies measuring anxiety disorder included 26,070 adult participants with ASD. Nine of the studies collected had a sample that included at least half of participants with intellectual disorder. Some of the studies also included older adolescents from age 16 and older. The studies consisted of using assessments to diagnose ASD, intellectual disorder, and the comorbid diagnoses and clinical interviews. Hollocks et al. did not find any significant differences in prevalence rates of anxiety disorders between studies with assessments versus clinical interviews.

Hollocks et al. (2018) found that 27% of participants were currently (current at the time the study was conducted) diagnosed with an anxiety disorder, and 42% of participants had been diagnosed with an anxiety disorder during their lifetime. Generalized anxiety disorder was diagnosed 18% currently with a lifetime prevalence of

26% of participants. Panic agoraphobia was currently diagnosed in 15% of participants with a lifetime prevalence of 18%. Lastly, post-traumatic stress disorder was currently diagnosed in 1% of participants with a lifetime prevalence of 5% of participants. Specific phobia was currently diagnosed at 6% with a lifetime prevalence of 31% of participants. Murray, Kovshoff, Brown, Abbott, and Hadmin (2019) found that out of 88 adults with ASD, 37% met criteria for moderate to severe anxiety. Furthermore, increased reported ASD symptoms were positively linked to self-reported feelings of anxiety. These estimates demonstrate how common anxiety disorders show up in adults with ASD. However, it is difficult to say for certain how these estimates represent the true prevalence rates.

Hollocks et al. (2018) mentioned that there is high variance between studies on methodology and sample selection. Furthermore, different assessments were used in the studies and some were slightly altered (i.e., change in wording) to fit the participant pool. Most studies relied on self-report assessments, which created difficulty in reliability because of the symptoms of ASD. Assessments might not be assessing other comorbid disorders but rather the person's inability to recognize or communicate their own experiences or emotions due to alexithymia or the difficulty in labeling emotions (Hofvander et al., 2009). Furthermore, some studies relied only on informants in the form of loved ones or caregivers to report on assessments what the adult with ASD experienced. Although this is troubling however, it is necessary to gather information from a population that needs more in-depth research. Multiple informants, or the use of information gathered from adults with ASD and a representative, were not used in any of the studies. So, interrater reliability could not be compared or measured (Hollocks et al.,

2018). Overall, it is clear anxiety and ASD go hand in hand. Next, social anxiety and OCD will be discussed as they relate to ASD.

Lastly, separation anxiety was currently diagnosed at 3% with a lifetime prevalence of 37% of participants. Although separation anxiety is not usually diagnosed in adults, studies are showing that it is diagnosed in adults with ASD. Gillott and Stranden (2007) also found high rates of separation anxiety in adults with ASD. However, they questioned if separation anxiety was from a caregiver or a general fear of change. While fear of change seems to be a feature of ASD, it is possible the scales used in the study could be measuring the fear of change. Gillott and Stranden conducted a study examining levels of anxiety and stress in adults with ASD. They had 34 adults with ASD and 20 adults with intellectual disorder. They found that adults with ASD showed three times higher scores that the adult group with intellectual disorder on anxiety subscales on panic disorder, agoraphobia, separation anxiety, OCD, and generalized anxiety disorder. Adults with ASD had significantly higher overall anxiety and stress.

Social anxiety disorder. Social anxiety disorder, also known as social phobia, is described in the *DSM–5* (American Psychiatric Association, 2013) as "marked, or intense, fear or anxiety of social situations in which the individual may be scrutinized by others . . . the individual is concerned that he or she will be judged as anxious, weak, crazy, stupid, boring, intimidating, dirty or unlikable" (p. 203). The diagnostic criteria for social anxiety disorder are (a) fear of social situations in which they could be judged by others such as meeting a new person, (b) fear they will exhibit anxiety symptoms and will be evaluated such as being humiliated, (c)fear of always feeling when faced with a social situation, (d) person avoids social situations, (e) fear is excessive and does not match the

actual threat, and (f) fear and avoidance is persistent and causes significant distress and disrupts functioning. The *DSM–5* (American Psychiatric Association, 2013) attempted to differentiate social anxiety and ASD by stating,

> social anxiety and social communication deficits are hallmarks of ASD. individuals with social anxiety disorder typically have adequate age-appropriate social relationships and social communication capacity, although they may appear to have impairment in these areas when first interacting with unfamiliar peers or adults. (p. 207)

Social anxiety is a common symptom in ASD and although many individuals with ASD report social anxiety, many individuals with ASD express interest and desire for social interactions (Carrington, Templeton, & Papinczak, 2003). However, those who have more severe ASD tend to enjoy solitary activities and did not report feeling lonely when alone. Adults with high functioning ASD enjoyed social activities, although they spent significant time alone (Chen, Bundy, Cordier, Chien, & Einfeld, 2016). Several studies found that lower insight into one's social impairment showed less social anxiety; the greater the social functioning, the increase in social anxiety (Bejerot, Eriksson, & Mortberg, 2014; Capriola, Maddox, & White, 2017; Chen et al., 2016). Many of the individuals with ASD were aware of their social difficulties and awkwardness. Those who are higher functioning are more able to adjust to social situations and possess an increased capability to understand others and become distressed by their interpersonal struggles. This realization can cause decreased self-esteem and self-worth (Ghaziuddin et al., 2002).

The *DSM–5* stated that the prevalence of social anxiety disorder in the United States is around 7% of the population. Social anxiety disorder is the most common anxiety disorder in neurotypical adults (Spain et al., 2016). Although true population percentages of adults with ASD and social anxiety disorder are unknown, the initial

percentages of participants in studies are showing high levels of comorbid ASD and

social anxiety disorder. Hollocks et al. (2018) found social anxiety disorder was the most

common anxiety disorder diagnosed in the sample with 29% of participants currently

diagnosed and a lifetime prevalence of 20%. Spain et al. (2016) found that 52% of the

individuals with ASD in the sample ($n = 50$) met the diagnostic criteria for social anxiety

disorder. A correlation between ASD scores and social anxiety disorder scores has been

found in several studies (Bejerot et al., 2014; Cath, Ran, Smit, van Balkom, & Comijs,

2008). Maddox and White (2016) found that 50% of their participants ($n = 28$) diagnosed

with ASD met diagnostic criteria for social anxiety disorder. Twenty-nine percent of

those participants reported experiencing moderate social anxiety, and 21% reported

experiencing severe social anxiety. Furthermore, these participants were non-treatment-

seeking individuals and were recruited only for an ASD diagnosis. The participants

expressed strong desires for social interaction and experienced a fear of negative

evaluation from others. These studies are exhibiting the common social anxiety disorder

symptoms adults with ASD experience. However, all these studies suffer from the same

limitations: small sample sizes, gender imbalances, most participants were Caucasian,

and the difficulty in that most assessments used had not been validated with ASD

populations. Most assessment instruments require a level of insight into own thoughts,

feelings and behaviors and this insight can be challenging for adults with ASD.

Obsessive–compulsive disorder. The OCD is described in the *DSM–5*

(American Psychiatric Association, 2013) as,

> presence of obsessions and/or compulsions… specific content of obsessions and
> compulsions varies among individuals, certain symptoms dimensions are common
> in OCD, including those of cleaning (contamination obsessions and cleaning
> compulsions); symmetry (symmetry obsessions and repeating, ordering, and

counting compulsions); forbidden or taboo thoughts (e.g. aggressive, sexual, and religious obsessions and related compulsions); and harm (e.g. fears of harm to oneself or others and related checking compulsions.). (pp. 235–236)

The diagnostic criteria for OCD are:

1. presence of obsessions, compulsions, or both in which obsessions are recurrent and persistent thoughts, urges or images that are felt as intrusive and unwanted and cause marked anxiety and distress and the individual attempts to ignore such thoughts, urges or images by performing a compulsion. Compulsions are marked as repetitive behaviors that the individual feels driven to perform in response to the obsession as well as behaviors or mental acts aimed to prevent or reduce anxiety and distress about some dreaded event or situation; however, behaviors are not connected in a realistic way.

2. Obsessions and compulsions are time-consuming and cause clinically significant distress or impairment. The *DSM–5* does not mention ASD in the differential diagnosis section.

The *DSM–5* (American Psychiatric Association, 2013) stated that the prevalence of OCD in the United States is 1.2%. This is a small percentage compared to the percentages that research has found for OCD in the ASD adult population. Hollocks et al. (2018) reported OCD was a close second as the most common diagnosis with 24% of participants ($n = 26,070$) currently diagnosed and 22% of participants were diagnosed at some point in their lifetime. Furthermore, Buck et al. (2014) found something similar; OCD was the second most common current and lifetime disorder with 33% of participants ($n = 308$) diagnosed with OCD. Russell, Mataix-Cols, Anson, and Murphy (2005) found that 50% of participants ($n = 40$) with ASD had a comorbid disorder, and

25% of those individuals were diagnosed with OCD. In a sample of a neurotypical

population of students at a university (n = 1,009), Wakabayashi, Baron-Cohen, and

Ashwin (2012) found that a correlation existed between ASD and OCD. So, participants

who scored higher on an ASD assessment evaluating ASD traits, then they also had

higher scores on the OCD assessment evaluating OCD traits.

Although many studies are finding high numbers of comorbid OCD and ASD,

Bakken et al. (2010) and Ghaziuddin et al. (1998) both found low numbers of participants

diagnosed with ASD and OCD. Bakken et al. found that OCD had the lowest prevalence

in their ASD group (n = 62). Ghaziuddin et al. (1998) found that 65% of 35 participants

were diagnosed with a comorbid disorder and only one person in the group was

diagnosed with concurrent OCD. So, even though OCD is viewed as common in

individuals with ASD, this is not always the case and OCD is not diagnosable in every

person with ASD.

Obsessive and compulsive behaviors are commonly seen in those with ASD as

they share overlapping symptoms with ASD. The *DSM–5* (American Psychiatric

Association, 2013) called obsessions in the ASD diagnosis as "highly restricted, fixated

interests that are abnormal in intensity or focus" (p. 50). The *DSM–5* (American

Psychiatric Association, 2013) labels compulsions in the ASD diagnosis as "stereotyped

or repetitive motor movements, use of objects, or speech" (p. 50). McDougle et al. (1995)

conducted a study examining the differences in repetitive thoughts and behaviors

between those with OCD plus ASD and those with only OCD. They determined that the

repetitive thoughts were vastly different for each group. Participants with only OCD

showed more cleaning, checking, and counting behaviors, whereas participants with ASD

plus OCD displayed repetitive ordering, hoarding, touching, tapping or rubbing, self-mutilation, and telling or asking something. Sexual obsessions were more frequently reported for those diagnosed with concurrent ASD and OCD (Cath et al., 2008; Russell et al., 2005). Contrary to previous research, Cath et al. (2008) stated that the ASD plus OCD group of participants in their study and the pure OCD group of participants ($n = 48$) showed no differences in the types of OCD symptoms. This is possibly due to low statistical power with a small sample size. Wakabayashi et al. (2012) found that individuals with ASD tend to have content specific obsessions, while those with pure OCD tend to have fewer specific obsessions.

In neurotypical cases of OCD, the compulsions are uncontrollable and unwanted, hence they try to hide their symptoms and they find their obsessions and compulsions altogether to be uncomfortable and create further distress. However, for those diagnosed with OCD and ASD, the repetitive ritualistic behaviors were not distressful, and the compulsions were reported to not occur against the person's will (Baron-Cohen, 1989; Helverschou et al., 2011). However, other studies found contradictory results. Participants diagnosed with ASD reported feeling obsessions and compulsions are just as unwanted, inappropriate, and distressing as those diagnosed with only OCD (Cath et al., 2008); while other practitioners believe these obsessions and compulsions are coping mechanisms to ward away anxiety and feelings of powerlessness (Ghaziuddin et al., 2002).

Individuals with concurrent ASD and OCD and those with pure OCD both struggle with executive dysregulation. Both groups tend to focus on small bits of information rather than global information processing (Wakabayashi et al., 2012). So,

shared traits exist between the two disorders; however, individuals with ASD do not always meet criteria to have a concurrent diagnosis of OCD as well.

Mood Disorders

Mood disorders are the most prevalent comorbid disorder with ASD (Ghaziuddin et al., 2002). Rates of depression in adults with ASD range from 20% to 30%; whereas, rates of depression in the general population is estimated around 7% (Hollocks et al., 2018). Major depressive disorder and bipolar disorder were the most prevalent mood disorder found in many of the ASD adult research populations. Rates of 36.4% out of $n = 44$ (Munesue et al., 2008), 46% out of $n = 113$ (Burns, Irvine, & Woodcock, 2018), 13 people out of $n = 35$ (Ghaziuddin et al., 1998), 26.8% out of $n = 71$ (Hedley et al., 2018), 43% out of $n = 46$ (Sterling, Dawson, Estes, & Greenson, 2008), and 35% (Wigham et al., 2017) of samples reported a diagnosis of a mood disorder. Furthermore, in a systematic review (Hollocks et al., 2018), adults with ASD ($n = 26,117$) 23% of participants had a current diagnosis of depression with 37% of participants reporting received a depression diagnosis at some point in their lifetime. These rates are showing the pervasiveness of mood disorders comorbid with ASD.

Depression is more common in adolescent and adult populations; whereas, is more common in children with ASD (Ghaziuddin et al., 1998). This may be due to a misdiagnosis because of the overshadowing of similar symptoms. The *DSM–5* (American Psychiatric Association, 2013) described major depressive disorder as requirement of five or more of the following symptoms: (a) depressed mood most of the day, nearly every day, (b) marked diminished interest or pleasure in all, or almost all, activities most of the day, (c) significant weight loss or weight gain or decreased or increased appetite nearly

every day, (d) insomnia or hypersomnia, (e) psychomotor agitation, (f) fatigue or loss of energy, (g) feelings of worthlessness or excessive or inappropriate guilt, (h) diminished ability to think or concentrate or indecisiveness, and (i) or recurrent thoughts of death, suicidal ideation without plan, suicidal attempts, or specific plan for committing suicide. Coding for major depressive disorder is based on a single or recurrent episode, current severity, any psychotic features, and remission standing. Description of differential diagnosis with ASD is not present.

Diagnosing a mood disorder in adults with ASD is complex and problematic. Symptoms of depression are commonly overlooked due to diagnostic overshadowing (Ghaziuddin et al., 1998; Hollocks et al., 2018; Vannucchi et al., 2014). Symptoms such as flat effect and social withdrawal can be attributed to ASD; however, they are also markers for depression. Depressive symptoms in adults with ASD may be exhibited differently than in the neurotypical population. Hyperactivity, irritability, impulsivity, hostility, distractibility, oppositional and aggressive behavior, increased compulsive behavior, increased stereotypical behavior such as flapping or spinning, regression in self-care, disruptive behaviors, and catatonia are unique features of depression in individuals with ASD (Ghaziuddin et al., 2002; Vannucchi et al., 2014). Adults with low-functioning ASD are more difficult to discern depressive symptoms. They might exhibit more aggression, regression in skills, develop mutism, weight loss, and overall decrease in functioning (Ghaziuddin et al., 2002; Helverschou et al., 2011). Adults with ASD struggle with recognizing and voicing concerning physical or mental symptoms, so instead they show behavioral changes and agitation (Russell et al., 2005; Stewart, Barnard, Pearson, Hasan, & O'Brien, 2006). This problem makes it more important that

clinicians are paying attention to other symptoms in order to identify underlying

unnoticed psychiatric illnesses.

In 1981, Wing first described Asperger's Syndrome in her seminal paper

"Asperger's Syndrome: A Clinical Account" and she took note that her patients had

comorbid psychiatric disorders. Wing stated, "clinically diagnosable anxiety and varying

degrees of depression may be found, especially in late adolescence or early adult life,

which seem to be related to a painful awareness of handicap and differences from other

people" (p. 118). Wing recognized that other psychiatric illnesses were present, and she

believed her patients' depression was connected to their recognition that they were

different. Adults with high levels of functioning with better social awareness and

understanding reported feeling lower self-worth and lower feelings of competency.

Individuals with high functioning ASD are more vulnerable to negative self-perspectives

and depression (Ghaziuddin et al., 2002). Those with higher IQ, social abilities, and

desire to form social relationships were more aware of their inadequacies and impairment

in social skills, experience failed attempts to socialize, can lead to depression (Sterling et

al., 2008). Furthermore, adults with ASD reported experiencing high levels of loneliness.

Increased feelings of loneliness are linked with decreased life satisfaction, lower feelings

of self-worth, and depression (Mazurek, 2014). Loneliness and depression are also linked

with suicidal ideation (Hedley et al., 2018).

Suicide

Recent research has uncovered suicidal behavior as a deeply concerning issue in

the adult ASD population. In the general population, adolescents and young adults are at

a higher risk of suicide as suicide is the second leading cause of death in individuals aged

10 to 34 years old (Centers for Disease Control and Prevention, 2019). Research suggests

adults with ASD are at a higher risk of suicide ideation, attempts, and mortality by

suicide than the general population (Hedley et al., 2018; Hirvikoski et al., 2016; Zahid &

Upthegrove, 2017). Furthermore, those who are high functioning ASD and those

diagnosed with Asperger's syndrome are at even greater risk for suicide (Hirvikoski et

al., 2016; Zahid & Upthegrove, 2017). This could be attributed to higher cognitive and

social functioning and the recognition of their difficulties, victimization, and the

development of other psychiatric illnesses, such as depression (Hannon & Taylor, 2013).

Those with higher reports of autistic traits had significantly higher rates of suicide plans

or attempted suicide (Cassidy et al., 2014). This information is showing a very

concerning picture of the severity of the suicide issue in the ASD population.

Suicide rates in the research on the ASD community are staggering. Prevalence of

suicidal attempts varies between 7% and 47% in the research, while suicidal ideation

hovers in 72% of cases (Zahid & Upthegrove, 2017). Cassidy et al. (2014) found that

66% of 374 participants with ASD reported suicidal ideation and 35% had planned or

attempted suicide. Hedley et al. (2018) found that 20% of 69 participants had reported

suicidal ideation. Balfe and Tantam (2010) reported 15% of 42 participants reported

attempting suicide and 40% had suicidal ideation. Kato et al. (2013) stated 43 out of 587

(7.3%) attempted suicide. Shtayermman (2007) found that 50% of participants ($n = 10$)

had clinically significant suicidal ideation. Raja, Azzoni, and Frustaci (2014) found that

half of their participants ($n = 26$) had never attempted suicide but had suicidal ideation.

Before the completion of the study, two participants had committed suicide. Furthermore,

Chen et al. (2017) completed a longitudinal study examining suicidal behavior in 5,618

adolescents and young adults with ASD and 22,475 in an age- and sex-matched control group over a 10-year period. They found that the ASD group exhibited an increase in suicide attempts (3.9%) versus the control group (0.7%). These results suggested that over time, the individuals with ASD had increased risk of suicide as they aged. Overall, the number is showing that suicide is a significant issue that needs to be addressed. Clinicians need to be assessing for suicidal behaviors when they meet with an adult with ASD at the first meeting.

Surprisingly, research examining suicide in the ASD population is rather new and started around 2007 (Segers & Rawana, 2014). Suicidal behaviors in the ASD population have been greatly overlooked. Deliberate self-harm is an extensive problem in neurotypical adolescents and young adults. Although self-harm is not a prerequisite for suicide and it does not always lead to suicide, it is tied to suicidal behaviors (Greydanus & Shek, 2009). Self-injurious behavior is commonly observed in low functioning ASD, such as head banging, biting, and face slapping. Most repetitive self-injurious behaviors are not intentional to cause oneself an injury, just part of the repetitive behaviors core to ASD (Segers & Rawana, 2014) or part of sensory-related issues. However, most clinicians are not assessing whether self-injurious behavior is unintentional self-injury or they are in the context of suicidal ideation. Therefore, suicidal ideation might be unnoticed because of diagnostic overshadowing (Hannon & Taylor, 2013).

Several risk factors for suicide have been examined and comorbid psychiatric illnesses are found as the most common (Zahid & Upthegrove, 2017). Although depression has been found to be the greatest risk factor for suicide, other mental illnesses have been found as well, such as anxiety (Balfe & Tantam, 2010; Hedley et al., 2018),

adjustment disorder (Kato et al., 2013), alcohol and substance abuse (Balfe & Tantam, 2010; Chen et al., 2017; Spencer et al., 2011), and schizophrenia (Raja et al., 2014). Comorbid depression and ASD seem to be a red flag for suicidal behavior. Individuals with depression were more likely to report suicide ideation, plan, and attempts (Cassidy et al., 2014; Hedley et al., 2018). Those with a history of depression, substance abuse, and self-harm were at a higher risk (Chen et al., 2017; Zahid & Upthegrove, 2017). Although a previous diagnosis of depression is a significant risk factor, some individuals with ASD have no history of psychiatric illness and present with serious suicidal behavior (Kato et al., 2013). This could be due to the lack of mental health care in the past as is common with individuals with ASD or that the depression was disregarded as a result of diagnostic overshadowing. Balfe and Tantam (2010) stated,

> anxiety and depression are often triggered in people with AS [Asperger's syndrome] as a consequence of their struggles to understand complex social milieus and because of their awareness of their differences from others. Anxiety may also be increased by experience of bullying and by experience of victimization. Two-fifths of respondents had thought about committing suicide at some point in the past, and 15% of respondents reported that they had attempted to kill themselves. Risk factors for suicide include childhood adversity, individual and personal vulnerabilities and exposure to stressful life events and circumstances. People with Asperger syndrome match this risk profile. (p. 5)

Experiences with bullying and victimization are another risk factor for suicide. Individuals with ASD experience high levels of victimization (Shtayermman, 2007). Balfe and Tantam (2010) reported almost all of their adolescent and adult participants ($n = 42$) reported being bullied, 40% reported that they had been sexually or financially exploited, 77% felt left out of things, and 62% felt put down by others. Brown-Lavoie, Viecili, and Weiss (2014) reported that 78% of the adult participants ($n = 95$) with ASD reported being sexually victimized. Those who are victimized by peers are prone to

developing depression and anxiety and trigger suicidal behavior (Segers & Rawana, 2014; Shtayermman, 2007). As ASD symptoms decrease, victimization increases (Shtayermman, 2007). The reason for this phenomenon could be the result of less attention and services in schools and, therefore, perceived as high-functioning, but different than peers so bullying increases.

A core deficit in ASD is social disconnection. Difficulties in communicating, forming and maintaining relationships, and emotional connecting create feelings of isolation and loneliness. Loneliness has been found to be strongly related to depression, low self-esteem, negative emotional experiences, and suicidal ideation. Those with more severe symptoms tend to feel lonelier (Hedley et al., 2018; Mazurek, 2014). Individuals with ASD tend to live with parents, visit places that require little social interaction such as the library or the cinema, and are sometimes unemployed, which makes for more difficulty in meeting and in the creation of a social circle (Balfe & Tantam, 2010).

Symptoms of suicidal behaviors might be exhibited differently than in the neurotypical population. High levels of impulsiveness and aggression (Kato et al., 2013), anger, irritability, less enjoyment, agitation, and significant emotional dysregulation are found in individuals with ASD and suicidal behaviors (Chen et al., 2017; Spencer et al., 2011). Even though impulsiveness was found in suicidal individuals with ASD, Kato et al. (2013) found that suicide attempts were not spontaneous with participants with ASD. This suggests that suicide attempts were more planned and thought out. Additionally, individuals with ASD use more violent and lethal means to commit suicide. Fatal cutting/stabbing using knives or sharp objects and carbon monoxide intoxication was attempted by more individuals with ASD than the neurotypical population (Kato et al.,

2013). Therefore, individuals with ASD were more likely to complete suicide on the first attempt.

Overall, suicide is a very concerning issue in general, especially within the ASD community. Information about adults with ASD and suicide is widely unknown. Furthermore, nothing is currently known about the methods counselors use to prevent suicide in adults with ASD. What is known is that suicide and comorbidity with ASD is a large-scale problem that has no true solution. In the next section, examination of currently used treatments and the barriers to those treatments will be discussed.

Types of Treatment and Treatment Barriers

Currently, the Centers for Disease Control and Prevention (2019) estimates that ASD impacts one in every 59 children and is four times more common in males. ASD can occur in all socioeconomic groups, all races and ethnicities, and all countries. Almost half (46%) of those diagnosed with ASD are functioning with average or above average intelligence. Treatments offered to those who are high functioning with no co-occurring intellectual disabilities are greatly missing (Bishop-Fitzpatrick, Minshew, & Eack, 2013; Lake et al., 2014). As the numbers are increasing, treatments for ASD symptoms and comorbid disorders are needed. However, despite the growing literature about the seriousness of mental illness and suicide in adults with ASD, very few treatments are available to adults with ASD with no co-occurring intellectual disabilities (Lake et al., 2014). While a body of literature exists examining children and adolescents with ASD, research on symptoms and treatments for adults with ASD is greatly limited (Lai & Baron-Cohen, 2015; Lake et al., 2014).

Two fundamental barriers exist for adults with ASD once they access mental health services. The first problem is the barriers professionals experience when working with individuals with ASD. A study by Dillenburger et al. (2016) was conducted with 798 United Kingdom professionals from health, social care, and educational settings as well as four adults with ASD and 14 parents of children, adolescents, and adults with ASD. This mixed methods study examined professionals' knowledge and training with ASD and looked at individuals with ASD or had a child with ASD experiences with professionals. They included professionals in nursing (27%), medicine and psychology (13%), allied health therapy professionals (occupational, speech, physiotherapy) (13%), welfare or social services (10%), administrative and secretarial (10%), and other (11%). All the participants had contact with a person with ASD and one-fifth had contact with a person with ASD daily. Surprisingly, only 29% of health and social service professionals (this group includes counselors and social workers) had received ASD training. Out of those, 19% had only one to two hours of ASD awareness training and 3% had one to two days of ASD training. This is a small amount of ASD trainings for as often as medical and psychological professions see individuals with ASD in their work.

Dillenburger et al. (2016) found that none of the professional participants had received ASD training during their educational experiences during their bachelor, master's, or doctoral degrees. A substantial number of professionals stated they believed ASD training should be mandatory and incorporated into trainings when hired. Some suggested information about symptoms and interventions should be given often during the professionals' educational experiences or early in the professional's career.

Participants recognized that information about adults with ASD was scarce even more so than information about children with ASD.

Dillenburger et al. (2016) interviewed adults with ASD about their experiences with professionals. All the participants had experiences with mental health services for the treatment of comorbid illnesses and symptoms such as anxiety, depression, self-harm, or alcohol abuse. Participants commented about the lack of trained professionals in adult diagnostics techniques and intervention services. They also criticized the lack of dedicated adult services. Many of the adults with ASD with a child with ASD remarked that they sought out an ASD diagnosis subsequently after their child's diagnosis. These individuals recognized they had the same symptoms as their child and received the diagnosis of ASD.

Dillenburger et al. (2016) also interviewed parents with a child, adolescent, or adult child with ASD. Participants agreed that professionals were highly untrained and unskilled to provide diagnosis or intervention services to their child. They discussed that access to the care their child needed was difficult and once they received the services, they were unsatisfied as a result of lack of support or adequate understanding of ASD. Moreover, some participants mentioned that professionals were not knowledgeable about the differences of females with ASD versus males with ASD and, therefore, were unable to provide the proper diagnosis. Parents with adults with ASD spoke about the problems with their adult child being dropped from services when they turned 18 years old and consequently no longer received the care they needed. This issue is a common problem as children transition into adulthood and no longer have access to the mental health,

educational, or other services they were provided during school (Lake et al., 2014; Lake, Vogan, Sawyer, Weiss, & Lunsky, 2015).

Overall, Dillenburger et al. (2016) brought to light the broad lack of knowledge and trainings about ASD across professions. The mental health field is not exempt from this group of professionals who lack the proper training to adequately offer effective services to individuals with ASD. In a study conducted by Brookman-Frazee et al. (2012) conducted a mixed methods study examining therapists' viewpoints on offering services to children with ASD at community health clinics in California. Sixty-one percent of participants were marriage and family therapists, 18% social workers, 13% in psychology, and 8% in psychiatry. Forty percent of participants identified with family systems, 12 % with cognitive-behavioral therapy (CBT), 7% with humanistic forms, 5% with psychodynamic, and 4% with other counseling theoretical orientations. A survey went out to 100 therapists and three focus groups were conducted with 17 of the completed surveyed therapists. Of their caseload 15.1% were children with a diagnosis of high functioning ASD and 35% currently had a child on their caseload with ASD. Seventy percent of the children with ASD had a comorbid diagnosis with ASD and presented with issues related to behavioral disruptions, anxiety and fears, social problems, and attentions and regulation issues. Most of the cases were severe and children stayed in the program for numerous years until they turned 18 years old.

Brookman-Frazee et al. (2012) reported that participants stated clinical cases with children with ASD were complex and very difficult to treat. Most participants stated they felt counseling progress was slow, coordination with other professionals was challenging, and the client had a lack of insight which further made counseling problematic.

Participants had significant negative experiences when working with children with ASD and felt wholly unprepared and insufficient to offer counseling to these children. Participants discussed issues with developing rapport with the children with ASD, noticed a very slow rate of change, and believed they did not know effective tools to work with them. They also stated the typical treatment strategies did not work with children with ASD, and they did not receive the proper training to work with them. Forty-eight percent of participants stated they did receive some ASD training at some point in graduate school or on the job; however, they all felt unprepared and frustrated with the lack of clinical preparation to offer counseling to children with ASD. The nature, topics, and amount of time the participants spent in the trainings were undocumented in the study. The Brookman-Frazee et al. (2012) study highlighted the significant problem of lack of training of counselors working with children with ASD.

Other studies have found similar results. Chiri and Warfield (2012) found that out of 2,088 families with children with ASD, a significant majority stated they had unmet mental health needs and access problems. Participants reported that professionals had a lack of skills in how to work with their child. Furthermore, less than half of participants ($n = 64$) in a study conducted by Williams and Haranin (2016) reported,

> other barriers to treatment of ASD/DD [developmental disorder] reported by less than half of participants were not having the knowledge, training, or skills to help with the presenting problems; lack of support or consultation available at their agency; child's lack of progress in treatment; and feeling that the mental health system was not the right place for children with ASD to receive services. (p. 91)

Only half of participants reported having some training or education about ASD before entering the workforce. Participants also stated they believed the current trainings approaches and resources available to them were insufficient to meet their needs. This

suggests that counselors not only do not feel prepared to provide counseling to ASD, but they also believe the current trainings approaches to working with ASD are not preparing them in their work.

Not only was accessibility of ASD trainings a barrier, but the different nature of working with individuals with ASD and how clinicians must adapt their skills when working with those with ASD was also a barrier to adequate treatment. Vulcan (2016) conducted a phenomenological study examining the lived experiences of 28 therapists working with children with ASD in a variety of community settings in Israel. The participants included three social workers, seven clinical psychologists, three art therapists, three drama therapist, 11 dance/movement therapists, and three music therapists who worked in an assortment of clinical and educational settings. The therapists worked with children aged 2 to 16 years old with most of their caseload in the three- to seven-year-old range. The author did not distinguish between high and low functioning children and did not present information about whether the children had intellectual disabilities or other comorbid mental illnesses. Participants reported feeling numerous difficulties including fatigue, dissociation, a sense of being lost, of being stuck, confused, boredom, not being present, overwhelmed, doubtful, and questioned their own choices to become a therapist. Many participants struggled with the lack of responses from the children with ASD unable to grasp the rules and signals of communication in the world of autism. Participants felt alone in the room with the child and not sure what to do with them.

Vulcan (2016) stated "these difficulties appear to challenge the interpretive work that characterize psychotherapeutic interactions and elicit questions about the very point

and efficacy of the treatment" (p. 329). The participants stated they did not feel the child was progressing in sessions, and it led them to doubt their own work. The themes generated from the interviews with participants showed two main categories of vulnerability and bodily awareness. Participants discussed their own vulnerability and reflected on their own histories and childhood experiences as a potential way to connect with the children with ASD. Some of them stated they identified the autistic parts of themselves to better understand the children with ASD. Another theme was the body awareness they had to develop in order to connect with a child who did not speak or spoke very little. Participants described using their body as a tool or body knowledge to understand what the child feels and attempt to match the child with ASD. Some said this experience was a source of insight; the body was a knowledge provider or knowledge carrier. Other participants reported this sensation was uncomfortable, overwhelming, and feeling too exposed.

Participants described the children's need of physical intimacy and unawareness of personal space boundaries as a source of anxiety for clinicians. Some reported experiencing a very powerful feeling of bodily-based countertransference. Transference is when a client transfers personal feelings and experiences from other people onto the counselor. Countertransference is when the counselor transfers personal feelings and experiences from other people onto the client (Longe, 2016). Those who described feeling bodily-based countertransference also described negative features of their experiences while working with children with ASD. Countertransference can sometimes be damaging to the counseling relationship and the client if the counselor does not attend to these emotions.

The study by Vulcan (2016) presented the idea that working with children with ASD is a different experience than working with neurotypical children. Vulcan stated,

> the nature of the autistic pathology compels the therapist to meet the most primary aspects of his or her psyche, including the preverbal, bodily self, so as to meet and connect with the child on the child's own ground in the most primary and literal sense. (p. 334)

Individuals with ASD have different needs than neurotypical individuals and seem to speak a different language. Participants in the Vulcan's study voiced the condition in which they had to speak to and understand the child from a nonverbal somatic standpoint, which required therapists to be in tune with their own thoughts and feelings and possessing a sense of flexibility in their approach. Counselors who are unaware of these requirements may continue to struggle and question why their methods are not working rendering them ineffective.

The studies presented all focused on clinicians working with children with ASD. Currently, there are no studies available examining counselors' perspectives and experiences working with adults with ASD. The current study attempted to fill the gap in research focused on understanding interventions used with adults with ASD from the viewpoint of the counselor.

The second fundamental barrier for adults with ASD to access mental health care is that current interventions may not be effective. Maddox et al. (2018) examined 268 adults with ASD and comorbid anxiety or depression and compared them to 1,072 age- and sex-matched neurotypical controls. The proportion of adults with ASD taking antipsychotics and stimulants were twice as high as the controls, and they were more likely to be taking medication from multiple classes simultaneously. The controls were more likely to be participating in individual talk therapy; whereas, adults with ASD were

more likely to receive case management. Adults with ASD who were in talk therapy were averaging more sessions per month than controls. Traditional talk therapy is less effective for adults with ASD. However, the authors did not report what kinds of talk therapy participants received or the intent of the medication use. Maddox et al. stated "we know very little about the current practices and patterns of treatment delivery for adults with ASD and co-occurring anxiety and depression in community settings" (p. 33). The current study attempted to fill the lack of information about current treatments used by counselors.

All in all, counselors may not be equipped to provide counseling to those with ASD and the methods that are currently employed may not be effective. Adults with ASD and caregivers are aware that professionals lack the necessary skills and individuals with ASD are continuing to cope with severe mental illness and suicidal behaviors. Sadly, medication may be the only option for many adults with ASD (Lake et al., 2015), and even medication is lacking because there is no FDA-approved medication offered to treat anxiety and depression in ASD (White et al., 2018).

Even though the two barriers to treatment exist for adults with ASD, a couple treatments are showing promising results. The CBT and mindfulness-based therapy (MBT) are currently the most effective treatments for individuals with ASD. Each treatment will be discussed as well as using modified psychotherapy with individuals with ASD.

Cognitive-Behavioral Therapy

The CBT is a type of intervention that had shown some success rates with youth with ASD and co-occurring anxiety disorders (Vasa et al., 2014). Initial research is showing some promise for relief of anxiety in adults with ASD (Scattone & Mong, 2013; Spain, Sin, Chalder, Murphy, & Happe, 2015). The CBT is a type of talk therapy/psychotherapy blended with behavioral therapy. Spain et al. (2015) stated,

> CBT is a type of talk therapy which primarily aims to help individuals to (1) notice and understand how their, thoughts, behaviors and emotions interrelate and (2) develop new ways of thinking about, coping with and responding to, anxiety provoking or distressing situations. (p. 152)

The CBT is a short-term structured goal-oriented approach. Clients are directed to create specific measurable goals and homework is commonly used. The therapy process is aimed at examining the client's belief systems about oneself, others and their environment (Corsini & Wedding, 2008).

The ASD is considered a developmental disability. A developmental disability means that the person failed to acquire the skills necessary for daily functioning. The person needs to be able to develop and build on those missing skills, so they are able to live independently. Modifications for CBT are designed to help the adult with ASD build and improve those life skills through creative means and teaching (Gaus, 2019). Modifications have been made to CBT in order to accommodate symptoms of ASD. The CBT is a structured approach; however, modifications can make sessions more concrete, practical, and focused on emotional identification, increase exposure chances, and add in an element of parental involvement (Walters, Loades, & Russell, 2016). In typical counseling sessions with adults, parents are not regularly included in sessions. In the ASD population, adults with ASD frequently live with their parents (Hofvander et al.,

2009; Raja et al., 2014), parents may continue to be caretakers of the adult with ASD and bear the responsibilities of managing health care needs. Therefore, if needed, parental involvement in treatment is recommended to aid in increasing generalizability of knowledge gained in sessions (White et al., 2018).

> Spain et al. (2015) offered some specific modifications,
>
> Several adaptations are proposed to be pertinent for enhancing engagement, acceptability and utility of CBT approaches. These include (1) use of written and pictorial methods to enhance discussion during assessment, therapy and to facilitate recall; (2) identification of idiosyncratic descriptions of emotions (e.g. anxiety or low mood); (3) tailor-made individualized outcome measures (e.g. analogue scales); (4) enhancement of emotional literacy prior to 'active' CBT treatment; (5) emphasis on behavioural change and skills development; and (6) a less socratic therapeutic style. (p. 153)

Other suggestions have been made such as using diaries, diagrams, role plays, visual cues, use of tape recordings, using a computer to communicate, structuring time, identifying and working towards life goals, increasing social opportunities and other rewards, creating intake contracts on logistics of sessions, and adjusting session beginning and end times to allow for slower information-processing (Anderson & Morris, 2006; White et al., 2018). Individuals with ASD can experience sensory-related problems, so counselors need to check with clients if they are feeling overstimulated by the counseling environment (Woods et al., 2013).

Part of modified CBT is teaching skills for core ASD issues. Individuals with ASD have social cognitive deficits and, therefore, they have trouble inferring and hypothesizing other people's intentions and nonverbal behaviors. Part of modified CBT is teaching social skills, so they are better at analyzing other people's behaviors, better understand social interactions, and then adjust their own behaviors (Gaus, 2011). Another important set of skills to focus on are coping skills and problem-solving skills.

Individuals with ASD struggle with executive functioning and consequently struggle daily with managing tasks, procrastinating, and difficulty in problem-solving. Simple solutions can be created in sessions to accommodate each person's struggles (Gaus, 2019).

Research has shown that the therapeutic relationship is an imperative part of the counseling process and the most essential piece of client change (Doran, 2016). Individuals with ASD struggle with developing and maintaining relationships, thus the therapeutic relationship/working alliance can be impacted. Individuals with ASD tend to be confused by insincerity and may even be suspicious of a counselor who sounds artificial, so genuineness and empathy are characteristics greatly needed in the counselor (Woods et al., 2013). Gaus (2011) suggested providing clients with ASD information about social expectations of therapy sessions such as when to arrive, where to sit, and how to behave; so as to decrease the likelihood of needing to correct them, which can produce increased anxiety.

A plethora of research studies are available discussing the success rates of modified CBT with children and adolescents with ASD in the reduction of mostly anxiety symptoms, but mixed reviews in the reduction of depressive symptoms. Data have indicated up to 71.4% of youth with high-functioning ASD responded to CBT treatment for decreasing anxiety symptoms (Vasa et al., 2014). High success rates in numerous studies examining children with ASD have presented modified CBT to be an empirically supported treatment for children with ASD (Kester & Lucyshyn, 2018).

While modified CBT is empirically supported for treating children with ASD, research examining CBT with adults with ASD is highly lacking (Gaus, 2011). However,

some initial studies are showing similar results to those with CBT in children with ASD. In a literature review by Spain et al. (2015) investigating six studies with 105 total adult participants with ASD, decreased comorbid mental illness symptoms was found including decreased anxiety, reduced obsessions and compulsions, reduction in low mood, and improvements in some social skills and moods. Spain, Blainey, and Vaillancourt (2017) examined adults with ASD and modified CBT in a group setting and found participants stated they felt more confident in a social situation and believed to have a reduction in anxiety in social situations. However, low mood was not changed by the treatment. A follow-up study by Nakagawa et al. (2018), examining the effects of CBT and pharmacological treatment on adults with ASD and comorbid OCD, found that even after four to 11 years after treatment, participants stated they attributed their improvement to the CBT treatment. Unexpectedly, they also found that the ASD plus OCD group showed a rise in depressive symptoms at the follow-up check-in.

Even though depression is the most prevalent mental disorder comorbid with ASD (Ghaziuddin et al., 2002; Hudson, Hall, & Harkness, 2019), most of the current literature focuses on the psychosocial interventions with anxiety. Currently, CBT research with individuals with ASD has, to date, no research explicitly focused on depression (Walters et al., 2016; White et al., 2018). Furthermore, research looking at improvement in suicidal ideation using CBT or any other treatment method is absent. Therefore, the present study looked at the treatment methods counselors were offering to adults with ASD including their mode on suicide interventions.

Mindfulness-Based Therapy

The MBT is a therapy based out of mindfulness practices. Kabat-Zinn (2011), the founder of the Mindfulness-Based Stress Reduction program stated,

> mindfulness is awareness, cultivated by paying attention in a sustained and particular way: on purpose, in the present moment, and non-judgmentally. It is one of many forms of meditation, if you think of meditation as any way in which we engage in (1) systematically regulating our attention and energy (2) thereby influencing and possibly transforming the quality of our experiences (3) in the service of realizing the full range of our humanity and of (4) our relationships to others and the world. Ultimately, I see mindfulness as a love affair- with life, with reality, and imagination, with the beauty of your own being, with your heart and body and mind, and with the world. (pp. 1-2)

Mindfulness is focusing on the present moment and accepting where and what it is. The MBT is a therapy where individuals are taught that all feelings and thoughts are accepted without needing to be changed. They are temporary mental phenomenon without needing to analyze or deconstruct them. The MBT includes experiential exercises and learning meditative skills. Currently, a growing body of literature exists about using MBT in neurotypical populations and showing positive effects of overall well-being, and decreasing depression, sleeping issues, and anxiety (Khoury et al., 2013). However, only two studies are present in the literature about using MBT with adults with ASD. Each will be discussed.

The first MBT study with adults with ASD was conducted by Spek, van Ham, and Nyklicek (2013). They had 42 participants randomized into a 9-week MBT group and a wait-list control group using a random controlled trial. The aim was to investigate whether MBT treatment would be beneficial in decreasing comorbid symptoms. The researchers modified MBT and called it mindfulness-based therapy autism spectrum disorder, specifying that this intervention study used high-functioning adults with ASD. They modified the phrasing, so it was more tangible, added a week onto the training, and

changed some of the material to accommodate slower processing. All participants were

diagnosed with ASD prior to starting treatment. Twenty adults were in the experimental

group where they followed group training lead by two trained therapists and were

required to practice 40 to 60 minutes of meditation at home six days a week.

Results showed that participants experienced a reduction in anxiety, depression,

and rumination and the control group did not see any improvements. Furthermore,

participants displayed the ability to obtain meditation skills and use them to cope with

daily life struggles so as to decrease comorbid symptoms. This ground-breaking study

has proposed that it is not necessary to stop or deconstruct negative thoughts or feelings

in order to decrease distressing feelings. The MBT asserts that adults with ASD can

decrease painful thoughts and feelings by accepting them as they are.

The second study by Kiep, Spek, and Hoeben (2015) examined the long-term

effects of MBT with adults with ASD on psychological and physical wellbeing over time.

Fifty participants from the Netherlands were used who were referred from local clinicians

for anxiety, depression, and struggled with rumination. Participants partook in nine weeks

of 2.5-hour sessions of MBT and practiced 40 to 60 minutes of daily meditation. They

gave out assessments looking at comorbid symptoms, mood scale, and rumination a week

before the start of treatment, after completing the 9-week MBT, and then again nine

weeks after the last session. The results showed that symptoms of,

> anxiety, depression, agoraphobia, somatization, inadequacy in thinking and
> acting, distrust and inter-personal sensitivity, sleeping problems, general
> psychological and physical well-being, and rumination declined significantly
> during the intervention. (pp. 641–642)

They also found an increase in positive affect during the treatment. They did not see a

decline in self-reported hostility, although it was not high from the beginning.

Furthermore, when examining the changes from post-MBT and the 9-week check-in, they found no significant differences. This shows that the MBT outcomes stayed unchanged and therefore MBT is effective in short and long term.

So far, MBT is showing significant reduction in comorbid symptoms and rumination in adults with ASD. Only two studies exist so far, so many more studies are required to show if it will be an empirically supported treatment for adults with ASD. Although CBT seems to be the treatment most recommended by professionals and researchers, other forms of psychotherapy are offered to those with ASD who are seeking counseling. Next, discussions of adults with ASD attending counseling with other forms of psychotherapy are examined.

Other Psychotherapy

While other forms of psychotherapy, besides CBT, have been found effective in neurotypical populations, little to no research has been completed examining general psychotherapy with adults with ASD. As previously discussed, adults with ASD seek out counseling more often and receiving psychotherapy stemming from other counseling orientations (Anderberg et al., 2017). Currently, only one study is available looking at other forms of psychotherapy and adults with ASD. As seen earlier in this section, counselors believed psychotherapy might not be as effective in the adults with ASD population (Brookman-Frazee et al., 2012). However, a study conducted by Anderberg et al. (2017) examining general psychotherapy outcomes with adults with ASD found different results.

Anderberg et al. (2017) examined the outcomes of general psychotherapy with young adults with ASD and compared their results with neurotypical peers at a university

counseling center located on a college campus. Seventy-six individuals with ASD, 91 individuals with potential ASD, and 21,546 neurotypical peers' information was retrospectively inspected from the years 1993 to 2015. The diagnosis of ASD was not verified and some cases it was not always clear, although the symptoms were present via the counselor who worked with them. The individual's information was still used as the researchers found no reason to take them out. Therefore, they were termed potential ASD.

Counselors working with the participants had a variety of counseling orientations, including cognitive-behavioral (modifications are unknown), person-centered, emotion-focused, and acceptance and commitment therapy. Results showed that adults with ASD presented with the same levels of distress as neurotypical peers; however, they stayed in therapy and remained in therapy far longer than neurotypical peers and attended two times the amount of sessions than their counterparts. Congruent with previously discussed research, it is hypothesized that adults with ASD did not feel the same amount of relief early on in sessions as counterparts and needed to stay longer to feel the same reprieve. Unexpectedly, the researchers found that a significantly high percentage of adults with ASD worsened in the first few sessions and then improved over time. This may be due to a more difficult adjustment to therapy or an increase in anxiety for a multitude of reasons. Even though they experienced a brief increase in negative symptoms, participants with ASD continued attending therapy and eventually improved just as much as the neurotypical peers. Results suggested that adults with ASD can improve in general psychotherapy albeit the sessions may look differently than typical sessions.

Many counselors seem afraid, not interested, and unsure how to work with adults with ASD. They may not accept clients with ASD into their clinical practice or agency because of these negative emotions about ASD (Gaus, 2019). The significant problem with comorbidity and suicidal behaviors in this population and the lack of interventions and treatments is profoundly distressing. More needs to be known about how to help this disregarded population. Jacobsen (2003) stated,

> for the therapist, the similarity in the therapeutic work is this: it is our job to understand the person we are with. We need to do this, whether or not he or she fits our usual way of understanding others. We need to express our understanding in a way that makes sense to our patients, because it is consistent with their experience of themselves and helps us both to know them better. This is what we hope to do in our work with everyone we see. (p. 87)

Interpersonal Theory

> We are really up against one of the most difficult of human performances-organizing thought about oneself and others, not on the basis of the unique individual *me* that is perhaps one's most valuable possession, but on the basis of one's common humanity. (Sullivan, 1953, p. 4)

Interpersonal theory was used as the foundation of this study. Interpersonal theory was first developed by Harry Stack Sullivan in the 1940s. However, it must be noted that there seems to be two separate but connected branches of interpersonal theory that exists currently. Both branches are born from Sullivan's work, but taken into different directions. One branch, interpersonal psychotherapy, was developed by Gerald Klerman and Myrna Weissman in the 1970s for the treatment of major depression. It is a structured, time-limited intervention used presently in clinician trials and found to be more effective than other psychotherapies for major depressive disorder (Cuijpers, Donker, Weissman, Ravitz, & Cristea, 2016; Markowitz & Weissman, 2004). The second branch is contemporary interpersonal theory and based out of the work of Donald Kiesler

and Edward Teyber. Contemporary interpersonal theory fleshed out Sullivan's original work and made it relevant to counselors today. When interpersonal theory is used in this study, it will reference the interpersonal process branch. I originally thought to find a developmental theory that would match the counselor's identity growth as a counselor; however, it became clear to me that this research is about the interactions and therapeutic relationship between a counselor and a client with ASD. Interpersonal theory highlights the importance of the interactions between people and how they can help and hinder growth. People with ASD desire relationships, although they struggle with the nuances of social interactions and consequently sometimes fail to build essential relationships for healthy development. When they forego important interactions, then their personality, belief systems, and understanding of the self and others are greatly impacted.

First, Sullivan's interpersonal theory will be described, then followed by Kiesler and Teyber's work will be examined. Sullivan thought it was important first to understand the key mechanisms that occur when a person was an infant in order to understand how those foundational beginning of life experiences and perceptions evolve over the course of the person's life. Sullivan gives a thorough explanation of how the infant experiences the world and how those experiences shape the person's attitudes and perceptions on interpersonal interactions with others and how to perceive oneself within those interactions.

Sullivan's Interpersonal Theory

Sullivan was an American neo-Freudian psychiatrist pioneer who believed people must be viewed in the context of the social world (Evans, 1996). He believed interpersonal relationships construct the fundamental development of the personality

(Morgan, 2014). He believed humans live in communal existence and, therefore, we live in continual interactions with our environments. We cannot be separated and, therefore, must be viewed within that context (Sullivan, 1953). He published numerous documents throughout the 1940s and wrote books titled *The Interpersonal Theory of Psychiatry* and *The Psychiatric Interview*. He outlined developmental stages and in each epoch included the development of learning, importance of sleep, and the impact of nursing on an infant. Sullivan believed the infancy stage is a critical epoch, whereas the infant learns most of the foundational beliefs about self and others. Several of Sullivan's major concepts will be presented as well as a brief overview of his developmental epochs.

Tension and anxiety are two major emotions Sullivan believed to initiate behavior. Tension can be two feelings: an intrinsic desire for action (tension of need) or a state of constant being (tension of anxiety). What the person does to relieve the tension, any behavior or mental experience, is called an energy transformation. For example, the infant lives in a state of euphoria until a state of tension of need occurs, such as hunger, he/she cries which is a form of energy transformation, then in turn produces a state of tension in the mothering figure and it is felt as tenderness toward the infant, and the mothering figure relieves the infant's tension of need by feeding him/her. Thus the need for tenderness is a relief of needs and requires cooperation from the mothering figure from the very beginning of life. When the infant receives the tenderness response from the mothering figure and the tension of need is relieved, the state of euphoria is restored, and interpersonal security is developed. The need for tenderness, or a desire for physical and emotional contact, continues throughout the person's life as an interpersonal need (Sullivan, 1953). Sullivan (1953) recognized that children have a need for physical

contact, at first from parents and later from an audience. Mischievous behavior, Sullivan wrote, is an expression of the need of tenderness.

Tension comes from two different ways: tension of needs, as described above which can be relieved, and tension from anxiety. As an infant, tension from anxiety in the mothering figure creates anxiety in the infant. An infant cannot create an action for the relief of this anxiety, and it creates a sense of helplessness and powerlessness in the infant. Tension from anxiety is the fear that one cannot get their physical and/or emotional needs met. Too much tension from anxiety early in infancy and childhood leads to somnolent detachment. Somnolent detachment is a state of constant anxiety which leads to interpersonal insecurity and unhealthy interpersonal patterns in later life. Sullivan described a life of constant anxiety as it "has almost the effect of a blow on the head" (Sullivan, 1953, p. 300). Anxiety is a detrimental force in a person's life. Too much anxiety denotes insecurity, a dangerous sign to self-respect, can damage interpersonal relationships, and can cripple the person's ability to develop secure attachments (Kiesler, 1996). An example of this is severe social anxiety commonly associated in ASD. The individual feels high levels of anxiety when attempting to initiate a relationship and becomes too fearful, so then they may withdrawal and lose out on the opportunity for social growth and connection.

All the person's interpersonal transactions develop into patterns that create and shape the personality. A central building block of the personality is what Sullivan called personification. Personification is a person's understanding of the interpersonal world through assumptions and beliefs about self and others. Through the initial interactions of the mothering figure, the infant develops personifications of the good mother (grouping

of behavior that satisfies the infant's needs) and bad mother (grouping of behavior that did not satisfy the infant's needs). Sullivan pointed out that the good mother bad mother personification is not about the actual person, it is the infant's understanding of the grouping of behavior that satisfied the infant or the grouping of behavior that did not satisfy the infant. The good mother behavior leads to interpersonal security, whereas the bad mother behavior, such as neglect, increase severe anxiety in the infant and the infant will anticipate the environment to be malevolent leading to serious problems later in life.

Another important concept in Sullivan's work is called dynamism. Dynamism is the human patterns of behavior to satisfy one's needs and avoid distress and anxiety. Kiesler (1996) described this process as the "basic strive to minimize insecurity . . . minimize the disapproval of significant other people, thereby minimizing the experience of anxiety" (p. 54). An example of this is when a child does a chore that they do not want to do, but do not want their mother angry with them. Sullivan named several different dynamisms a person will experience during a lifetime. He described the self-dynamism, which is the development of the sense of self based on the interpersonal interactions the person experiences. People view themselves based upon how the accumulation of how others have treated them. The perception of self is also molded by the experiences of anxiety and all the behaviors that are associated with bringing minimal and moderate amounts of anxiety. Anxiety can disintegrate and damage the self-dynamism. An example of this is an adult with ASD who has been shielded as a child and as a young person from the world and told that he is different and cannot do the same things as other people. Now as an adult he feels powerless, unworthy, and believes other people are better than him.

The self-system dynamism is the anti-anxiety system in order to maintain interpersonal security. People develop what Sullivan called a gradient of anxiety or the learning of socially appropriate behaviors initially through the mothering figure's rewards of tenderness and through punishment (not receiving tenderness) and later refined from peers and other important relationships. Children learn that certain behaviors create less anxiety, such as smiling and behaving as the adults have instructed, and other behaviors create more anxiety, such as biting or throwing toys. These learning outcomes are stored in the self-system and are shaped through educative experiences. For an individual with ASD, they might miss out on these learning opportunities and continue to reenact the same behaviors repeatedly without understanding the positive or negative reactions from others. For these children, their self-system might not develop or develop at a slower pace due to social cognition deficits.

Sullivan (1953) created phases of personality development, or human developmental epochs, in which a human progress through seven stages of life: infancy, childhood, juvenile, preadolescence, early adolescence, late adolescence, and adulthood. Each phase has major interpersonal learning experiences. The infant phase is most crucial for development of healthy interactional patterns. This phase is where the person learns tensions of needs, anxiety, theorem of tenderness, and perspectives on the self. The childhood phase is marked by the extension of interpersonal experiences with others outside of the family. This phase encompasses the child's ability to respond to outer demands, use language as a means to communicate, fear of punishment, and increased feelings of anger.

During the juvenile phase, Sullivan believed that peer relationships are the most impactful on shaping interpersonal growth by learning social hierarchy, social cooperation, compromise, and competition. He noted that the impact of loneliness can be detrimental to the developing personality and too much loneliness creates overwhelming feelings of unworthiness, Sullivan called disparagement.

The next era, pre-adolescence, marks a great change on a child acquiring mostly same-sex friendships, or chums. The arrival of the need for intimate interpersonal relationships creates a more complex and deeper connected relationship than in the previous era. This intimate relationship is a steppingstone for the highest form of interpersonal connected Sullivan called love, but it is marked by a validation and attempting to gratify the needs of the other. When a person has a lack of this developmentally crucial relationship, it can lead to the experience of loneliness. Sullivan (1953) described "loneliness in itself is more terrible than anxiety" (p. 262), and a person who is lonely will seek out another even if it causes anxiety. The two previous stages may be the most difficult for an individual with ASD because impairment in social cognition creates social awkwardness and lack of social skills halts them from forming relationships with peers. Social isolation and feelings of loneliness can develop and in turn create anxiety and depressive symptoms (Woods et al., 2013).

The early adolescence phase is the stage when a person starts to experience feelings of sexual desire; Sullivan called this the lust dynamism. The child is now interested in opposite-sex relationships and in a complex collision of needs for lust, security (self-esteem), and intimacy (connected relationships with the other gender). In this phase, self-esteem, or the perceptions on self, is based on the safe interpersonal

relationships the person has and the feedback that they receive that matches what they believe about themselves. The goal of this phase is the need of intimacy and avoidance of loneliness. Sexual behavior is simply the result of the nature of the person's interpersonal relationships. This phase is when the person develops their personifications of who is desirable and who is not desirable. Individuals with ASD feel sexual desire and motivation to form intimate relationships; however, many lack accurate sexual information and lack of sexual experiences, which can lead to anxiety about dating and confusion about sexual identity. Many may experience aversion to physical touch, which creates a complex scenario when attempting a romantic intimate relationship (Gaus, 2011).

The last phase, late adolescence and adulthood, begins when a person finds "what he likes in the way of genital behavior and how to fit it into the rest of life" (Sullivan, 1953, p. 297). In other words, when the person has developed an understanding of one's own sexuality and moves towards becoming fully human, which takes a lot of time, and some do not ever achieve this phase, even as adults. For an individual with ASD this phase may not occur or may occur a lot later in life. Many adults with ASD do not go on dates often and many do not get married (Roth, Gillies, & Reed, 2014).

Sullivan believed that healthy adjusted persons who have arrived in late adolescence should be mature, confident, assertive, able to judge others wisely, able to establish intimacy, able to handle bouts of anxiety, have satisfactory interpersonal relationships, and communicate effectively. When this does not happen, issues within the self-system have occurred and people hold distorted personifications of the self and others including stereotypes and prejudices. He noted that self-respect is needed in order

to have respect for others. If a person has a negative view of others, then he possesses an inadequate self-system and a distorted perspective of the self. Sullivan believed we need others to grow, learn, and change, and when a person experiences isolation from an early age, then one has restrictions in the freedom of fully living. Sullivan did not expand on the idea of freedom of fully living; however, I would assume he meant being open to interpersonal learning, growing, and changing and the freedom from interpersonal fear.

Although Sullivan was a pioneer and a psychology rebel during the time of the popular Freudian psychoanalysis, many counselors do not recognize or know his name or his work. Unfortunately, Sullivan is vastly unknown because his work was so vague, and his theory was not organized (Yalom, 2005). Sullivan was too unclear about his description of being fully human and the lack of descriptions of the development of the adult (Evans, 1996). However, Sullivan's work was impactful to those who followed him and is seen later in the work of the popular developmental theories by Eric Erikson, Abraham Maslow, and Daniel Levinson (Evans, 1996) and gave rise to the development of family systems theory, as Sullivan trained the two family systems founders, Don Jackson and Murray Bowen (Teyber & Teyber, 2018).

Contemporary Interpersonal Theory

Two psychologists, Donald Kiesler and Edward Teyber, expanded on Sullivan's seminal interpersonal theory. Kiesler was a professor of psychology at Virginia Commonwealth University and wrote numerous articles and books about interpersonal theory and practice. Kiesler died in 2007 at the age of 74. Teyber is a professor of psychology at California State University, San Bernardino, and has written books about teaching new counselors, children, and families. This section will outline the

interpersonal process work of both psychologists that pertains to this study, first with Kiesler and followed by Teyber.

Kiesler (1996) described six assumptions central to interpersonal theory and the development of the personality:

1.   Human transactions. Interpersonal theory emphases are on the interactions between people.

2.   Construct of self. The perspective of self is developed through the interpersonal interactions with others. This is called the self-presentation, and it is unaware and recurring patterns in which we view our self and in response, how we view and seek out relationships with others.

3.   Basic dimensions of interpersonal behavior. The covert and overt behaviors occurring in an interaction is a mix of two dimensions of interpersonal behaviors: control and affiliation. Control is dominance and submission behaviors and affiliation is friendly and hostile behaviors. Humans have two basic motives: the need for control (power) and the need for affiliation (love).

4.   Mutual influence. Interactions have mutual influence on each other. Both people are being shaped and impacted by the other.

5.   An interactionist position. The person's behavior is the combination of the person's beliefs about interactions and the situational-environmental events. The situational-environmental events are the situation and the psychological environment of the people who are interacting.

6.   Communication. The verbal and nonverbal exchanges over the

progression of two people interacting. Kiesler (1996) noted that through

our verbal and nonverbal behavior, we attempt to "influence others into

reactions that confirm our definitions of self and others" (p. 5).

Kiesler noted that contemporary interpersonal theorists were giving more time to the

covert, cognitive processes during interactions between people. Sullivan called these

personifications, but did not discuss in depth what occurs during this cognitive process.

These cognitive processes include the self-schema, which parallels Sullivan's self-

dynamism. The self-schema is the perception of the self-based on past experiences that

lead, shape, interpret and store information related to personal information. The self-

schema is developed over time through interpersonal interactions with others, especially

significant others including parents and peers. They are,

> readily activated with little information; they influence what we attend to,
> particularly self-consistent information; and they are used to actively solicit self-
> confirming evidence from others and to present ourselves in ways that will elicit
> such evidence. (Kiesler, 1996, p. 68)

Teyber (2006) originally created the interpersonal process model and expanded on

his theory in the most current text by Teyber and Teyber (2018). He took interpersonal

theory and made it applicable for training new counselors. The interpersonal process

model takes on a more integrative approach to contemporary interpersonal theory. He

incorporated other theories such as attachment theory, object relations theory, cognitive

behavioral, and family systems theory. He believed that family experiences are the most

impactful on a person. Family relationships are laden with intense emotion; therefore,

repetitive patterns in family interactions shape a person's sense of self and interactional

style. Patterns of invalidation in one's family of origin create misperceptions about self and others. Hence, it is important for the counselor to validate the client's experiences.

Teyber and Teyber (2018) called the interaction between the counselor and client the interpersonal process. It was important to shift from the overt content and focus on the relational process between the two people involved in counseling. The creation of the five-stage model of counseling interventions starts with the development of the working alliance, the client's journey inward, working within the process dimension, working-through, and termination.

Maladjusted Behavior

Sullivan did not believe in the traditional belief of a categorical mental disease system as was popular during the 1940s; he believed mental illness was patterns of insufficient interpersonal relations or the complications in interpersonally living (Evans, 1996; Sullivan, 1953). He was not fond of the idea of classifying mental illness and actively spoke against it (Evans, 1996). He believed all people were more alike than we are different in his one-genus hypothesis. He recognized that mental illness can have a biological cause, but social and cultural experiences are far more powerful. Sullivan described mental illness as the experience of intense anxiety and the person is left with little ability to cope. Sullivan wrote that when a person experiences intense anxiety, they fail to learn other skills and, therefore, have a hole in that area. Later, when an event evokes that memory, they will feel intense consuming anxiety (also called awe, dread, loathing, and horror). The person is rendered powerless and crippled by anxiety.

Another cause of inadequate interpersonal relations is when a person does not fulfill the required needs during the developmental epochs. If the person did not meet

their needs of cooperation (increases feelings of shame), need for peers and experiences of ostracism, feelings of disparagement (chronic low self-esteem), social isolation, and too many feelings of loneliness, jealousy or envy can also warp the person's perspectives on self and others. Sullivan believed maladaptive behavior was the impact of anxiety at the different developmental epochs, how the self-system coped with those experiences and how those experiences shaped the person's interpersonal relational patterns. Experiences of anxiety and depth of feelings of loneliness is the cause of all mental disorders (Evans, 1996).

Kiesler (1996) went on to state that mental illness, better known as maladjusted behavior, is inadequate interpersonal communication. Kiesler (1996) stated,

> when one person, through verbal and nonverbal behavior, continually evokes or pulls from significant others a rigidly constricted range of intense and predominantly aversive impact responses for which the abnormal person assumes little responsibility because the negative consequences were unintended. The person's inability to detect and correct these self-defeating, interpersonally unsuccessful communications result in continual aversive-rejecting impact responses from others. (p. 127)

These defects in communication, or duplicitous communication, are the universal symptom of a maladjusted person. They have fragmented perceptions of self and that is exhibited through fragmented communication. Kiesler (1996) named seven characteristics of an maladjusted person: (a) extreme interpersonal behavior, such as violating cultural rules, (b) rigid interpersonal behavior regardless of the situation or audience, (c) self-other perception inconsistencies, such as beliefs that one's behavior does not affect others, (d) duplicitous communication, verbal and nonverbal messages that are inconsistent, (e)maladaptive transaction cycles, a person's inflexible and intense interpersonal behavior cause another person to avoid them, which reinforces the person's

maladaptive behavior, (f) stress causes instability, a maladaptive person's erratic interpersonal behaviors escalate when presented with stress, and (g) feels high levels of interpersonal suffering.

Consistent with Kiesler, Teyber and Teyber (2018) also perceived maladaptive behavior as inflexible interpersonal coping. People develop disruptive internal working models, or the mental images of interpersonal relationships and how they work between self and others established initially between the young child and their caregivers. The internal working model consists of roles, expectations, and repetitive interpersonal interactions in the family of origin. Teyber and Teyber stated

> types of problematic interactions with caregivers were repetitive or ongoing, they gave rise to disruptive IWMs [internal working models] with pathogenic beliefs about oneself, faulty expectations of others, and a narrow or skewed view of what will usually occur in close relationships. (p. 224)

The person develops internal working models based on how they were treated initially and then those experiences organize who the person believes who they are and how others will respond to them, then their reactions and behaviors are built on those internal working models.

People have disruptive unmet needs stemming from childhood and later in life experience anxiety. Their unmet needs are denied but continue into adulthood and are displayed in their adult interpersonal relationships. In order to cope with that powerful anxiety, a person then develops an interpersonal coping strategy that is rigid and used in every context even when it becomes toxic (Teyber & Teyber, 2018). Shame, the perception that one is bad at the core, impacts the individual tremendously. Believing one is bad includes feelings of worthlessness, imperfect, loathed, unwanted and faulty at the core of who they are. These people grew up experiencing contempt from caregivers and

their intense feelings of shame cripples the person's ability to adjust their interpersonal coping strategies (Teyber & Teyber, 2018).

Perspectives on Therapy

Sullivan's foundational beliefs about human nature and psychotherapy were rooted in the understanding of interpersonal relationships. His building blocks for counseling were a combination of three elements: the therapeutic relationship, goals of counseling, and treatment designed to fit the client's problems of living (Evans, 1996). Each element will be briefly discussed.

The relationship. Interpersonal theory posits that the relationship is an important aspect in therapy. Counselor and client have interdependent functioning, or the interactions of each person affect the behaviors and responses of the other (Kiesler, 1996). In order to develop the counselor–client relationship in the beginning of counseling, they must have interpersonal complementarity. The interpersonal complementarity is a person's natural interpersonal action of eliciting reactions from others that confirm beliefs about self that lead to repeating the same behaviors as before (Kiesler, 1996). A high level of interpersonal complementarity leads to what Zetzel (1979) called the working alliance or the therapeutic alliance. The working alliance is the strength of the counseling relationship between client and counselor that provides a foundation for client change.

Teyber and Teyber (2018) also believed the working alliance was foundational in counseling. They stated, "the working alliance is established when clients perceive the therapist as a capable and trustworthy ally in their personal struggles- someone who is interested in, and capable of, helping them with their problems" (p. 38). The

therapeutic/working alliance has a large body of research over the years and research has suggested that a stronger working alliance has been linked with better treatment outcomes (Doran, 2016). The Teyber and Teyber five-stage intervention model begins with the development of the working alliance. They looked at the working alliance as a collaborative process by offering empathy, eliciting the client's most pressing struggles and joining in the exploration process of creating treatment goals. The counselor needs to have an active approach in the relationship to build the collaborative relationship through empathetic understanding, by creating emotional safety, and accurately understanding and reflecting the client's distress. Empathetic understanding is the foundation of the working alliance and a key in client change. Accurate empathy is not a personality characteristic but is developed through a counselor's attempts to collaborate and understand the client's experiences (Teyber & Teyber, 2018).

In Sullivan's perspective, the goal of the relationship was to create and sustain an environment of interpersonal security by providing empathy, engaging and deep respect, so the client can repair anxiety-driven interpersonal beliefs in the here-and-now relationship with the counselor. Sullivan believed empathy was an interpersonal process. The counselor can learn a lot about a client simply by watching, attending and asking inquiries, however the counselor cannot ever fully know or understand the client's world (Evans, 1996). Sullivan (1953) found it important to give focus on the client's intentions rather than what the counselor has assumed. This requires a higher level of interpersonal complementarity.

Although a high level of interpersonal complementarity at the beginning of counseling is necessary; however, once the working alliance is established, the

counselor's new role is to stop responding in the way the client desires. This stage is when the intense work of counseling begins. Kiesler (1996) stated,

> The goal of interpersonal therapy is for the therapist and client to identify, clarify, and establish alternatives to the rigid and self-defeating evoking style of the patient. Their task is to replace constricted, extreme transactions with more flexible and clear communications adaptive to the changing realities of specific encounters. The therapist's priority task is to stop responding in kind, in complementary fashion, to the client's duplicitous communications- not to respond in the same way as have others in the client's life. (p. 238)

This is not done without care and empathy towards the client. The counselor must be aware of their own messages as well. But the work cannot be started until the counselor begins to become aware of and label the interpersonal maladaptive patterns (Kiesler, 1996).

Goals of treatment. The main goal of treatment was the client's interpersonal learning (Sullivan, 1962). When assessing a clients' interpersonal functioning, the first step is to discern what problems of their interpersonal functioning are to be changed, what are the problems of living (Kiesler, 1996). The counselor will want input from the client directly; however, one of the major sources of information will come from the client's behavior and interactions with the counselor, which will bear a resemblance to how they interact, treat, and react to other people. People are constantly sending nonverbal messages, even when they are being silent, and these are far more impactful than the verbal messages. Nonverbal messages emit messaged about emotion and relationship meanings. Part of a counselor's job is to pay attention to the nonverbal messages and analyze the meanings. The counselor's greatest assessment tool is his/her own experiences of the client. Furthermore, the counselor comes to the relationship with his/her own culture, understandings, experiences, and background; therefore, focus must

be given to the counselor's behavior and nonverbal messages to the client. Both channels, counselor to client and client to counselor, are just as important in the therapy process (Kiesler, 1996).

Sullivan wanted clients to learn new interpersonal patterns by correcting ridged beliefs in the self-system and teaching more effective patterns (Evans, 1996). The two goals in interpersonal process model are to change beliefs about self and others and help clients come to a resolution to the presenting problems (Teyber & Teyber, 2018).

Treatment. Sullivan (1962) believed treatment had to be changed to fit the problem. Psychotherapy is an educational process and techniques must be augmented to fit the person and the problem. The counselor must keep an investigative mindset and systematically inquire about interpersonal problems, while maintaining flexibility with techniques. The client's insight and changing of faulty personifications and the impact on interpersonal relationships is the concentration in counseling.

The counselor's role is to disrupt the client's maladaptive transaction cycle. The maladaptive transaction cycle is the problematic, repeating relating issues that happen between the client and the counselor in the course of counseling (Kiesler, 1996). These issues reflect the same thematic interpersonal issues the client has with other relationships in life. An assumption in interpersonal theory is that clients will behave, react, send messages, and respond in a similar way they would with other people. Therefore, a counselor's role is to disrupt the maladaptive transaction cycle, and the rigid and extreme behavior, by exploring those damaging patterns and creating new relational patterns inside and outside the counseling room (Kiesler, 1996). Kiesler (1996) suggested using a technique called metacommunication. Metacommunication is a counselor's use of his/her

own feelings, experiences, and reactions to the client in the here-and-now. Using

metacommunication provides, "first by not providing the complementary response bid for

by the patient; second, by pursuing conjoint exploration and validation of the automatic

and unaware transactional game occurring between patient and therapist" (Kiesler, 1996,

p. 285). Metacommunication can be a powerful use of feedback into the client's overt and

covert destructive messages and help to change self-defeating interacts.

 Similarly to the metacommunication technique, a method called process

comments, or the here-and-now intervention in which the counselor and client explore

what is occurring in the moment, are used. Six ways a counselor can exhibit an active

open stance through: (a) offer feedback about interpersonal patterns, (b) offer different

perspectives to expand self-beliefs, (c) interpersonal feedback, (d) use process comments,

and (f) examine and discuss the client's responses to the counselor by offering in vivo

relearning in the counseling room (Teyber & Teyber, 2018). This in vivo relearning used

to provide insight for a client is a method called a corrective emotional experience. The

client will reenact the same interpersonal issues they have with others in the counseling

relationship, and the counselor will provide a new and effective response that allows the

client to recognize and repair the interposal issue and then create more adaptive

interpersonal patterns (Teyber & Teyber, 2018).

 The five stage model's interventions begin in stage two: the client's journey

inward. This stage is when the intense work of counseling begins where the counselor is

attempting to aid in the exploration of the client's problematic ways of responding and

the client's responsibilities of their own problems. This stage is comprised of the client

examining their repetitive interactional patterns, how they have been helpful and not

helpful, and begin developing healthier ways of responding. The third stage, working with process dimension, is the stage where the client's interpersonal struggles can be brought into the working alliance and reenacted with the counselor in the process dimension (Teyber & Teyber, 2018).

The next stage in the Teyber and Teyber (2018) model, working-through, is the stage where the client actively practices their newly acquired adaptive interpersonal patterns. Clients will usually need multiple reenactments in the therapeutic relationship to change their internal working models, interpersonal coping strategies, and maladaptive behaviors. The last stage of the model, termination, is an important stage for the client's continued growth and mental health. This is when the client and counselor can discuss the impact of ending the relationship, forestall the future struggles, areas of personal progressions, and provide a model of ending a relationship. Unresolved losses and endings can be discussed earlier in sessions when a counselor actively can open exploration about the end of counseling. The five-stage model offers new counseling students a foundation for clinical training on how to integrate interpersonal theory into daily counseling sessions with clients.

All in all, interpersonal theory adds a unique perspective on how to view adults with ASD. Adults with ASD desire interpersonal relationships and intimacy, however, the mechanics on how to develop and maintain significant relationships are challenging. As the deficits commonly seen in ASD become apparent in a child with ASD, their interactions with others and others' interactions with them begin to change and mold their beliefs about themselves and others. Those beliefs are brought into the counseling relationship and the counseling process. Counselors can use the five-stage model to

explore and change the maladaptive transaction cycle through process comments. The interactions and relationship of the counselor and client is the foundation of counseling and must be examined.

Conclusion

In this chapter, important information related to understanding the plight of adults with ASD was presented and discussed. A review of the history of ASD illuminated the extensive transformations of the perspectives of ASD over time and how it has impacted our viewpoints on ASD at the current moment. An overview of empirical research relating to comorbid anxiety, depression, and the trouble of suicidal behaviors demonstrate the large problem of mental health issues in adults with ASD. The lack of treatment and intervention options for adults with ASD became apparent through the literature review. Interpersonal interactions and interpersonal relationships were discussed using the interpersonal theoretical lens. To my knowledge, this is the first-time interpersonal theory has been used to examine adults with ASD. Counseling is an interpersonal process in which the counselor must adjust the methods to fit adults with ASD as is suggested by counselors using CBT and MBT. However, information about how general counselors adjust or do not adjust their methods to work with adults with ASD is unknown. I presented evidence that the counselor's perspectives on working with adults with ASD is lacking. Therefore, further understanding of counselor's perspectives on working with adults with ASD is highly needed.

Understanding the counselor's perspective is the first step; however, the knowledge gained from this study can create a domino effect into other professionals in the counseling field. Currently, there is an absence of research studying counselor

educators' methods for teaching about ASD or what treatments are considered the most effective for adults with ASD. So, it is unknown what is currently taking place in the classroom and what counselors-in-training are learning about ASD. It is highly important that all counseling professionals are aware that mental illness and suicide is a concern in the adults with ASD population. The results from this study can be used by counselor educators to understand how to equip counselors going into the field professionally and personally so they feel prepared before working with adults with ASD. Future studies can incorporate this study's results into the development of training protocols and lesson plans on how to better teach about ASD and train counselors on how to adjust their counseling skills to fit adults with ASD.

CHAPTER III

METHODOLOGY

Introduction

Quantitative research, like photography, excels as producing images characterized by precision. Qualitative research, like portraiture, can offer a glimpse at what lies beneath. Both photography and portraiture require great skill, and both qualify as art. (Haverkamp, Morrow, & Ponterotto, 2005, p. 124)

In this chapter, a discussion will be presented about qualitative research,

epistemology, phenomenological research, and the procedures of this study including

data collection, data analysis, and trustworthiness and rigor. Chapter II explained the

history of autism spectrum disorder (ASD), problems with comorbidity, lack of

treatment, and interpersonal theory. The review of the literature suggested the need for

more research about adults with ASD and the lack of information about how counselors

are providing services to adults with ASD. The purpose of this study was to explore the

lived experiences of counselors providing counseling to adults with ASD. I addressed the

following research question:

Q1   What are the lived experiences of counselors providing counseling to
        adults with autism spectrum disorder?

Qualitative research is,

interested in uncovering the meaning of a phenomenon for those involved. Qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences. (Merriam & Tisdell, 2016, pp. 5–6)

Qualitative inquiry aims to elucidate experience and bring it into awareness (Polkinghorne, 2005) and understand the meaning of human action (Schwandt, 2007). Qualitative design is focused on the understanding of experiences, how people think and feel about experiences and what meaning they derive. Qualitative research poses that multiple realities exist, and research is an attempt to capture the essence of human experience and make sense of it (Merriam & Tisdell, 2016).

The research question is best answered by the qualitative research approach because of several reasons. First, in Chapter II the importance of interactions between people as the shaping factor for the developing person from an interpersonal theory lens was explored. Qualitative research allows for studying those important interactions and their meanings between counselors and clients (Wang, 2008). Secondly, the lack of research available focused on adults with ASD and the fact there is nothing currently in the literature focused on counselors' practices with adults with ASD requires more in-depth exploration (Maddox et al., 2018). Important variables in the interactions between counselors and clients with ASD have not been identified, and, therefore, qualitative methods can be used to identify and explore those elusive variables (Morrow, 2007). However, qualitative research is not just used as a prequal to quantitative research when little information is known (Wang, 2008). On the contrary, qualitative research can provide rich understanding of processes, reasons for reactions, consideration for different contexts, and bring to light the participant's internal thoughts and behaviors even if quantitative results are available (Creswell & Poth, 2018). Qualitative methods can investigate the deeper human experience (Polkinghorne, 2005) and bring to the forefront new or surprising knowledge (Morrow, 2005). Third, a complex understanding of

counselors' experiences and methods of counseling adults with ASD is desired. This complex understanding can only be achieved by listening to the counselors' stories (Creswell & Poth, 2018) and that is best done by creating languaged data derived from the accounts people have voiced about the experience (Polkinghorne, 2005).

Lastly, the call for more qualitative research in the counseling field has been active for many years (Haverkamp et al., 2005; Morrow, 2007). Qualitative design is more closely related to counseling practices and paradigms; therefore, it is more suitable with social science research (Morrow, 2007). Polkinghorne (1984) noted

> because their [people] actions are intended and interpreted within a complex matrix of expressive interactions, the precision of deductive reasoning is often more problematic than helpful in the investigation of the subject matter of counseling psychology, which is human meaning and choice. (p. 425)

This study examined the interactions of counselors and clients, and then further studied the counselors' thoughts, responses, feelings, and overall experiences within those interactions. I wanted to know what meaning the counselor derives out of interactions with clients with ASD in his/her own rich words.

Theoretical and Philosophical Foundations

Crotty (1998) proposed there are four questions that are the foundational elements of any research and must be clarified and discussed:

1. What *methods* do we propose to use?
2. What *methodology* governs our choice and the use of methods?
3. What *theoretical perspecti*ve lies behind the methodology in question?
4. What *epistemology* informs this theoretical perspective? (p. 2)

These four foundational questions guided me in the creation of this study and shaped what choices I made for this study. Crotty (1998) stated "inevitably, we bring a number of assumptions to our chosen methodology. We need, as best we can, to state what those

assumptions are" (p. 7). My assumptions were based out of how I answered Crotty's questions. I will discuss Crotty's questions in reverse as I believe epistemology and theoretical perspectives are required first so as to understand the methodology of the study. Epistemology and theoretical perspective will be explained in this section and methodology and methods in a later section.

Epistemology

Epistemology is defined as "a theory of knowledge that explores the relationship between the inquirer and the knowledge, or between the knower and the respondent" (Lee, 2012, p. 407). While there are many epistemologies available, constructionism, also known as social constructionism, is the epistemology that guided this study. Constructionism derived out of the constructivist paradigm and though they are similar, they have differing viewpoints. Constructivism focuses on the individual's mental construction and perception of knowledge; whereas constructionism focuses on the idea that knowledge is created through social meanings, social actions and generational meanings (Lee, 2012; Young & Collins, 2003).

In the constructionism paradigm, meaning is not found but constructed. Meaning is created when a person is engaging with an entity or phenomenon and develops meaning for it. A meaning, also called a truth, is not objective nor is it subjective, a person constructs what the truth is based upon one's own interactions with others, personal history and how the truth is derived from socially constructed reality (Crotty, 1998). Crotty (1998) pointed out that "all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an

essentially social context" (p. 42). Social constructionism accepts that social processes shape a person's perception of the world, and the social world is shaped by those social processes and how we relate and interact with one another (Young & Collins, 2003).

Meaning is always shifting, and different cultures have diverse perceptions and viewpoints of the same phenomenon. There is no true meaning and no valid interpretation as all interpretations are valid to the person interpreting the phenomenon (Crotty, 1998). Numerous constructions are possible of a phenomenon at the same time (Lee, 2012). Thus, multiple meanings are formed, and researchers can solely rely on the participant's perceptions of the phenomenon (Creswell & Poth, 2018). Constructionism was applied as the epistemology for this study because it mirrored the research question. I was asking participants to explain their perceptions and experiences on their interactions with adults with ASD. Through those educational experiences, social meaning was constructed on the perceptions of adults with ASD, how to work with them, and what are and are not effective strategies on providing counseling to adults with ASD. Crotty (1998) stated,

> Research in constructivist vein . . . requires that we not remain straitjacketed by the conventional meanings we have been taught to associate with the object. Instead, such research invites us to approach the object in a radical spirit of openness to its potential for a new or richer meaning, it is an invitation to reinterpretation. (p. 51)

The constructionist standpoint was fitting for this study as this study was asking participants to interpret their own meanings in their interactions with their client(s) with ASD.

Theoretical Perspectives

The counseling theoretical foundation for this study was interpersonal theory. Interpersonal theory posits that,

human behaviors can be understood only in relation to its historical and current interpersonal contexts . . . what needs to be studied and understood is the patterns of transactions between client and other persons . . . not the behavior of the client in conceptual isolation. (Kiesler, 1996, p. 4)

The research question for this study sought to understand the counselor's experiences with interacting with adult clients with ASD.

Congruent with constructionism, interpersonal theory validates that the social environment is what creates and shapes a person. A person does not construct meaning in isolation, and a person is not developed in isolation. Human social behavior is circular as we impact others and are impacted by others (Kiesler, 1983). The person's self-system is a regulating system that developed out of social learning and controls social awareness (Sullivan, 1953). Thus, in interpersonal theory, meaning and truth exist in the person's perception based on one's self-system.

Phenomenological Research

In the last section, Crotty's (1998) questions about epistemology and theoretical perspective were answered. In this section, I will address Crotty's Question 2 by describing what methodology guided this study. This study was a phenomenological study exploring the lived experiences of counselors working with adults with ASD. The phenomenon in question is the interactions, relationships, and struggles the counselors endure while working with adults with ASD. I will generally explain phenomenology and then describe the type of phenomenology that this study was based out of, transcendental phenomenology.

Phenomenology

Phenomenology was born out of the philosophical work of Edmund Husserl, a German mathematician and philosopher. The word phenomenology is taken from the

Greek word phaenesthai, which means to show up, to flare up or to appear.

Phenomenology is the study of a phenomenon that has appeared and interacted with a

person's consciousness and then they created meaning for that phenomenon (Moustakas,

1994). Van Manen (2014) stated,

> phenomenological method is driven by a pathos: being swept up in a spell of wonder about phenomena as they appear, show, present, or give themselves to us. In the encounter with things and events of the world, phenomenology directs its gaze toward the regions where meanings and understandings originate, well up, and percolate through the porous membranes of past sedimentations- then infuse, permeate, infect, touch, stir us, and exercise a formative and affective effect on our being. Phenomenology is more a method of questioning than answering, realizing that insights come to us in that mode of musing, reflective questioning, and being obsessed with sources and meanings of lived meaning. (pp. 26–27)

Experience, wonder, meaning, and understanding cannot be captured and quantified by

the scientific method, rules of logic, objectifying themes, or a systematic set of measures

(van Manen, 2014). Experiences are all the essences of life. I wanted to know what was

the essence of being a counselor to adults with ASD? Experience is what it is, and

phenomenologists want to gain a greater understanding of the meaning of ordinary

phenomenon. Phenomenologists focus on the experience of a person's lifeworld, or the

life as it is lived, and the phenomenon that people encounter every day (Vagle, 2018).

Van Manen (2014) pointed out, "lived experience names the ordinary and the

extraordinary, the quotidian and the exotic, the routine and the surprising, the dull and the

ecstatic moments and aspects of experience as we live through them in our human

existence" (p. 39).

A phenomenological study examines the shared meanings for numerous people

who have experienced the same phenomenon in attempts to decrease the experiences into

understanding the universal essence of the phenomenon (Creswell & Poth, 2018). I

sought to know how counselors finds themselves in relation to the phenomenon and understanding how it is for counselors to experience working with adults with ASD in their lifeworld. I wanted to explore how counselors are being and becoming while they were connecting, suffering, changing, and feeling while interacting with their clients with ASD (Vagle, 2018).

Transcendental Phenomenology

Several types of approaches to phenomenology exist and they vary on where the focus lies. One main type of approach to phenomenology is transcendental phenomenology derived from the work of Edmund Husserl and expanded by Clark Moustakas (1994). Transcendental phenomenology is the philosophical framework and model that guided my process of human inquiry. Transcendental phenomenology focuses on the participant's stories of their experiences and less on the researcher's interpretations (Creswell & Poth, 2018). Four core steps of the research process were examined in attempts to simplify knowledge: epoche, transcendental–phenomenological reduction, imaginative variation, and synthesis.

The first step is the epoche. In this stage, researchers are challenged to do two main tasks. First, although we as researchers are connected to our pasts, we are challenged to put away our preconceived understandings, prejudices, and knowledge about everyday familiarity called bracketing (Moustakas, 1994). The epoche does not refute reality nor does it dispute that the world outside exists; this step is the space for researchers to discard previous knowledge and cleanse their minds. The second task is to allow phenomenon to enter anew into consciousness in order to see it as something new so it may be approached with openness and allow it to appear naturally. Researchers must

look upon phenomenon with fresh, unknowing eyes; however, we must keep our sense of wonder (Moustakas, 1994). Van Manen (2014) stated, "phenomenological research begins with wonder at what gives itself and how something gives itself. It can only be pursued while surrendering to a state of wonder" (p. 27). Wonder is vital to any research project and propels the researchers to go further and delve deeper into the phenomena.

In the epoche, researchers must be transparent with themselves and allow the phenomena to unfold without judgment and accepting it for what it is. Moustakas (1994) remarked, "Epoche includes entering a pure internal place, as an open self, ready to embrace life in what it truly offers . . . we are challenged to create new ideas, new feelings, new awareness and understandings" (p. 86). During this stage, researchers need to bracket, or set aside, their judgements and their preconceived understandings of the phenomenon (Heppner, Wampold, & Kivlighan, 2008). Although preconceived ideas are put aside, the conscious person, the researcher is not put aside. Researchers must have constant presence and awareness of their own reactions in order to keep receptiveness to the phenomena (Moustakas, 1994). For me, the epoche challenged me to put away my experiences with clients with ASD, the obstacles I encountered, the emotions I experienced, and the judgments I made about how to treat or approach clients with ASD. I did this by writing in a researcher reflexive journal and practiced meditation throughout the interviewing process.

The next step is the transcendental–phenomenological reduction. The goal of this step is to use written descriptions to document what the researcher is observing and what the researcher is feeling internally. A researcher must keep a constant sense of presence, listening, and connection to the phenomena before one as well as attempting to see it

from all angles (Moustakas, 1994). In this step, all perceptions and statements are valid and equal in value, called horizonalization. Each perception is a horizon with only the surface within view and a vast unknown behind it (Moustakas, 1994). Statements that are off-topic or repeated are removed to identify the more important statements, the horizons, so they can be clustered into themes and organized so they give a thorough description of the phenomenon (Moustakas, 1994).

The third step in transcendental phenomenology is the imaginative variation. This step is best described as the time to,

> seek possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles or functions. The aim is to arrive at structural descriptions of an experience. (Moustakas, 1994, p. 98)

In this step, a researcher is attempting to describe the essences and meanings of the phenomenon. The structures that make the phenomenon are identified and captured in words and then clustered together to uncover the universal meanings (Moustakas, 1994).

The last step, synthesis, consists of integrating the identified structures into a whole picture and labeling the essences of experience. A researcher is seeking the universal meaning of a phenomenon from the participants' perspective at the current moment in time and situation. Potential meanings of the phenomenon are limitless; however, the essence they find are what presented itself at this given moment (Moustakas, 1994). Overall, qualitative design, constructionist paradigm, interpersonal theory, phenomenology, and transcendental phenomenology were the foundational pillars of this study. These important philosophies were the blueprints to this study and guided me as I moved through the procedures of this study.

Procedures

In this section I will describe Crotty's (1998) first question about the methods that were used to answer the research question. I will discuss the design procedures for this study including the Institutional Review Board handling, setting, participants and selection methods, recruitment, and lastly, data collection.

Institutional Review Board
Handling

I submitted an Institutional Review Board application to the University of Northern Colorado Institutional Review Board; approval letter is in Appendix A. I include the informed consent document in Appendix B, demographics survey in Appendix C, online call for participants message/e-mail in Appendix D, and interview questions in Appendix E. Minimal risk is defined by the University of Northern Colorado Institutional Review Board as the amount of potential harm to the participant in the study is no greater than what they would experience in daily life. Risk to participants is considered minimal as discussing experiences with their adult clients with ASD was no more harmful than a dialogue with a colleague. I received Institutional Review Board approval before proceeding to the recruitment phase.

Face-to-face interviews were recorded with a digital audio recorder application and stored in a password protected laptop. Electronic interviews were also recorded through the digital audio recorder. No artifacts were collected. Both types of interviews were transcribed verbatim. During transcription, all identifying information was removed and a pseudonym was given for further identification. After transcription of the interviews, documents were uploaded to a password protected Dropbox folder and saved to my personal password protected laptop folder. Once transcribed, I read the document

two times before coding commenced. Once the analysis and writing sections were complete, recordings were destroyed.

Setting

The setting for this study was counselors who were working with adults with ASD in the United States. I recruited a variety of counselors from across the United States because ASD is not restricted to one area. Participants needed to have a variety of training program backgrounds and had access to different ASD trainings and educational opportunities based upon geographical locations.

Participants and Selection
Methods

In this study, a commonly used sampling method in qualitative research was used, purposeful sampling. Purposeful sampling means that a researcher is selecting the participants based off pre-determined criterion and their relevance to the research questions. This process is commonly overlooked; however, it is a significantly imperative process as the researcher chooses who matters as data (Reybold, Lammert, & Stribling, 2012). Two types of purposeful sampling strategies were used, criterion-based sampling and snowball sampling.

Criterion-based sampling is imperative in a phenomenological study because it assures each participant has experience with the phenomenon under investigation (Creswell & Poth, 2018). I screened all potential participants to ensure they had direct experience with providing counseling to adults with ASD. Snowball sampling, also called network sampling, is when a researcher has selected a couple of participants that meet the study's criteria and during the interview, the researcher asks the participant to refer them to others who also meet the criteria (Merriam & Tisdell, 2016). Therefore, the network of

participants and potential participants grows larger and larger. Once the interview was finished, I asked each participant for recommendations of other counselors who potentially fit the criteria. Most participants gave me names of other counselors I could contact. Thus, recruitment was an ongoing process until saturation was attained. Saturation was reached when the interviews were no longer accruing new information or insights (Merriam & Tisdell, 2016).

Polkinghorne (1989) suggested to interview between five and 25 participants. Due to the time-consuming nature of the present study, I had a minimum of five participants and aimed for about 10 participants. Similar qualitative studies had an average of about 20 participants; however, the studies did not narrow the participant pool to include only those who identified as a counselor (Brookman-Frazee et al., 2012; Vulcan, 2016). This study only recruited those who identifies as a counselor, which created a smaller potential participant pool and a small number of counselors were needed. This study had a total of 11 participants.

In phenomenological research, the emphasis is to identify participants who have a rich direct experience with the phenomenon (van Manen, 2014). Therefore, several restrictions were applied to limit the scope of this study. First, the participant pool was limited to include those only considering themselves counselors; consequently, licenses were restricted to a licensed professional counselor (LPC), licensed professional counselor–intern, licensed professional counselor–supervisor, licensed professional clinical counselor, licensed clinical professional counselor, licensed marriage and family therapist and any other licenses that identify a professional as a counselor. Other mental health professionals (licensed clinical social worker, psychologist, psychiatrist, etc.) were

omitted to establish a clear professional counselor identity. This was significantly needed so participants had a similar training background and perspectives that were consistent with counselor values, attitudes, and beliefs (Lile, 2017).

Second, participants were required to have graduated with a master's or doctorate degree from a Council for Accreditation of Counseling and Related Educational Programs (CACREP) approved university. The CACREP is the governing body that accredits counseling programs in order to offer quality training and supervision to students. The results of this study were intended to guide university educators and supervisors in how to train and supervise counseling students on how to provide services to adults with ASD.

Third, counselors needed to be actively working with adults with ASD. Participants who were currently in the thick of providing services to adults with ASD were desired as their experiences were fresh on their minds. If the counselor had not been providing counseling to an adult with ASD for six months or more, then they were excluded from the study.

Recruitment

Following Institutional Review Board approval, I recruited participants in four ways. First, I posted a request for participants on the American Counselor Association national community forum, American Counselor Association Connect, by joining several groups aimed at linking practicing counselors. The recruitment message is attached in Appendix D. Second, I was a member in several national and local counselor and counseling groups on social media and social networking services, Facebook and LinkedIn. I posted the same recruitment message in these groups after attaining approval

from each Facebook or LinkedIn group administrators. Also, I searched through an online counselor directory, Psychology Today, and sent a recruitment messages to counselors who I thought fit my criteria based off their profiles. Then I sent out a similar e-mail in the Counselor Education and Supervision national e-mail listing.

Third, I was a member of a local mental health professionals' group, the Keller Counselors Association. This group was comprised of local professional mental health providers located in Keller, Texas, and surrounding areas. I asked the board of directors if I could speak at the beginning of the monthly meeting about recruiting participants. Once I attained approval, I spoke briefly at a meeting and informed the members about the participant criteria, purpose of the study, and described what was required. Furthermore, I asked members to refer potential participants to me if they fit the criteria and were not present at the meeting. Lastly, I recruited participants through word of mouth and leveraging my professional counselor network. I discussed participant criteria, purpose of the study, and study participant requirements with my colleagues and counselor contacts.

As I employed snowball/network sampling in this study, recruitment also took place during participant interviews. After an interview ended, I informed the participant about referring any other counselors to me if they also fit the criteria. When a potential participant contacted me, I discussed the study through e-mail and briefly screened for the correct fit with participant criteria. Many counselors initially contacted me; however I had to screen out several due to not fitting the study's participant criteria. All participants were given a $15.00 gift card to Amazon.com for participating in the research. I did not have a pre-determined number of participants for my sample. In qualitative research it is common that sample size are determined based on saturation or redundancy in the

participant's responses during data collection (Merriam & Tisdell, 2016). After

transcribing interviews, I reviewed responses and when I noticed the same information

throughout participant interviews and began to see repetition in observable behaviors and

responses, then I knew saturation had occurred and recruitment ceased after the 11th

participant. I did not have a pre-determined number of participants; however, five to 25

participants were recommended for a phenomenological study (Polkinghorne, 1989). I

had a minimum of five participants and aimed for about 10 to 12 participants in total. In

total, I had 11 participants in the study.

Data Collection

Data collection consisted of two semi-structured interviews and no artifacts were

found during the collection process such as participant's drawings or other writings about

the phenomenon. For a phenomenological researcher, it is important to stay open to the

multiple forms an essence may present itself as and invite that voice into the research

(Vagle, 2018). This research practiced openness and allowed for all expressions of the

essence.

Semi-structured interviews. Data were primarily collected through two semi-

structured interviews. The interview served as the essential form of gathering human

experience. Interviewing serves great purpose as it can be,

> used as a means for exploring and gathering experiential narrative material that
> may serve as a resource for developing a richer and deeper understanding of a
> human phenomenon, and (2) the interview may be used as a vehicle to develop a
> conversational relation with a partner (interviewee) about the meaning of an
> experience. (van Manen, 1997, p. 66)

Interviewing provided the researcher with an avenue in which to learn and become more experienced (van Manen, 1997). Furthermore, the interview served as a meaningful dialogue of the phenomenon (Salmons, 2015).

Using a semi-structured interview basis, the interview was directed by a list of questions; however, the choice of wording and how the questions were used were flexible and fluid during the interview. Target questions were used to elicit information about experiences with the phenomenon; however, they were conversational (Merriam & Tisdell, 2016). Interviews were opportunities to learn more about the phenomenon and the goal was to uncover as much as possible about the phenomenon from each person (Vagle, 2018). I wanted participants to tap into their inner experiences with their adult clients with ASD and explain what they experienced in great depth as if they were reliving the experience (Moustakas, 1994). Therefore, it was useful to ask questions that were grounded in sensory experiences. Moustakas (1994) presented seven questions as a general interview guide to aid in mining substantial and meaningful experiences of the phenomenon. The general interview guide presented by Moustakas as it applies to this study was used for the first interview and is offered in Appendix E.

During the interview, open-ended questions and comments were desired (Moustakas, 1994). Researchers generated questions or topics to cover in the interview, then in the interview follow-up (see Appendix F), questions were created spontaneously (Salmons, 2015). However, the researcher needed to help participants stay focused on the experiential aspect of the phenomenon rather than discussing opinions, beliefs, judgements, and accounts about the phenomenon. Lived experience descriptions or in-

depth stories of experience provided the best material for phenomenological research (van Manen, 2014).

Van Manen (2014) described six existential methods to guide interview inquiry so interviews stay rooted in phenomenological material: (a) lived relation (relationality), (b), lived body (corporeality), (c), lived space (spatiality), (d) lived time (temporality), (e) lived things, and (f) lived technology (materiality). All these methods are part of everyone's lifeworld and are universally experienced. Using these six methods, I assured that I was focused on the lived experiences descriptions and stayed attentive to the essence being described.

The first method, lived relation or relationality, guided my interview questions on how the phenomenon was experienced by the participant and others regarding how this phenomenon connects or disconnects people. This method of inquiry attended to how the people were impacted by the counseling relationship surrounding the client and the counselor. The next guiding method, lived body or corporeality, references how the body was experienced with respect to the phenomenon. The question was eliciting how was the "phenomenon we study perceived, sensed, touched by the body" (van Manen, 2014, p. 304)? This method covered how a counselor experienced the connection with the client through their body and what they experienced physically while working with the client.

The third method, lived space or spatiality, referred to how the environment and the space around us impacts us with respect to the phenomenon. This was an important method when working with adults with ASD as sensory issues can affect how they present in a session. The space around them during sessions may be too overstimulating, which could prevent them from connecting with the counselor. The fourth method, lived

time or temporality, referred to the experience of time regarding the phenomenon. Two

conditions of time exist, objective cosmic time such as on a watch and subjective lived

time (van Manen, 2014). For example, if a counselor and client were connected and

engaged in deep meaningful work, time may feel as though it passed quickly while time

may feel as though it was lagging when a client and counselor were not connecting.

The fifth method, lived things or materiality, referenced how things were

experienced regarding the phenomenon. Van Manen (2014) stated,

> in a real way, we see and recognize ourselves in things of our world. And the
> things tell me who I am . . . how are things extensions of our bodies and our
> minds? How can things be experienced as intimate or strange? Things can
> disappoint us or reflect our disappointment back to us. (p. 307)

For example, when a counselor decided to use objects in session, such as sand, paints, or

figurines in their work with adults with ASD, I inquired about their feelings towards the

objects themselves.

Lastly, lived technology also materiality, guided my questions on how counselors

experience technology in respect to the phenomenon (van Manen, 2014). A counselor

could offer cyber counseling or online therapy to adult clients, some of whom may have

ASD. This method was able to get at the feelings and thoughts about the relationship

when it is through a medium such as the Internet. All six of these methods were useful on

guiding the participant to bring their experiences to life during the interview process.

Electronic interviews. The transferability of the results of this study were

increased because participants were located from various locations across the United

States. I did not want to limit my range of participants to include only those who I could

physically meet for the interviews. Therefore, electronic/online interviews or e-interviews

were a desired alternative (Salmons, 2015). E-interviews were used for the purpose of

collecting data and conducted interviews with participants who lived in far geographical location from this researcher.

An online telecommunication application, Skype or FaceTime, was used for e-interviews. These applications allowed for video conferencing in a convenient setting and time as well as little to no financial cost (Lo Iacono, Symonds, & Brown, 2016). Video conferencing allowed for synchronous discussions and physical images, which aided in developing the relationship and rapport between interviewer and interviewee (Salmons, 2015). Some have argued that developing rapport with participants could be more challenging during e-interviews than face-to-face interviews (Carter, 2011). However, others agree that developing rapport is not a problem during e-interviews and e-interviews could even enhance rapport due to the ease and convenience (Deakin & Wakefield, 2013; Lo Iacono et al., 2016).

Data gathered through face-to-face interviews and e-interviews were perceived as the same during handling and analysis (Salmons, 2015). However, consideration needed to be given to the environment during the e-interview because distractions could disrupt the interview and cause problems in the collection of data (Jangorban, Roudsari, & Taghipour, 2014). Also, the intimacy created during the interview could be disrupted if technological difficulties arise, such as a dropped call or frozen screen due to a lost connection (Seitz, 2015). However, the advantages outweigh the disadvantages and, therefore, were used in this study. No technological issues occurred during my e-interviews and did not need to be documented and disclosed during data analysis and descriptions.

Other artifacts. Artifacts play an important role in qualitative research. Artifacts were "three-dimensional physical things or objects in the environment that represent some form of communication that is meaningful to participants and/or the setting" (Merriam & Tisdell, 2016, p. 162). Many different types of artifacts could be collected in qualitative research including public records, personal documents, visual documents, objects from the environment, and researcher-generated documents. Although I did not intend to collect artifacts, I thought it was important to note that I also could not predict what might arise during my interviews at the beginning and I wanted to keep an openness to the possibility an artifact may have value. Vagle (2018) pointed out,

> I argue that an open mindset to the gathering of phenomenological material is important and useful in all approaches to carrying out phenomenological research . . . literally any source of phenomenological material has the potential to help open a phenomenon. (p. 86)

If an artifact became useful, I could have encouraged the participant to describe it and their descriptions would have become part of the verbal record. I wanted this to stay in the forefront of my mind as I started and continued the data collection process. However, no artifacts were found in this research.

Data Analysis

In the previous section I illuminated how the procedures of the study were done. In this section I will discuss how data analysis was conducted. Data analysis was the process of making meaning from the data by breaking it down, reducing, and then interpreting what participants described (Merriam & Tisdell, 2016). It was recommended that data collection and data analysis occur simultaneously. It was helpful to see what was emerging from the research and then the researcher was better able to guide future interviews (Saldaña, 2016). Analysis has been called an interactive process (Merriam &

Tisdell, 2016) and an interwoven process (Vagle, 2018). It was a process in which the

researcher returns repeatedly to get a grasp of the meaning participants are trying to

convey.

It was suggested to keep research questions and goals, theoretical framework, and

any other important research information in front of you so while you were coding, those

imperative concepts were fresh in your mind (Saldaña, 2016). I had a piece of paper with

my research question pinned to my corkboard on my desk next to my computer. After the

first interview was transcribed, preliminary open codes were created. Codes were

researcher created representation of important bits of information, notations, and came in

the shape of colors, words, phrases, letters, numbers, or symbols (Merriam & Tisdell,

2016). Initial codes were created using different color highlighters, words, symbols, and

phrases. Codes are heuristic (Greek word for to discover) in nature and they were

designed for exploration of patterns. Coding required several cycles of revamping,

reorganizing, and creating new connections (Saldaña, 2016). Numerous cycles of coding

were required because the codes transformed, became no longer useful or did not fit, or

too many codes started to fit into one category, so I broke them apart and a new cycle

began. Codes were a filing system so I could go back and retrieve them when needed

(Miles, Huberman, & Saldaña, 2014). Several cycles of coding occurred throughout the

research analysis process before categories were created.

The next step was unifying the codes into groups in attempts to consolidate

meaning called axial coding. The emerging patterns of codes then were organized into

categories that were representative of the frequent patterns in the data (Merriam &

Tisdell, 2016). Subcategories were created to further group patterns of data (Saldaña,

2016). When the categories were created, the next stage was to theorize how they related to each other. Merriam and Tisdell (2016) pointed out, "analysis is moving toward the development of a model or theory to explain the data's meaning . . . for a theory seeks to explain a large number of phenomena and tell how they are related" (p. 220). Theories are a way we could draw conclusions about the future and these theories was how a researcher could answer their research question, the ultimate goal of a research study (Merriam & Tisdell, 2016).

Trustworthiness and Rigor

All qualitative research must discuss the importance of rigor and trustworthiness of a research study. In qualitative research many truths exist, which in turn makes it difficult to research multiple truths and produce results that could apply to many populations (Merriam & Tisdell, 2016). However, the scientific community needed to know that qualitative studies were trustworthy and had integrity so they could have an impact in the field of counseling. For this reason, qualitative research exhibited validity, or the appropriateness of the tools used, the study design and the choices made within the study were suitable for the goals and that the results are applicable to the participant population (Leung, 2015).

Rigor, also known as research quality, was considered high when the following are clear and described adequately in a written study:

> researcher characteristics, conceptual framework, contextual factors, research paradigms and traditions, research goals, research questions, data collection methods and procedures, and coding and data management processes. (Hays, Wood, Dahl, & Kirk-Jenkins, 2016, p. 173)

The researcher was tasked with presenting their steps throughout the study honestly and establishing rigor, but it is up to the researchers and the consumers to determine the

trustworthiness of the study. Establishing rigor should be high on the priority list for researchers (Hays et al., 2016). Therefore, numerous strategies were employed in a study to establish validity and rigor. In this section I will discuss several strategies to enhance validity and trustworthiness in my study through credibility, consistency/dependability, and transferability.

Credibility

Credibility, also called internal validity in quantitative research, was how well the findings parallel reality. If the findings are measuring what the researcher believes they are measuring, then the study is creditable. As stated before, qualitative research does not describe an objective truth, so several strategies were available to increase the credibility of my study (Merriam & Tisdell, 2016). Each strategy will be described and how it will play a role in my study. The strategies that were used are triangulation, member check, peer review, and researcher reflexivity.

Triangulation. Triangulation was the first strategy that was used in my study. Triangulation refers to the use of various sources, methods, investigators, and theories to lend credibility to the results (Creswell & Poth, 2018; Merriam & Tisdell, 2016). In this study, triangulation was achieved by performing interviews in different places through face-to-face and electronic means as well as interviewing participants at two different points in time. Although interviewing is the primary source of data retrieval, I stayed open to other forms of sources that arose during the process. Merriam and Tisdell (2016) remarked that comparing participant stories and experiences with what a researcher has learned about in articles and books are also a form of triangulation. I have read countless articles, books, and accounts of adults with ASD, and counselor's experiences with adults

with ASD to have a detailed understanding of the literature. I was able to compare my participant's narratives with my pre-existing knowledge. However, although I do possess a knowledge bank about the phenomenon, I stayed loyal to bracketing and prevent my judgements to cloud my thoughts and feelings during the data collection process.

Member check. The second strategy I used was member check. A member check was when a researcher requests feedback from participants on the preliminary developing interpretations from the data. This entails taking the data, categories of codes during analysis, initial explanations, and theories back to the participants so they could make suggestions, provide edits, and give their opinions and thoughts (Creswell & Poth, 2018). Conducting member checks throughout the process ensures credibility of the results of the study (Merriam & Tisdell, 2016). This strategy could be considered one of the most vital strategy of credibility (Creswell & Poth, 2018). After all the interviews were coded and categories were formed, I conducted a member check with all the participants to ensure I developed a theory that reflected their experiences and meaning for the phenomenon. The feedback was integrated into the coding, categories, and theories that were developed.

Peer review. The third strategy I used was peer review. Peer review is when a researcher pursues an external peer who could review and check the coding categories and theories for accurate representation of the participants' experiences. Creswell and Poth (2018) suggested choosing "an individual who keeps the researcher honest; asks hard questions about methods, meanings, and interpretations; and provides the researcher with the opportunity for catharsis by sympathetically listening to the researcher's feelings" (p. 263). I previously used and continued to use peer reviewing and consulting

throughout this research. The research committee and committee research chair also served as a peer review critiquing and reviewing my research to ensure all facets of my study is trustworthy.

Reflexivity. The last strategy I used is researcher reflexivity, also called researcher position. Reflexivity is how the researcher recognizes that they were impacted and impactful in the research. The researcher needed to exhibit transparency about their own background, judgments, and assumptions about the phenomenon (Merriam & Tisdell, 2016). This allowed the reader to have a more accurate understanding of how the researcher devised the study design, the connections, and theories in the findings of the study (Creswell & Poth, 2018). Miles et al. (2014) called this the analytic memo. The analytic memo is a place where the researcher could express thoughts, reactions, draw conclusions, describe how he/she relates to the stories or the phenomenon, explained the choices made in coding, how he/she perceived the codes similarities and differences, and what it meant to him/her, describe developing theories, problems or concerns about the study, and write ethical problems and future direction for the study. The analytic memo could be the strongest tool the researcher possessed so one can keep track of their thinking and make sense of the data (Miles et al., 2014).

Reflexivity is connected to what Moustakas (1994) described as bracketing judgments and biases; however, the conscious person was not set aside nor forgotten. I, as the researcher, know that I was present in the study and my influence was embedded in the study itself; therefore, I was clear about my stance and allowed the reader to make the judgments. In chapter I, I presented my researcher stance and explained my experience with the phenomenon. Another form of transparency was completed through journaling

throughout the research process. I had been writing about my thoughts, feelings, and reactions to the information I was learning during the research process. I believe it was important to reflect on where I was, how my perceptions have changed, and how the research had already impacted my vision of the future. Overall, four main strategies were employed to increase the credibility of my study through triangulation, member checks, peer reviews, and researcher reflexivity.

Consistency/Dependability

Consistency, also called dependability, was similar to reliability in quantitative research. Reliability was the degree the study could be duplicated and produced the same results. Reliability innately holds the belief that a single truth lies out in the world and if a researcher can duplicate another researchers study, then one will produce the same outcomes (Merriam & Tisdell, 2016). However, qualitative research is not conducted with the stance of one single reality, but multiple realities exist in the world and human behavior is never equivalent from person to person nor moment to moment for the same person. If a qualitative research study is replicated, it will not produce the same findings; however, the findings are not voided. The main questions are "whether the results are consistent with the data collected" (Merriam & Tisdell, 2016, p. 251) and "have things been done with integrity" (Miles et al., 2014, p. 312)? Researchers need to make sure results make sense and show dependability within the parameters of the data and the research questions. The essence of qualitative research was how consistent it was (Leung, 2015). Strategies for increasing consistency were triangulation, peer reviews, intercoder agreement, and an audit trail.

Triangulation and peer review. Triangulation, as discussed in the credibility section, was achieved by using consistent patterns with all participants such as obtaining two interviews from each participant, writing in my researcher journal after each, staying open and aware of potential useful artifacts, creating clear patterns in my coding, and overall keeping logical patterns in my work. A second strategy was peer reviews. As stated before, peer reviews were harnessed several times throughout the coding process to make sure my codes make sense and fit the data.

Audit trail. The last strategy, audit trails, was used for consistency. Audit trails is a trail of all the procedures on how data were collected, how the codes and categories were created, and what was the thinking process behind the choices that were made within the study (Merriam & Tisdell, 2016). As stated before, my researcher reflexive journal contained all the choices I made, my thoughts and reactions, reflections on my work, and my concerns. Merriam and Tisdell (2016) commented that the audit trail is a "running record of your interactions with the data" (p. 253). During data collection and analysis, I created a special book of codes that contained all my reasons for codes, interpretations, thought processes and developing theories about my data.

Transferability

Transferability, also considered external validity in quantitative research, was the degree that the results could transfer to other situations and people. In qualitative research, the goal was not to be able to generalize the findings to a group of people or situations because there is not one truth that can be applied to numerous people. The idea is that the findings could give working hypotheses and provide guidance for the future based off the in-depth understandings found in the study (Merriam & Tisdell, 2016).

Qualitative research allows for reader generalizability, meaning the reader could determine if the results can be pertinent to their own situation or to others in similar situations provided enough in-depth information from the study (Merriam & Tisdell, 2016). Two main strategies will be discussed to improve transferability is maximum variation and rich, thick descriptions.

Maximum variation. The first strategy, maximum variation, was selecting a wide range of participants from various settings so a reader could apply the findings to match their own situation (Merriam & Tisdell, 2016). I integrated maximum variation in my study by locating and selecting counselors with a variety of training backgrounds, range in years of experience as counselors, practicing in diverse settings such as private practice or community agency setting, and possessing degrees from various universities.

Rich, thick descriptions. The second strategy was using rich, thick descriptions by providing in-depth accounts of participants, the settings, and the themes of the study. This created verisimilitude, or statements that help the reader feel as though they experienced or could experience the events in the study. This is done by providing narrative excerpts from an interaction, experience, observed behaviors, or describing in detail how a person feels (Creswell & Miller, 2000). Researchers presented quotes from participants, field notes, or documents (Merriam & Tisdell, 2016). By providing a story-like experience, readers could make decisions if the findings were applicable to themselves or other settings (Creswell & Miller, 2000). I used this strategy by providing quotes from my participants and offering detailed accounts of interactions, experiences, and notes I had written in my researcher reflexive journal.

Summary

In this chapter I have explained qualitative research, the research procedures, and the methodology for this study. I described the epistemology, theoretical perspective, and methodology as constructionism, interpersonal theory, and phenomenological research with a focus on transcendental phenomenology. I illuminated the procedures of the study including the Institutional Review Board approval procedures, setting, participants and selection methods, recruitment, and the data collection actions. Next, I presented the plan for the data analysis and actions to take to increase trustworthiness and rigor by describing the strategies for credibility, consistency, and transferability of this study.

CHAPTER IV

FINDINGS

In this chapter, the findings for this study will be presented. Participants were initially recruited through online professional groups, snowball sampling, and through the Counselor Education and Supervision listserv. Half of the participants were recruited through my personal professional network and word of mouth from other participants. The other half of participants were recruited through a recruitment post on several professional groups on social media and messages sent to targeted professionals advertised through an online mental health directory, Psychology Today.

The first round of interviews ranged from 40 to 65 minutes and the second round of interviews ranged from 15 to 30 minutes. The interviews were transcribed verbatim with roughly 297 pages of verbal data. Two initial interviews took place in the participant's counseling office inside a counseling room. Nine of the initial interviews were conducted through electronic communication software. Two interviews were scheduled to take place in person but were cancelled by the participants and rescheduled to an electronic interview. During the second round of interviews, all interviews were conducted through electronic communication software. Saturation was attained after the 11th interview in which I noticed that I was hearing similar information from previous interviews and no new insights could be discovered (Merriam & Tisdell, 2016). Therefore, I ceased the inclusion of new participants.

Participants

In this study 11 professional licensed counselors participated. The participants completed a brief demographic questionnaire and information about their clinical background and basic information about counseling adults with autism spectrum disorder (ASD). The participant age ranged from 20 to 60 years old with two participants aged 20 to 30 category, six participants aged 31 to 40 category, one participant aged 41 to50 category, and one participant aged 51 to 60 category. Two participants identified as male, while nine identified as female. Ten participants identified their ethnicity as White, and one participant identified as Black/African American. Nine participants stated they held a master's degree and two stated they held a doctorate degree. Participants included three licensed professional counselor (LPC)–interns, seven LPCs, and one LPC–supervisor). Seven participants reported they worked exclusively in private practice, one reported working in private practice and a university, two reported working in an agency setting, and one reported working in a hospital as well as a private practice.

Participants also volunteered basic information about their counseling work with adults with ASD. Five participants reported working full-time (40 hours a week), three reported working more than full-time, one reported working part-time (20 hours a week), one reported working more than part-time but less than full-time, and one participant reported working less than part-time. Six participants reported working six to 15 years as a counselor and five reported working less than five years in practice. Seven participants stated they were currently providing counseling to two to five adults with ASD, two reported working with one adult with ASD, and two reported six to 15 adults with ASD.

Participants reported how many hours of training or education about ASD they received in their graduate program: four stated they received no training, one reported one hour or less, three reported two to five hours, and three reported six or more hours. Nine participants reported seeking out training after graduating from their graduate program, and two reported they have not received any training. Six participants reported they worked out of a cognitive behavioral/behavioral theoretical framework, four stated they were humanistic, and one reported they worked from an eclectic theoretical framework. Several of the participants were considered experts in the field of ASD in the professional counseling community. Many of the participants actively recruited individuals with ASD to their counseling practices through marketing materials and identified themselves as counselors who work with individuals with ASD.

Participant Profiles

Amy

Amy self-identified as a White female in the age range of 20 to 30 years old. She possessed a master's degree and was an LPC–intern. She worked in a private counseling practice setting and was providing counseling to one adult with ASD for the first time. Amy discussed she was a relatively new counselor and continued to work towards her full licensure. She took a cognitive behavioral therapeutic approach and blended processing emotions and experiences with social skills training. Amy described feelings of comfort with the client; however, she struggled with the family members and developing empathy for them. Amy talked about her personal experiences with individuals with ASD and her childhood friend who had ASD.

Bryan

Bryan self-identified as a White male in the age range of 31 to 40 years old. He possessed a doctorate degree and was a LPC. Bryan worked full-time in a private practice setting with numerous adult clients with ASD and had a history of providing counseling to adults with ASD. He was referred most of his clients from a state program that offered services to adults with intellectual and cognitive disabilities. Bryan worked with a significant number of clients with problematic sexual behaviors and sexual addictions. Bryan stated he worked from a cognitive behavioral theoretical approach and incorporated immediacy and social skills training. Bryan described that he felt more freedom to be more direct and blunt with his adult clients with ASD than he usually felt with neurotypical clients. He talked about the lack of formal training in counseling adults with ASD and how he learned through his own experiences, performing research and consulting with others. Bryan discussed his initial work with adults with ASD and how the population fit well with his patient and even-natured personality.

Cora

Cora self-identified as a White female in the age range of 41 to 50 years old. She possessed a master's degree and was a LPC. Cora reported that she worked full-time in a private practice setting with several adults with ASD and had a history of working with individuals with ASD, including children and adolescents. Cora described in depth her experience with a young adult female with ASD she had been working with for several years. Cora explained that it was important for counselors who work with ASD to have a strong sense of self and grounded in who they are in order to work with individuals with ASD, because this population can be challenging in many ways. Cora explained that she

did not receive training in her counseling graduate program and began working in an

ASD clinic during her program, where she received some training and developed a

passion for working with individuals with ASD.

Dakota

Dakota self-identified as a White female in the age range of 31 to 40 years old.

She possessed a doctorate degree and was a LPC–supervisor. Dakota reported she

worked full-time in a private practice and was an adjunct professor at the local university.

She stated that she had worked several years with individuals with ASD, including

children and adolescents and had numerous adult clients with ASD on her caseload. She

described her work as humanistic and talked about her experiences with an adult male

client with ASD as he was coping with grief and her emotional reactions to his behaviors

in session. Dakota explained how strongly she believed in attending to the emotional side

and validating the emotions of adults with ASD, which is usually missed. She talked

about how she did not receive training on ASD in her graduate counseling program and

was impacted by a child client going through the diagnosis process of ASD and his

family early in her professional career. She described how this experience helped develop

her passion for working with individuals with ASD.

Ella

Ella self-identified as a White female in the age range of 31 to 40 years old. She

possessed a master's degree and was a LPC. Ella stated she worked less than part-time in

a private practice setting and described her counseling style as eclectic. She worked with

highly complex cases that included adults who were sex offenders, and many of her

clients have multiple mental health diagnoses, including intellectual and cognitive

impairments. Ella described an aggressive adult male client with ASD and how she had to check in with her own emotions often. Ella explained how she did not receive training in her graduate counseling program and started working in a counseling agency offering services to sex offenders, where she encountered adults with ASD. These experiences inspired her passion for working with adults with ASD and intellectual disabilities.

Fiona

Fiona self-identified as a White female in the age range of 20 to 30 years old. She possessed a master's degree and was a LPC–intern. She stated that she worked more than full-time in a counseling agency setting and had one adult client with ASD. Fiona explained that she worked with numerous children and adolescents with ASD, but not as many adults with ASD. Fiona described her counseling style with adults with ASD as cognitive behavioral and solution focused. Fiona talked about her personal experiences with ASD as her cousin was diagnosed with ASD when they were children and shared a close relationship. She explained how when she began her counseling career, clients started coming to her with ASD and she found her passion in working with them. Fiona described the lack of training in her counseling graduate program and lack of resources and trainings on how to work with adults with ASD.

Greg

Greg self-identified as a White male in the age range of 31 to 40 years old. He possessed a master's degree and was a LPC and certified substance abuse counselor. Greg stated he worked in a private practice setting while working on his doctorate in counseling. Greg articulated that his style is humanistic and person-centered in nature. Greg described his experiences while counseling a young adult male with ASD and his

struggles with the intrusive family members. Greg stated that he placed focus on rapport building and believed it took more time and patience to work with adults with ASD. Greg also expressed his fear that he did not possess the skills necessary to help his adult clients with ASD.

Hallie

Hallie self-identified as an African American female in the age range of 31 to 40 years old. She possessed a master's degree and was a LPC and a board certified behavior analyst. She worked full-time in a hospital and a private practice setting. Hallie worked primarily with children and adolescents with ASD and other similar diagnoses, but also offers support to numerous parents with ASD and offers counseling to adults with ASD. Hallie described her style as behavioral-based and used a solution-focused model. She described her approach as directive and goal-based, but collaborative and usually includes the family in counseling the adult with ASD. Hallie described her struggle with blending her counseling skills with her applied behavioral analysis skills and finding her place between both worlds.

Isla

Isla self-identified as a White female in the age range of 20 to 30 years old. She possessed a master's degree and was a LPC. She stated she worked more than part-time in a private practice setting while working on her doctorate in counseling. Isla stated she worked with numerous adults with ASD and ran a dialectical behavior therapy skills group in which many of her clients with ASD are members. She reported that she offered a person-centered humanistic approach and incorporated dialectical behavior therapy skills, but she also structures each session and uses grounding techniques and social skills

training with clients with ASD. Isla described experiences with a male adult client with ASD and her approaches to handling her client's suicidal ideation.

Jolette

Jolette self-identified as a White female in the age range of 20 to 30 years old. She possessed a master's degree and was a LPC–intern. Jolette reported that she worked full-time in private practice setting and sees clients individually and provides group counseling for adult males with ASD. She described her experience with an adult male with ASD and her approaches to handling the family involvement in sessions. She also described her experiences leading group therapy with several adult males with ASD and her role within the group as a facilitator. Jolette described how important it was to her to develop rapport with adult clients with ASD and provide a space for them to get to know each other before the working on deeper issues.

Kaia

Kaia self-identified as a White female in the age range of 51 to 60 years old. She possessed a master's degree and was a LPC. Kaia reported that she worked more than full-time in an agency setting where she primarily sees individuals with ASD of all ages in counseling and provides biofeedback services. Kaia discussed her experiences with an older adult male client with ASD who had a gaming addiction. She talked about how she is directive and uses rational emotive behavioral therapy as her approach to counseling. She expressed her concern over the high rate of suicidal ideation and how the symptoms look different in adults with ASD than it does with neurotypical adults. She explained how she uses a directive approach to assess and understanding their suicidal ideation.

Table 1 shows the demographics for the participants as well as how many adults with ASD they were providing counseling to and the graduate training about ASD that they received during their graduate counseling program.

The Analysis Process

In this section I will discuss the analysis process and steps I took while analyzing the data. As discussed in Chapter III, the lens that I approached gathering data and analyzing data stemmed from Moustakas' (1994) transcendental phenomenology. Throughout the data gathering process, I was aware of the epoche and wrote in a reflexive journal after each interview and throughout the analysis process. During the next step, the transcendental–phenomenological reduction, I wrote notes before, during, and after each interview that could be also used as my audit trail. Once I possessed the transcript, I proceeded to create codes through open coding in the attempt to make sense of the data by using different color highlighters, symbols, words, and notes written in the margins of the transcriptions (Merriam & Tisdell, 2016). I had several cycles of coding, and the codes changed several times after each interview. I wrote down groups of similar data in a notebook several different moments in time so I could go back and refer back to specific paragraphs in each interview transcript.

Table 1

Participant Demographics

Pseudonym	Age	Ethnicity	Gender	Education	License	How many	Graduate training (hours)
Amy	20-30	White	Female	Master's	LPC–Intern	1	1 or less
Bryan	31-40	White	Male	Ph.D	LPC	2 to 5	None
Cora	41-50	White	Female	Master's	LPC	2 to 5	None
Dakota	31-40	White	Female	Ph.D	LPC–super-visor	2 to 5	6 or more
Ella	31-40	White	Female	Master's	LPC	2 to 5	None
Fiona	20-30	White	Female	Master's	LPC–intern	1	None
Greg	31-40	White	Male	Master's	LPC, CSAC	2 to 5	2 to 5
Halle	31-40	Black	Female	Master's	LPC, BCBA	2 to 5	6 or more
Isla	20-30	White	Female	Master's	LPC	2 to 5	2 to 5
Jolette	20-30	White	Female	Master's	LPC–intern	6 to 15	2 to 5
Kaia	51-60	White	Female	Master's	LPC	6 to 15	6 or more

Note. BCBA = board certified behavior analyst, CSAC = certified substance abuse counselor, LPC = licensed professional counselor.

The initial set of codes are as follows: counselor graduate school education, patience, flexible, regression, client experience, directness, social skills, validation, lack of trainings, diagnosis issues, counselor's personal experiences with ASD, counselor-client connection, responses to suicide ideation, coping with the population, family involvement, slow progress, experiential learning, frustration, unsure, enjoyment, and support system. After further examination, the open codes could be combined to create categories through axial coding (Merriam & Tisdell, 2016). Table 2 displays the comparison of Round 1 initial themes and Round 2 categories.

In the imagination variation step, the categories/structures were identified in order to describe the essence of the phenomenon (Moustakas, 1994). After creating the four structures, I organized the codes into subthemes within the main structure, now called the theme. The first theme, counseling emotions, could be divided into two subthemes: negative emotions and positive emotions. The second theme, previous experience with ASD, could be divided into two subthemes: education and personal experiences with ASD. The third theme, counseling approaches, could be grouped into four subthemes: counselor characteristics, the therapeutic relationship, counselor style, and unique aspects. The final theme, self-care, could be grouped to form to subthemes: self-talk and support systems. Table 3 illustrates the round three evolving themes and subthemes.

Table 2

Initial Themes in Round 1 and Round 2 Themes

Round 1	Round 2
Counselor graduate school education	Counselor emotions
Patience	Previous experiences with autism spectrum disorder
Regressions	Approach
Client experiences	Self-care
Directness	
Social skills training	
Lack of training	
Diagnosis issues	
Counselor personal experiences with autism spectrum disorder	
Client–counselor connection	
Responses to suicide ideation	
Coping with the population	
Family involvement	
Slow progress	
Support system	
Validation	
Experiential learning	
Flexible	
Frustration	
Unsure	
Enjoyment	

Table 3

Round 3 Themes

Theme	Subtheme
Counselor Emotions	Positive emotions Negative emotions
Previous experience with autism spectrum disorder	Education Personal experience
Counseling approach	Counselor characteristics Therapeutic relationship Counselor style Unique aspects
Self-care	Self-talk Support system

After this round of cycling review, the themes and subthemes had emerged, and it seemed the themes were complete. These initial findings were sent out to all participants for feedback. Five out of the 11 participants responded stating that the themes represented their experiences and they approved of the themes and subthemes.

Furthermore, to promote credibility, a peer review was performed by sending out the themes document to a trusted colleague for review. An example of the document e-mailed to all participants and the peer reviewer is located in Appendix G. The peer reviewer was a colleague of the researcher and received a Ph.D. in Counselor Education and Supervision. They had in-depth training on conducting research and completed their own qualitative dissertation. The peer reviewer gave detailed feedback specifically about

Theme 1 and Theme 3 focused on the two subthemes: counseling style and unique aspects. They suggested that the wording should be changed and gave suggestions for rewording Theme one and Theme three. After further examination, more changes were made. Theme 1 was changed from counselor emotions to counselor reactions and the subthemes were changed from positive emotions and negative emotions to struggles and rewarding; Theme 3 subthemes, counseling style and unique aspects, were combined and renamed techniques and the creation of the fourth subtheme, client suicidal ideation concerns; and Theme 4 subtheme, self-talk, was changed to professional emotional boundaries. I struggled with where to place the subtheme, client suicidal ideation concerns. In the end, I realized that counselors were approaching this issue similarly to how they approached counseling with adults with ASD, so it was placed in Theme 3, counseling approach, as its own subtheme. Table 4 presents the Round 3 changes made and the final themes and subthemes.

Overall, four main themes and 10 subthemes remained. The main themes are counselor reactions, previous experiences with ASD, counseling approach, and self-care. The 10 subthemes are struggles, rewarding, education, personal experiences, counselor characteristics, therapeutic relationship, techniques, client suicidal ideation concerns, professional emotional boundaries, and support system. The final step of transcendental phenomenology is synthesis. This step is when the identified structures and themes are integrated into a whole picture. The current themes are a representation of the participants' experiences at this given moment when they are inside the counseling room and when they are on their own time (Moustakas, 1994).

Table 4

Final Themes

Theme	Subtheme
Counselor reactions	Struggles
	Rewarding
Previous experience with autism spectrum disorder	Education
	Personal experiences
Counseling approach	Counselor characteristics
	Therapeutic relationship
	Techniques
	Client suicidal ideation concerns
Self-care	Professional emotional boundaries
	Support system

The research question for this study was:

Q1   What are the lived experiences of counselors providing counseling to adults with autism spectrum disorder?

The four themes illustrated the past and current experiences of counselors who work with adults with ASD both inside the counseling room and on their own time. Theme 1, counselor reactions, displayed their internal experiences while they are with the client with ASD and away from the client. Theme 2, previous experiences with ASD, reflects the participants' previous exposure and educational experiences with ASD. Theme 3, counseling approach, contains the counselor's actions and experiences while providing counseling to the adult client with ASD in session. Theme 4, self-care, mirrors

the counselors' experiences after the client was gone and demonstrates how the counselor copes with their reactions and emotions. Each theme and subtheme will be discussed.

Theme 1: Counselor Reactions

This theme, counselor reactions, reflects the counselors' internal emotions and thoughts about counseling adults with ASD. This theme includes two subthemes: struggles and rewarding. The findings for this theme will be presented in rich, thick descriptions of the participants' own words to reflect the essence of their internal experience and promote transferability. All the participants' names are pseudonyms given to the participants and not their true names. Some information from the direct quotes will be omitted to keep confidentiality of places or people.

Subtheme: Struggles

First is the subtheme struggles**.** This subtheme incorporates aspects of counseling with adult clients with ASD that the counselor finds difficult including feelings of frustration and doubt. Feelings of frustration will be discussed first, then feelings of doubt. All 10 participants but one discussed some feelings of frustration and endorsed this subtheme. Feelings of frustrations stemmed from three sources: the client, the client's family members, and other professionals. Each will be discussed in detail from the counselor's own language. Three participants, Bryan, Cora, and Isla endorsed feeling frustrated with their client during the counseling sessions.

An example of feeling frustrated by the client was when Bryan discussed two different adult male clients with ASD and his frustrations with their behaviors. While describing one client with ASD, he stated, "I'll feel frustrations sometimes because he'll like to argue with me about lots of things and he'll always have sort of justification to not

push himself or want to engage further or try something." Frustration is not the

predominant feeling Bryan felt with this client, but he did feel frustrated in moments with

him. Bryan also described a different male client with ASD who exhibited many

aggressive behaviors and concerning sexual obsessions. Bryan and his client had a break

in the therapeutic relationship, and the client was angry and combative towards him.

Bryan described his response to this experience as,

> eventually, like I would get really agitated with him about those issues especially
> when he was trying to manipulate me like that and so eventually I had to take a
> step back and I tried lots of different tactics of just not engaging with him but I set
> very clear boundaries.

Furthermore, Bryan reported "just a lot of frustration, a lot of anger, a lot of, I guess, even

hopelessness, on my part of 'What do I do with this?' but like I said, there is a lot of trial

and error and a lot of working through it multiple times." Bryan set clear boundaries in

the relationship with the client to keep both of them safe. Bryan offered to refer the client

to another counselor, and the client adamantly refused. So, Bryan continued to find ways

to help the client work through his anger.

Cora also expressed frustration towards her adult female client with ASD whom

she has been working with for many years. Cora stated,

> but I think our relationship is really close, I think it's easy to get frustrated
> because she is so high functioning, to see her struggle with like the immature
> parts of it, ASD, like getting mad because a sibling did something so minor to her
> that it blows into this big fight and it ends up lasting for hours and chairs are
> being thrown and fits and kicking and poking and things like that.

Cora felt frustration with her client's immature behavior and her inability to read other

people's emotions.

Isla also described frustration with her young male client with ASD. This client is

in the process of learning how to go out on dates with women and she stated:

It probably frustrates me the most and it's so hard and difficult because the way I want to approach it in a way of doing role plays or how he must maybe misinterpreting how people are viewing him or how they're looking or things like that and he wants nothing to do with it. He's like, "No, I'm this person who has anxiety and depression and I act out this way."

Isla felt frustrated with how angry this client is with himself and his denial of his ability to change. She also explained that she becomes frustrated with the lack of life skills this client exhibited. Isla stated, "that can be kind of frustrating in that experience of like 'Come on, just get it, how are you not getting this?' and I'm like, 'because he doesn't know and that's just how his brain is wired' kind of thing."

She becomes frustrated, but then has to remind herself about the struggles this person experiences. This occurs many times for her. She explained:

think sometimes like I'll get frustrated with him or I'll be like, "Okay, I want to be done, I kind of want to give up and throw in the towel" but then I'm like, "Okay, no, nobody else has been there for him." Let me try to help as much as possible, obviously, he doesn't know how people perceive him or he'd not be here.

In this moment she is ready to stop trying because she is so frustrated, but she has to remind herself what this person is experiencing, and she is able to continue working with him. Several participants discussed feeling frustrated with the client and their reactions to difficult situations with their adult client with ASD.

Four participants discussed the struggle of feeling frustrated with their client's family members. Amy, Greg, Hallie, and Cora described feeling frustrated with the family members of their adult clients with ASD. Amy expressed her frustration with the family system surrounding her adult male client with ASD. She stated:

I want to be their [clients] advocate and I'm aware of things that their support system could be doing or maybe even should be doing to better support them and I feel frustrated with that support system when things aren't being done. And, so I feel that a lot when I work with him.

Amy struggled with empathy for her client's mother who was not understanding how the

client's ASD diagnosis impacted him and demanded that the client do particular tasks

that were difficult for him.

Greg shared a similar experience as Amy in his frustration towards his client's

mother. He explained that the parent came into the intake session with his adult male with

ASD and the mother was dominating the conversation without the client speaking at all.

Greg stated,

> I'm feeling a little frustrated, a little disoriented . . . maybe a little confused, just
> wanting to get to him and not through her and not have her bouncing everything
> off . . . he's a little disoriented, a little frustrated, certainly not comfortable,
> uncomfortable.

Greg and Amy both discussed their desire to hear the client's voice, but believed it was

squashed by the parent in the session. Hallie also experienced a family system that was

not supporting the client's treatment. She was discussing an adult male with ASD who

was home-bound because of other severe mental and physical illness along with ASD and

how frustrated she became with the family for not following through with the treatment

goals. She stated, "I actually felt some level of frustration with the family which I think is

common when there are families who refuse to be consistent with treatment planning."

Cora similarly described her frustration with the family of her female adult client

with ASD by stating,

> And all of them want to blame the one person who is on the spectrum for all
> problems in the house, like no matter what is, no matter how big, no matter how
> small, no matter if it was a parenting issue or a couple's issue . . . it didn't matter
> what it was, she was the scapegoat on everything.

In this instance Cora felt frustration with her client's family because they blamed all their

troubles on her client and Cora believed it was unfair. At this moment in the interview, I

could see that Cora was becoming frustrated, verging on angry, as she was speaking

about this frustration as evidenced by her facial expressions, quick hand motions, and

vocal tone. All four participants endorsed struggles in their frustration with the imposing

parent on sessions or lack of support from the client's family members.

Four participants discussed their frustration with other professionals in the field of

mental health on how they provide treatment to adults with ASD. Cora, Dakota, Ella, and

Jolette all described how frustrating they feel about other professionals' lack of

understanding about ASD. Dakota discussed her frustration with other professionals' lack

of knowledge about ASD and how they damage a client's self-image. She stated,

> I have found that there is a lot of people who say they work with this population
> that have no business working with this population and that's been really
> frustrating. I have known personally some counselors who have made statements
> that show me that they don't know what they're-talking about and I've also had
> clients come to me who have previously been to therapists and they tell me some
> of the things they said. I even see evaluations that I'm like, "How did they make
> this conclusion?" Sometimes they're clearly on the spectrum but the evaluation
> shows they aren't or vice versa.

Ella is describing her emotions about the difficulty in diagnosis and the lack of awareness

of ASD traits and complexities. Jolette reflected this frustration by stating,

> don't just go in willy nilly and treat it like, Oh, I guess I have to sort of thing
> because I think that's where we see a lot of people when they're dissatisfied with
> counselors because someone will come in and work with them and I am like
> frustrated that they're working with this population.

Ella and Jolette are both expressing their dissatisfaction with other mental health

providers and their lack of understanding the issues adults with ASD face.

Ella described her frustration with other professionals' choices of treatment for

adults with ASD by reporting,

> Like, I think sometimes, too, in this field it's really frustrating because people
> want to take a cookie cutter approach and that's impossible because what one

person with ASD is capable of doing another person with ASD is not capable of doing or vice versa. And then you throw in any other kind of diagnosis and it's just going to make it that much more complicated.

Similarly, Hallie described the frustration in how other professionals apply a "cookie cutter" approach to adults with ASD and how it negatively impacted the client. She specified, "but mental health just isn't as cookie cutter as that so a sense of relief and then also I felt a little bit of frustration for him because I think if he had the appropriate services and support his life would've looked dramatically different." Hallie's client did not receive the care he needed and now was really struggling as an adult newly diagnosed with ASD. This statement displays an example of frustration with the deficiency of proper diagnosis and absence of services that could have greatly increased this client's functionality, life skills, and overall satisfaction with his life.

A second struggle that the participants discussed was feelings of inadequacy, insecurity, doubt, or unsure. Five participants endorsed this part of the subtheme. Amy, Isla, Jolette, Ella, and Greg all discussed moments of feeling unsure, doubtful, inadequate, insecure, overwhelmed, or overall not confident during the counseling process with an adult client with ASD. One important piece to note was that Amy and Jolette expressed the most feelings of doubt and both were LPC–interns working on their full licensure. Both participants have only been working in the field for a short time. Greg, although he has worked in the field for some time, had just opened his own private practice and expressed insecurities regarding being in his own practice.

Amy discussed her fears about her own abilities to provide the best service to clients with ASD. She stated, "however, part of me feels worried that as a clinician I am aware of what I need to be doing to best serve and so I think that there is like this

underlying concern that I have that I might not be . . . delivering the best practices to the

individual." Greg reflects the same concern when he reported, "right now it's hard to feel

this pull between like 'is it right for me to be working with these clients? Am I the best

provider?'" Both participants were displaying examples of the internal struggle of anxiety

if they were the best counselor for this type of client. Amy continued with this worry by

stating,

> it's more me, the perfectionist in me wants to ensure what he needs is what I'm
> able to deliver. I think sometimes there is a piece of me that wants to be a bigger
> advocate for him especially in the context with his parents though he is an adult
> and I'm not exactly sure where the line draws between his autism and his
> depression.

In this example, Amy was sharing her insecurity of knowing if the issue stems from the

depression or the ASD.

Likewise, Greg also expressed feeling insecure offering counseling to adults with

ASD. Greg stated, "a little bit concerned about how this would be perceived by the

referral source, by my supervisor, by the family that in some ways feeling inadequate that

I don't have the skills necessary to make this talk therapy process useful for this client."

In this example Greg was expressing his doubt in his own abilities to provide the client

with the best care. He followed-up in his second interview by saying,

> it's hard to talk about feeling inadequate as a professional even though we're
> taught to be vulnerable, even though we're taught to be self-aware and humble, I
> think is part of our values as professionals but it's hard to say like, 'Hey, I might
> not be the world's leading autism treatment provider in the world', I'm doing the
> best I can for my clients and I'm going to continue to do that.

Greg was exposing his feelings of inadequacy and doubt by explaining the difficulty in

owning those feelings.

Jolette reflected these self-doubts when two clients in her adult men with ASD group started to argue. She reported,

> I think probably because I'm newer in my career I think there is a sense of like "Okay, am I doing this right? How involved should I get?" that kind of thing. So, I think there is all like the self-doubts stuff that comes up which I'm thinking is normal [laughs]. But I think there was just a lot of self-doubt of "What should my role be here?"

Jolette was expressing her feelings of insecurity about what her role was in the group and how she should handle the client argument. Jolette felt afraid when she initially started the adult men with ASD group. She continued by stating, "so, I felt so new and there was a ton of self-doubt of like am I the best person to do this especially when there is so many people in our office that are really good at this. So, I'd say that probably been an overwhelming emotion." She expressed that after several months leading the group, she now felt more secure and believes herself more of a facilitator in the group. Isla brought up a different insecurity that she felt regarding how to handle an adult client with ASD and his inability to see the bigger picture. She stated,

> Sometimes I feel overwhelmed because I'm like, "How am I going to come back?" . . . like I remember one time I was like, "Okay, let's check facts" and he was like, "Nope, this was it, this is how it is" and like that very black and white . . . and I'm like, "I don't know where I'm going to go with this" like literally the pause and panic of like, "How do you combat someone's thoughts that are so black and white of this is it and this is how it's going to be?"

The quote is an example of a moment Isla felt unsure of how to handle a situation with a client and not sure how to help the client see past his "black and white thinking."

Dakota felt anxious when her adult male client with ASD would quiz her on information that was discussed or her knowledge about ASD and she was not sure about her answers. She stated:

> So, sometimes I feel anxious, like I'll notice sometimes my breathing will get very shallow and I'll have to remind myself to like take deep breaths so that I don't know, like our neurotransmitters are talking or something, our mirror neurons are like there and so I will be anxious and so I'll have to remind myself. I don't feel pressure anymore, like I used to feel a little intimidated and he was needing me to prove myself or am I going to have all of the right answers because he kind of quiz me, drill me every once in a while.

Dakota took some time to recognize the purpose behind the client's need to drill her with questions. She reflected on her own internal responses and knew she was mirroring the client's own anxiety. Overall, the participants who endorsed this subtheme spanned in number of years in practice and all came from varying theoretical orientations. This suggests that this subtheme could impact a wide variety of counselors who are providing counseling to adults with ASD.

Subtheme: Rewarding

The second subtheme is rewarding. This subtheme incorporates the feelings of enjoyment, humbleness, passion, increased empathy, and decreased judgement that the participants expressed. All participants, but Amy and Greg, endorsed this theme by described feelings of pleasure from working with individuals with ASD. Bryan felt fulfillment in the work by stating, "I mean, I'm glad that I can try to be a person for them that they can connect to and hopefully provide them something that they don't get from other relationships and can push them to grow. I mean, I think there is a sense of fulfillment in that for me." Fiona echoed this desire to help by describing "I think they just make me want to know more. Since I am passionate about it, sometimes I might put myself in a different stance of 'I have to help this person, I have to let them get some progress.'" This quote by Fiona showed her desire to do everything she could for her clients with ASD because she is so passionate about helping the population.

Isla also has desire to make change for her clients by reporting,

> it's a very humbling job. There are certain aspects of it where it's like "Oookkkaaay" but other ones where it's like it's super humbling and I always wake up every day like, "Okay, if I have nine clients on my calendar, I'm going to at least change one person's life today."

In the same way Fiona and Bryan stated, Isla is exhibiting her passion for helping her clients grow and learn and how they have impacted her. She went on by stating,

> I think the only thing to know, too, is like the work can be like super difficult if you don't understand it and I think that just goes to show that you have a lot to learn and a lot to grow from it but it can be super humbling and super rewarding to see it done.

Four participants, Ella, Dakota, Hallie, and Kaia discussed how working with individuals with ASD has increased their empathy by understanding how everyday situations can impact a person with ASD. Ella discussed how working with adults with ASD has made her humbler, and she has much more understanding for her clients. She said,

> just being in Wal-Mart, in itself is a huge struggle for that person and being around all of those people and the lights and noises, if they have trouble processing noises, it's a struggle for them. So, yeah, working with this population has made me much more humble and much more open-minded essentially.

Hallie also described in depth about how working with individuals with ASD has impacted her life:

> I think, for one, I think you have to have passion to be in any helping care support anything fields. But it has definitely, I think, made me a lot more grounded, given me a lot more perspective. It's a constant reminder that some of the things that I think about and stress about, it's just not what other families could potentially face So, it is definitely making me more compassionate, maybe more . . . just in tune with what it's like to not just be a parent with a child that has underdeveloped mental delay or mental illness disability but just for the person experiencing it . . . how different their world is. And then if we just go with kind of the typical sensory challenges. . . me, walking outside to sound and light could potentially be a challenging experience for my adult with autism and how does

that processing impact their day? And so it's just changed my view on life completely in how I view people.

Both participants touched on how sensory issues could impact their client on a daily basis. Kaia's experiences have made her more empathetic to the struggles her adult clients with ASD face. Kaia said, "Asperger's, it probably has given me even a greater understanding but when I see other people I'm like, 'I know that issue'. I immediately have more empathy. So, I think it's given me more empathy."

Dakota agreed that working with clients with ASD have made her more empathetic and less judgmental by stating,

and so I do think it makes me try to pause and be more empathic in two people's situations or just less judgmental because I don't know the whole story. I also think being an advocate and so I know early on when I got interested in this field I just became so passionate advocating for mental health needs for this population.

In this example, Dakota felt less judgmental of people in everyday life because she did not know what people were experiencing. Jolette also felt that she had learned to suspend judgment by working with this population. She said, "So, yeah, if anything, I think it just made me more positive and more asset-based than maybe I was before . . . I think if anything just the ability to suspend judgement." Jolette expressed enjoyment by working with this population and believed it had greatly increased her confidence as a counselor while decreasing her judgment of others.

Overall, nine out of the 11 participants endorsed the subtheme of rewarding. Similarly, to the subtheme struggles, the participants spanned in number of years in practice and theoretical orientation. This subtheme answered the research question of the lived experiences of counselors who provide counseling to adults with ASD by presenting the idea that they felt a sense of enjoyment, humbleness, and fulfillment in

their clinical work with the population. In summary, the first theme of counselor reactions contained two subthemes: struggles and rewarding. This theme answered the research question of describing the situations that were difficult and/or instilled a sense of fulfillment for the counselors who provide counseling to adults with ASD. Even though not all the participants provided information for each piece of the subthemes, the majority of them had similar experiences while providing counseling to their adult client(s) with ASD. This theme adds depth and complexity to the challenges that counselors face while counseling adults with ASD. Many of their previous experiences with ASD have shaped their feelings of inadequacy or developed their feelings of passion for working with the ASD population. Therefore, the second theme, previous experiences with ASD, will be explored.

Theme 2: Previous Experiences with
Autism Spectrum Disorder

The second theme found during the research analysis process is the participants' previous experiences with ASD. Two subthemes emerged from the data in regard to the participants' histories with ASD: education and personal experiences. The first subtheme, education, will be explored followed by the participants' personal experiences with ASD. In the subtheme education, two branches of educational appeared: graduate school education and ASD trainings outside of the university. This theme answered the research question by exploring the participants' educational experiences with ASD and personal histories with individuals with ASD.

Subtheme: Education

All 11 participants discussed their educational experiences with learning about ASD and, therefore, endorsed this subtheme. Amy stated that she received no education

about ASD in her graduate master's degree program by stating. "I don't know if there was any . . . they've never talked about it at all." Bryan shared a similar experience and reported, "In my master's program I don't think we talked about it at all and then . . . yeah, not really." He learned by providing counseling to adults with ASD and learned over time. Bryan said, "but I never really got it other than kind of learning on my own, doing research, understanding the diagnosis more, consulting with other people." Dakota also shared the same experience, she said: "So, in my master's training, I had no training in autism." Kaia also found that she did not receive enough during her graduate program. She said: "Was there enough information? No." Kaia's experience with graduate school was good, but she believed there did need to be more information about ASD.

Two of the participants, Jolette and Fiona, reported information about ASD was "sprinkled in" to basic foundational courses. Jolette said,

> I would say like the same amount that we probably spent on other things. Like I didn't take a class on autism . . . so it was kind of sprinkled in and then I'll say when I did that group in practicum there was a training there so I got to learn a little bit more. But no, I'd say not a ton. Probably not as much as I need to be doing when I'm working in it now, if I'm being honest.

In this quote, Jolette received some basic ASD education before she co-led some psychoeducational groups for adults with ASD during her master's graduate degree program but did not learn enough to be doing the work that she is currently doing with adults with ASD. Fiona also noticed that ASD education was added in while discussing other topics. She reported,

> probably [talked about it]very little, nothing like a whole class by any means. It was a subject that was covered when we were talking about different diagnoses but as far as specific training on how to work with or what strategies implement with a client like that, I can't say that I did.

She learned the symptoms listed in the DSM, but no further education about ASD.

Hallie was enrolled in two programs, a counseling master's program and an applied behavioral analysis program. She stated she did not receive education about ASD at all in her counseling program and received education about ASD during her clinical training during her applied behavioral analysis program. She explained,

> so at [university], my actual graduate counseling program, it was just traditional play therapy courses . . . and so there was actually no course content specific to autism. I actually didn't realize or understand the prevalence and importance and all of that until I was working at that clinic and so that was my exposure.

These three quotes from Jolette, Fiona, and Hallie show that education about ASD was not explicit or given enough focused time for a counselor be equipped with enough education to understand ASD.

Two participants described how they learned about ASD through class discussions about applied behavioral analysis, a behavioral program designed for children with ASD targeting specific behavioral skills. Isla learned about ASD during class discussions by reporting:

> I think I maybe a little bit, like sadly enough, it's like "Oh, yeah, there's people out there that are autistic. They're going to need special help with like social stuff, they're different" . . . yeah, that's pretty much it. Like the most I learned was being in the workplace and learning about it and understanding, "Oh, that's how they learn" and how to use ABA [applied behavioral analysis] principles. I was trying to think of what class. . . . Maybe it was like theories, they brought it up like ABA and it was only for a little bit and then it's like a breeze over, behavioral therapy . . . like using behavioral therapy and ABA and then was like, "Oh, that's what you use with people that are autistic, okay, moving forward" . . . it's not something that's talked about.

Isla's educational experience with ASD was brief and she believes they skimmed over discussing ASD because individuals with ASD are only treated with applied behavioral analysis, not counseling. Greg also discussed how he learned about ASD while course content focused on behavioral theories. Greg stated,

> I know that while we talked about behavioral therapy that we talked about ABA [applied behavioral analysis] and we talked about the autism spectrum and ABA, applied behavioral analysis being the treatment for kids with autism, on the autism spectrum. That's about all I can remember, maybe an hour, maybe a couple of hours of discussion about it and that's not like credit hours.

Greg did not receive any time focused on ASD and he thinks that what counselors-in-training are taught in typical counseling programs does not fit for individuals with ASD.

Cora explains this further:

> so, in our master's program I can't recall one little bit about autism. . . . I just feel like what we're taught in graduate school is the very basic foundation of treatment with individuals because you have to be able to in the moment, switch from what you're doing to something else if it's not working. And I think that in our program we were taught like you need to pick a theory and you adhere to this theory but individuals that are on the spectrum that aren't going to be following what would be a traditional, typical developed individuals processing of emotion.

Cora, similar to Greg, was describing how traditional content taught in counseling programs are not helpful for counselors who will work with adults with ASD. He believed graduate programs teach ridged adherence to one theory and he knows that will not work with an adult with ASD. Furthermore, Ella's interactions with children diagnosed with ASD was vastly different than working with adults with ASD. She said,

> I had no experience inside school, nothing, zero. I mean, we obviously talked about it but no . . . and then with my experience out [of school] it was kind of a culture shock to be honest. You know, you hear about it and again, I've interacted with kids who are on a spectrum but it's very different, very different with adults.

Ella believed working with adults with ASD was a "culture shock" when she first started. Ella, Greg, and Isla all talked about how ASD needs a different set of skills than what counselors learn on how to work with neurotypical adults or even children with ASD.

Four participants, Greg, Bryan, Isla, and Hallie, brought up the point that more discussions about ASD needs to occur at the graduate level of training. Greg elucidates this point and stated,

> I think about the big picture of our profession and I think this is a population that obviously the number of people being diagnosed is increasing all the time and we can do a much better job of preparing counselors in training for populations like people with autism and I mean, these are the kind of things that brought me back to school of wanting to make sure like I'm part of training good counselors moving forward.

He realized that counselor educators need to be talking about ASD more often to counseling students and he planned to educate his students about ASD when he becomes a counselor educator. Isla reflected these feelings when she said,

> but I hope that your research really proves that training needs to happen. There has got to be more education or something, I got back and I'm going to teach in the fall and I'm just looking at it and I'm like there is just no curriculum that's about autism, and like including it, it's like "Oh, special needs, okay, you're going to have to accommodate for physical needs but it's like what about autism, what about their overall well-being? And it's just not something that's there. It's terribly sad, yeah."

Isla illuminates that counseling program courses tend to touch on the topic of physical special needs but lacks the discussion and education about mental special needs such as ASD. Bryan highlighted this further to include people with other mental disabilities when he discussed,

> just thinking about it more and I think there should be more of a focus on autism and how people trained on it and incorporate it more into programs and or even courses . . . and I'm sure they're out there but courses that focus on people with disabilities in general and the different types of autism versus the cognitive disability versus a traumatic brain injury versus some of the other ones.

Bryan was stressing the importance of discussing the needs of clients who have other cognitive challenges in counseling programs. Counseling students need more education about physical and mental disabilities because they will encounter these challenges in the counseling field.

Greg spoke about the need for better education in counseling programs by verbalizing, "I would just say that for future counselors I'd hoped that this population is

something that is discussed more in programs. Obviously, more people are being diagnosed on the spectrum more than ever before." Greg was explaining that ASD is diagnosed more often than in the past and counseling program need to add more education about ASD into their curriculum. Hallie added, "I think the specialized training and not just kind of like the general training that we all have. . . . I think to add some additional either coursework, classes, training, so on and so forth." Many of the participants were illuminating the need for better education about ASD and the type of care that individuals with ASD need in the counseling room. Overall, the subtheme, education, describes the lack of understanding and skill development on how to work with adults with ASD. This subtheme answers the research question by exposing participant's initial educational experiences with ASD and how that has shaped them into the counselors they current are.

The participants all voiced that they had received little to no educational exposure to ASD in their graduate programs. Attending additional trainings also impacted how they view and perform counseling. All participants discussed if they had received outside trainings about ASD. Amy had received no additional trainings about ASD. Bryan had not attended any additional training but thought he needed to go. He stated,

> It's probably something where there needs to be more resources. I'd like more resources or training and again, I'm sure they're out there but I don't think I've ever gone to like a formal training that I've paid for. They've got to be out there, I probably should find them.

In his follow-up interview he stated, "it definitely makes me think that I should probably get some more specific training on it, read up on it more, since being out of school and it's been a while probably." Bryan realized that he needs additional education and information about how to better work with his unique population of adults with ASD and

other cognitive deficits. Ella had some training in an agency where she provided group counseling to adults with intellectual and cognitive disabilities, but it was not thorough enough. Jolette attended some training before she worked in a nonprofit agency providing psychoeducation to adults with ASD. She stated she should have learned more about ASD but did not learn enough. Kaia went to trainings about rational emotive behavior therapy and psychodrama, but nothing focused only on ASD.

Two participants described trainings that they attended were given by professionals who were board certified behavior analysts. Cora stated:

> but it was through training that I received working there either from the BCBAs [board certified behavior analysts], from the executive director and then from there I went and I took additional graduate level courses to learn more about autism that were directly about autism. And then from there I extended my training beyond that through courses that were designed to train individuals on the spectrum but with my own time, got my own money invested post-graduation, I went, "There is no reason anyone should be seeing individuals that are the spectrum without it." It's just a totally different world.

In this quote, Cora believed counselors need training in order to provide counseling to adults with ASD. Similar to Cora's experience, Fiona also received training from a professional with their board certified behavior analyst. Fiona illuminated the challenge in finding training specific to counseling adults with ASD. She said:

> I've been on my supervisors about bringing in someone to do a training and they did a good job, they brought in a BCBA [board certified behavior analyst], I just don't think he was as helpful as what I was hoping. And to me, I'd really be interested in talking to a psychologist or someone who has got their doctorate or someone who is just an LPC but works primarily with autism. I'd love to have someone like that come in and say, "Hey, here's some tools, techniques, tricks, resources." That's more of what I'd be looking for but as far as other training. [Nonprofit agency name], they did a training about a year ago that I went to and it was informative but at the same time it was very BCBA based and it was . . . like a lot of school situations, like how to handle problematic behavior in schools. Which I understand, that's what these teachers see and that's what they're interested in handling but I think it's definitely lacking in training from a

therapeutic perspective and it's not that I haven't looked for it, it's just hard to find.

Fiona was dissatisfied with the lack of opportunities of trainings to learn more about counseling adults with ASD. She highlighted that she has searched for counseling specific training for this population and has not found what she is hoping to find. Two participants described that they sought out trainings about ASD through their own means and desire. Dakota took extra classes during her doctorate program and offered to teach some ASD courses in another department. Hallie needed to maintain both her LPC and her board certified behavior analyst, so she sought out education about ASD constantly.

Isla explained that she was "super passionate about being properly trained" to work with the ASD population. Hallie stressed the importance of proper training by stating:

> but I think any person coming into this field should have more specialized training and have some additional coursework, additional exposure, additional just learning. You wouldn't just start working with the dissociative identity disorder population. Like that's required at the different level of experience and expertise in my opinion. So, I think general therapy in terms of like lifestyle adjustment and coping skills and all of that is great but when you get into special population I think you need training.

Hallie made the point that a counselor needs proper training to work with a complex mental illness such as dissociative identity disorder. She believes this is true for ASD as well. Isla corroborates this point by describing how confusing an adult with ASD might be to a new counselor who did not receive the proper training to understand and provide counseling to an adult with ASD. She stated:

> I mean, even me, like I've been working with this population a lot and like I feel like I still need the training and the background . . . I mean, I'm a multicultural Nazi, like I can get on my podium and speak about it, how people with autism they're going to respond differently in counseling. They're not going to be attentive to you, they're not going to be checking how you're emotional body

language looks, they're not going to be intuitive with their own body language. And that's hard for a new counselor to kind of understand like, "Why are they not looking at me? Why are they not getting this?"

Isla illuminated the challenges that a new counselor might encounter when beginning to work with an adult with ASD and lack the proper educational reference. In Jolette's words, "if you're going to work with this population like make sure you know what you're doing." This statement sums up what several of the participants were stating about how ASD education is important. Greg also made a point that ASD is not something that counselors can read about and understand right away. He stated,

> I just feel like autism is one of those things . . . just like anything else but I think uniquely with autism that the book doesn't sum it up, what you read about the deficits, seeing someone and being in their presence, you get a better much feel for like what does it mean that they struggle with emotion connection or reading social cues like that's something that's a line in a book that doesn't sum up like how truly hard it is just to make eye contact and like express emotion in some way.

Greg was discussing the importance of being with adults with ASD in order to understand the complexities of their challenges. Most of the participants discussed previous experiences with individuals with ASD that pushed and inspired them to work with individuals with ASD in a counseling setting. These experiences will be discussed in the next section.

Subtheme: Personal Experiences

A surprising piece of the results of this study was the common personal histories of the participants with individuals with ASD. All of the participants had a personal connection to ASD through a friend with ASD, a family member with ASD, or work experiences with individuals with ASD. Three participants had a connection through a family member, one participant had a friend with ASD, and seven participants had a

connection to ASD through a previous job either before, during, or right after their master's degree program. Three participants worked in a program that offered applied behavior analysis to children with ASD. Participants with a friend with ASD or family member with ASD will be discussed first followed by those who had experience in a work environment with individuals with ASD.

Four of the participants had direct personal experience with a friend or family member with ASD. Amy's mother is a speech pathologist and would lead social skills groups for children with ASD. She would come to the groups from aged 6 to 18 years old and act as a peer that the children could interact with and practice their skills. Amy stated, "And so it was never like weird or different to me because I was always around it, it was every week. And so especially when I was younger, like you just didn't know they were different." She went on to explain that she formed a friendship with one of the kids in the group and they continue to stay in touch and go to Dodgers games together when she is in her hometown. In this quote, when Amy was a child, nothing was different about the kids in the group, they were just her friends and felt comfortable.

Two participants reported that they had a cousin with ASD. Fiona described her cousin by stating,

> Just having that perspective of just being empathetic and unconditional positive regard and he's the same but different and different can be a good thing. It's just something that we just all grew up loving him and grew up embracing who he was and we all knew his little quirks and we let him do this thing. . . . So, as a family member he is someone who just sparked an interest. . . . And so I think that's always been an interest I had.

Fiona was aware that her cousin was different growing up, but that did not stop her from embracing and accepting who he was. Isla shadowed the same experience when she described her own experiences with her own cousin with ASD. She explained:

> I always knew he was different and I didn't know why and it kind of like, "He's off, he's nerdy, he looks a little bit different than everybody else, there is just something quirkier about him . . . just always a little bit different." And I remember I went over there for a summer and he was like responsible for taking care of a rabbit. And I went over there and I was like, "Oh, my God, Daniel, I think the rabbit is dead, like what did you do?" And he flipped because that was his only responsibility and I was like "Oh, my God, why is he acting like this?" and he was like hitting himself and I was like, "Holy crap!" I didn't know what to do so I had a panic attack but I didn't even know what it was at the time. I was like, "Okay, what the hell is going on?" And my aunt was like, "Okay, he's autistic and this is what that means" and so then after that I was like, "Okay, I've got to know more about this" and so then I went to school for a bachelor's in psychology where you learn about different people and then worked as an applied behavioral analysis technician and I worked with kids from ages 2 to 18 who were diagnosed with autism so that I could learn more about it.

Isla had an eye-opening experience when she observed her cousin's response to the rabbit dying. It unleashed her desire to understand and learn more about ASD. Kaia's son was diagnosed with ASD and she became very active in the ASD community as a parent. She was on the task force at a university to open their new ASD clinic. She said, "that's actually how I ended up in grad school was because I was on the task force and I hung out so much that one of the professors was like, 'You should really should get your master's' and I'm like 'Okay, I'll do that.'" So, her interest in ASD stemmed from her son and inspired her to become a counselor who works with adults with ASD.

Seven of the participants were inspired to work with ASD after work experiences. Three participants described their work experiences with ASD as coincidence. The job "fell into their lap" and they developed a passion for working with individuals with ASD. When Bryan started working after he received his master's degree, he fell into a job working with people with disabilities. He stated,

> it was a big agency and basically I ended up working, kind of taking over their program for people with disabilities like that and again, they're mostly cognitive/intellectual disabilities and just being in that system sometimes people

with autism would come through also and so yeah, when I started doing that work it was a fit and worked with my style, my personality.

He believed it was a good fit and found his passion for this population. Dakota also detailed an experience early in her counseling career when she started providing counseling to a child whom she suspected to have ASD but was not diagnosed. She explained that there was "just something really special about him and his mom." She was present with the family as the child was diagnosed with ASD and the mother's struggle was greatly impactful on Dakota. She explained:

> And that whole journey with before having the diagnosis and after and seeing what changed about my work with him and what didn't and then working so much with his mom. She had such a hard time with him, like understanding him, and her parenting strategies weren't working like they did with her other children and she really struggled as a mom. And then when she got the diagnosis there was a sense of relief and then a sense of grief. It was like, "Okay, now I can understand but oh, my gosh, this is his lifelong thing that we're going to have to deal with and what does that mean?" that was so impactful so not only did I like working with him and seeing that process but it was almost her that impacted me more, seeing me impact on the family dynamic, seeing the impact on the parent who loved her child so much and wanted to so much to help him but didn't really have a good understanding of what was going on before the diagnosis and then once she got it, she had so much to learn about the diagnosis and then what it meant for her specific son. And so that was so impactful for me. . . . But I wasn't really specializing in autism at the time . . . then from there, kind of my passion for working with people on the spectrum just kind of grew and it definitely started with children and then kind of went to adolescents and adults after that.

This quote exemplifies how one family's challenges could impact the counselor's life that after this experience, Dakota went on to get a doctorate degree and wrote research about children with ASD.

Hallie's own experience is similar to Dakota's experience. Hallie was seeking a part-time job and a friend recommended she worked at a clinic that worked with children with ASD. It was "happenstance" and she thought she did not want to work with children. She stated,

> I started working for this clinic and I absolutely was just in love with the population. I love the behavioral approach. I was actually in a theories class and I had a hard time connecting with anything that was not behavioral based and just more solution focused and so I just loved it.

She started looking for a job because she needed a job and realized she loved working with children and loved working with individuals with ASD. Greg also began by working with children with ASD in an ASD clinic providing basic behavioral therapy after he graduated with his bachelor's degree. He reported, "we were the people that did the directing behavioral therapy and enacted the behavioral plan that was developed by the trained applied behavior analyst professionals, the people that did the treatment planning. That was my first mental health job." Greg became inspired by his work at this clinic to continue his work with individuals with ASD but in a different capacity. Jolette had her own experiences working as an applied behavior analyst technician when she was a student in her bachelor's degree program. Jolette was studying to become a teacher during that time and stated,

> It just kind of aligned and so I was like, "Oh, I can try this" and someone connected me to some company, I don't even remember, this was a very long time ago . . . I worked with one family every weekend and spent some time with their daughter but I don't even know if I was doing ABA [applied behavior analyst] correct. I was like 18.

She became a middle school teacher and worked with students that had ASD. She was not sure that she is completely sure she wants to specialize in the ASD population, but she has developed a passion for working with them at the moment.

Likewise, Cora's interest in working with individuals with ASD stemmed from a job right after she graduated with her master's degree. She stated, "when I graduated I started working for [Autism Clinic name] at [university name]. And so that's where I started my internship at . . . I played an executive role there." She worked mostly with

children at the clinic but found a passion for helping them. Ella also found a passion for

working with adults with ASD while working at an agency that offered group counseling

to sex offenders. Her first experience with the population was challenging, and she did

not work with adults with ASD for some time before she started working at the current

private practice. She explained her first experience:

> And so, I think the first time I really did this work I was working at an agency
> that, of course, was sex offenders and I was filling in and I did not work with
> anyone with disabilities before and so I was filling in for a group and everyone in
> this group had either a developmental or intellectual disability and so anyway this
> one client was arguing with me when I was going over the female anatomy, that's
> what we were talking about, sex education. And this one client was arguing with
> me about the picture of the female anatomy and all the vagina and all these things
> . . . and really was arguing and "I didn't know what I was talking about" and I'm
> like, "Oh, my God!" and it was like the first experience and then "Gosh, people
> with disabilities" . . . and especially with this client did have autism or was
> autistic and it's like "I don't know if I can do this!" and I didn't work with people
> with disabilities for a while after that and then I got back into it and honestly, I
> love it, I really actually enjoy working with them more than neurotypical [people].

This experience greatly impacted Ella, but she somehow found her way back to working

with adults with ASD and loves what she does. Many participants described their initial

experiences with ASD as coincidence, but their passion for providing care to individuals

with ASD has enabled them to provide the best counseling services that they can.

Overall, the two subthemes, education and personal experiences, contained the

participants' experiences with graduate level education with ASD, their trainings about

ASD and their personal experiences with ASD. These two subthemes answer the research

question of the lived experiences of counselors providing counseling to adults with ASD

by illuminating their initial experiences with ASD from an education stance and a

personal stance. These experiences have impacted their desire to continue working with

individuals with ASD and shaped their journeys to the present moment and why they

counsel adults with ASD. In the next section, Theme 3: counseling approach will be explored.

Theme 3: Counseling Approach

Theme 3 is counseling approach with 4 subthemes: counseling characteristics, therapeutic relationship, techniques and client suicide ideation concerns. This theme incorporates the personality traits a counselor needs to have and including the approaches the counselor takes with an adult client with ASD. Theme 3 answered the research question by providing the lived experiences of counselors while they are in the session with the client. Each subtheme will be discussed starting with counselor characteristics, followed by the therapeutic relationship, techniques, and finally client suicide ideation concerns.

Subtheme: Counselor Characteristics

The subtheme, counselor characteristics, incorporates the personality traits that a counselor possesses that fits well with the needs of an adult client with ASD. Two pieces emerged from the data that participants discussed: patience and directness. Each will be discussed using the counselor's own quotes and statements starting with patience and lastly directness. While the need for these characteristics bleed into the context of the therapeutic relationship, they play an overall somewhat separate and important role that several of the participant's verbalized several times throughout each interview. Therefore, they deserve a distinct subtheme and extra focus.

Seven out of 11 participants endorsed the need for patience as a counselor who works with this population. One participant, Jolette, stated that patience was not necessary, but a counselor needs to have the "ability to suspend judgement." She had a

bad experience when she co-led a psychoeducational group for adults with ASD when she was a student in a master's counseling program. After that experience, she was not sure she wanted to work with the population again and by chance she found a position in a private practice that works with adults with ASD. Now, she stated she enjoys working in a group setting with adult males with ASD. Jolette had to stop her own judgments of the population and open herself up to experiencing something new.

Bryan, on the other hand, described how he has been called patient often. He stated, "People have always said to me over the years, 'Oh, you have to have a lot of patience to do that kind of work' and it fits for me and I'm a very even keel kind of personality and so I guess it's just a good match." He believed his personality traits fit naturally with working with adults who have intellectual and cognitive disabilities. Greg also believes possessing the characteristic trait of patience is one of his strengths. He reported,

> So, I believe one of my strengths as a counselor is patience and these are the kind of clients that require a little more patience. Whether it's insurance companies or agencies are on board with that is a different story but my whole philosophy is we've got to take our time when someone needs a little more time . . . I believe I'm a pretty patient person as a counselor and I strive for that.

Greg aims to be patient no matter who approves of it. Dakota also spoke to the need for patience no matter where pressure is coming from. She said,

> I think I'm pretty patient in general. I think where I'm at in my career, I really have developed a lot of trust in the process and so I don't find that I get impatient although I can understand how people who work with this population might get impatient, either they, themselves, or maybe feeling pressure from other family members or something like that.

Isla believes a counselor must be patient when working with adults with ASD, and clients have to have patience, too. She understands that more time is required, and

she explains to clients they also need to understand the process takes more time. Isla also

stated she has to be flexible and go where the client needs to go. Kaia believes a

counselor needs flexibility to "work on the thing that they are in need of." Kaia

explained,

> you just have to be always flexible . . . because you might read your notes before
> the session and go, "Okay, I'm going to work on this today" but then they get
> there and you're like, "Well, guess all of that is going out the window" but that
> doesn't mean that that is a failure it just means like they need something different
> today and "so we're going to be working on this and we'll go back to this some
> other time when they want to."

Here Kaia is detailing how a counselor must be patient and flexible at the same time in

order to meet the client where they are at. A counselor must be prepared to switch their

plans for the session with adult clients with ASD.

Ella felt more patient as a counselor after working with adults with ASD. Her

experiences with working with adults with ASD has made her a more patient and

understanding person overall. Fiona agreed with this statement as she said:

> we have to have a ton of patience I think with anyone with any type of a
> diagnoses but with autism, for sure. It requires a lot of patience. . . . So, definitely
> having more patience and I think more patience as a therapist. Like the example I
> can think of is, again, normally if we have two no shows we get them off of our
> list. They've signed a paper saying that they know that's going to happen but with
> someone with autism just having patience and realizing, "Hey, this is a social
> situation they're wanting to overcome, they're learning responsibility" but just
> getting patience and then giving patience for treatment to happen, knowing that
> might take longer.

In this quote, Fiona has to practice patience with her adult client with ASD. She is giving

leniency to them because she thinks of this experience as a learning experience for the

client. Cora speaks to another point in that a counselor must be confident in one's

abilities as a counselor. She stated,

> I think you have to learn a lot more patience and I think you have to be more grounded in who you are as a person as well as a therapist. So, someone who is not sure of them self I think will flounder working with adults that are on the spectrum.

In this example, Cora is elucidating how patience is required, but also a counselor needs to be "grounded" in who one is as a person and as a counselor. She explained that counseling this population is challenging and a counselor must not let the client tear them down or question their abilities.

Another characteristic that was discussed frequently was the counselor's need to be direct, concrete, or blunt with the client. Eight out of the 11 participants talked about the need for acting in a direct manner with adults with ASD. Being direct includes directing towards discussing an issue, such as behaviors or social skills, asking leading questions or using concrete or blunt language. Bryan called this "not beating around the bush" and Ella called this "just calling it out" and Hallie described this as being "straight to the point," while Jolette said she "doesn't sugar coat it." Isla's sessions with adults with ASD are more structured. She asks the client to make an agenda on a dry erase board of the talking points that they want to attend to in that session. She said it helps clients stay focused "so that they're not able to be super distracted kind of like drifting off at certain things."

Amy starts a conversation about topics such as hygiene with her young adult male client with ASD. She reported,

> he was struggling with hygiene at one point. And so I kind of asked him about his hygiene process and what that looked like and then kind of filled in the gaps. Like more like suggestions, like "if you're struggling an armpit stinking halfway through the day, then you could try this or you could try showering in the morning." things like that . . . I have to draw conclusions with him . . . and so I guess you could say use leading questions not to get the answers but help direct him to think about some of those things just because I have noticed that.

In this quote, Amy is explaining how she directly asks the client for information and uses leading questions to guide him through the discussion. Cora reported that she does the same. Cora asks specific targeting questions to help the client process. She said,

> I'm very clear about making concrete statements instead of abstract thought and so instead of saying "Well, what was going on with your family?" I'll say, "Tell me about your dad, what's going on with your dad?" or "Tell me about your mom, how are doing with your mom?" So, I try to remember all the key people that are in their lives and so just saying, "Tell me what did you over the weekend?" I'm very clear and precise with questions.

Amy and Cora both have learned that targeting questions and leading the discussion allows for more useful processing.

Jolette and Bryan discussed how using a more directive style has impacted them as a counselor. Jolette felt fearful of being direct with clients, such as telling them they need to wear deodorant, and it was difficult for her to become more direct with her clients with ASD. She stated she "very much like sugar coated things" and being non-directive fits more with her personality. However, she learned to be more directive with her clients with ASD and that has improved her counseling skills and ability to be directive with any of her clients. She reported:

> and I would actually say that the work that I've done in skill building and being really direct with my clients on the spectrum has made me a lot more comfortable being direct with my neuro typical clients. So, that's kind of an interesting way to look at it but absolutely, because it's like "I'm not going to pussyfoot around it, like, hey, did you take shower today? Let's talk about this, we've got to figure it out. If you're not sleeping let's figure out what's going on" and I think it's made me stronger, too, in my practice, I think people appreciate the honesty and genuineness there.

Jolette has noticed that becoming more directive has made her more honest and genuine with her clients. Bryan spoke about how adults with ASD may not understand subtle cues the counselor may give them. He stated,

I'm definitely more blunt and more direct and I say things . . . .I don't beat around the bush as much I guess, is a way to put it because I think this guy in particular and really all of them that I've worked with, they need that kind of really direct feedback and direct engagement and making it very concrete and understandable because if I do like a sort of subtle backdoor kind of approach they're just not going to get it.

Bryan is elucidating that making his statements clear and concrete helps his adult clients with ASD to understand his feedback. He believes his adults clients with ASD "need, the structure and level of directness."

Bryan, like Jolette, discussed how he grew as a counselor because of his work with adults with ASD. Bryan brought up the idea that he feels more freedom to be blunt and direct with his clients with ASD than he feels with neurotypical clients. He believes his adult clients with ASD do not get as offended and he feels hesitant to be as blunt with neurotypical clients. He said, "I generally . . . I think there is a lot of freedom in it for me to be that more blunt kind of person . . . I think it's just that there is that freedom in that I don't have to sensor myself maybe the same way that I would." In this instance, Bryan is speaking about how he does not need to sensor himself as must with his adult clients with ASD and is able to speak his mind more freely.

Hallie and Kaia speak to how adult clients with ASD struggle with understanding open-ended question. Hallie suggests that she will ask open-ended questions and then moved to more directive questions. Kaia asks open-ended question can create a sense of feeling overwhelmed in a client with ASD. Kaia reported:

They do differ from my other clients in that in talk therapy, like traumatic silences don't necessarily work with people on the spectrum. "Well, how does that make you feel?" doesn't necessarily work with them. It's a little bit more directive as far as how we discuss the issue . . . I think that not being able to use a more directive approach, if it's too much because I hear that sometimes from the client, they'll say like, "Ask me how I feel? I don't know how I feel, I don't know what else to say" and they get very frustrated by that and it actually shuts them down

even more. If they don't have the network to figure out that pathway, like they'd rather have you show them how, "how do I connect that to a feeling? Tell me how that works."

In this quote, Kaia was describing how open-ended questions about feelings can actually make the client shut down. Hallie also noted how open-ended questions may not produce a response. Her clients are "black and white in terms of perspective taking" and so she uses clear, concrete, "straight to the point" language so there is no confusion. She uses many examples and tries to connect them to the client's life because the " hidden rules of society and social rules that we just have learned from observing life is not always that simple and easy for someone on the spectrum." She reported that she asks open-ended questions, but if she cannot get a response then she "going back to the black and white and then expanding from there. So, just really trying to see the world their perspective but then getting the information that I need to help them." Hallie tries to be both non-directive in asking open-ended questions and directive by asking specific questions. Cora described how she does that same with her adult client with ASD. She stated, "so, sometimes you have to be direct and sometimes you have to be non-direct and sometimes those are very mixed with each other in a five-minute moment. And so I think you have to learn that flexibility." Here, Cora is stating that being flexible as a counselor is important when working with adults with ASD. Sometimes they may need more directness, concrete examples, and being blunt and sometimes they may need open-ended questions with less guidance.

All in all, this subtheme of counselor characteristics was endorsed by all of the participants through discussions of the counselor exhibiting patience and directness with their adult clients with ASD. The subtheme of counselor characteristics is how the

counselor initially starts and maintains the therapeutic relationship. The next subtheme

that will be discussed is the therapeutic relationship.

Subtheme: Therapeutic
Relationship

In this subtheme, the pieces of the therapeutic relationship will be explored

including the counselor–client connection, client slow progress, rapport building,

validation, and client regression. The counselor–client connection, client slow progress,

and rapport building are pieces of the therapeutic relationship that are intricately

interwoven as the participants discussed how the connection took time and the nature of

progress in sessions are slow. Many of the participants explained how they focused on

rapport building and "getting to know one another" in the beginning of sessions and they

believed they spend more time in this stage of counseling than they typically do with

neurotypical clients. A large portion of all 11 interviews focused on discussing the

therapeutic relationship, and all of the participants reported that the counselor–client

connection took time; therefore, all 11 participants recognized this theme.

Isla stated that the therapeutic relationship is a driving force for change and the

most important aspect in counseling. She explains the therapeutic relationship as, "you

may not know these certain things about you but I accept you for who you are and I'm

going to try and understand where you're coming from and your experience to the best of

my ability because it's your experience." In this quote, Isla is talking about what she

covertly expresses to the client through her responses and actions in session. She goes on

to explain what she verbalizes to the client:

> I always tell them, "hey, look, the most important catalyst for change for me is the
> relationship and so me and you are not connecting, please let me know. If you
> don't feel comfortable with that, you can write me a letter, you can draw a picture

of me and it can have a big X over it, whatever you want to do that makes you feel comfortable because I want to make sure that I find a counselor for you that you're going to connect with because if you're not connected to me, then you're not going to want to change, you're not going to want to be here and if you're not going to want to be here then you're not going to want to do the work to have a better quality of life or engage in certain things or have really good relationships. That's the most important part." Like I've had clients who are like, "Hey, we're not connecting right now. I didn't want to tell you, I hate confrontation, this is so bad" and I'm like, "Okay, I get that, I totally get that."

In this quote, Isla is telling her client that the therapeutic relationship is the key to change and if it is not working for them, then they need to discuss it with her. Dakota and Greg both talked about rapport building with the client and the need for time to develop the counselor-client connection. Greg's main goal for his current adult client with ASD is to focus on the rapport building early in their sessions together. He stated:

this client likes certain kinds of music, is very interested in these particular bands and so I'm more than happy to take twenty minutes of our session and just ask him about that and he really opens up and wants to talk about this music is meaningful to him and what concerts he's been to and why it makes him feel comfortable or happy. So, because we're still what I call early in the counseling process, I don't want to say retreat but stay in a realm of like "let me make you feel comfortable in my office space talking to me as another human being" above any like very structured goal oriented work at this point. Yeah, as with any client, if we don't have that connection we're not going to make any progress any way. So, somebody on the autism spectrum I think it might take even a little more time and energy to build that connection.

In this piece of the interview, Greg was explaining that he is a humanistic counselor and believes that the relationship is the most important element to focus on at the beginning of sessions. So, he allows the client to talk about the things he or she wants to talk about even if it is focused on the music that they love. He focuses on the counselor–client connection and knows it will take "time and energy" to build the relationship that they need to create change. Dakota discussed how she also spends time on the therapeutic relationship because progress is slower than with a neurotypical person. She explained:

>I would say that what I do might not be a whole lot different but the pace seems to be a lot slower than those on the spectrum. Well . . . I think, again, it depends so much on the individual. So, if I have someone who is very depressed and on the spectrum and they're not…maybe there is more silence in the session . . . and they're a little bit less connected . . . more because of the autism and not because of the depression piece then I feel like we're going to spend more time in the session building that safety and that therapeutic rapport so that takes a little bit longer to establish sometimes and so therefore the process seems slower maybe than with a neuro typical person coming in with depression. So, I guess that's kind of what I mean by slower, it's not that they're not able to make progress at the same rate, I think our therapeutic relationship establishes at a different pace and so therefore we get to the working stage of therapy, it takes us longer to get there to learn coping skills and kind of implement change.

In this statement, Dakota is reiterating that progress is slower with adults with ASD, but they are able to get to the working stage of therapy. She spends more time creating a sense of safety for the client. Greg reflected this by stating the process takes more time to build trust and

>I'm willing to take as many sessions as we need to, to build that trust because without that, I mean, my perception is without a therapeutic alliance and trust between me and the client nothing that I can say, no advice I could give, and no questions I could ask are going to get us to a more meaningful place.

Greg believes that if the relationship is not established, then the working stage of therapy is not possible because the client will not be willing to change in a meaningful way. Dakota reported that she has to be "so adaptable and flexible in my approach and the first part of the counseling process is really learning to kind of communicate their language and what does our specific dance look like? What is our way of being kind of look like?" Dakota believed she had to be flexible and read what the client needs in the beginning in order to establish the connection.

Amy's adult male client with ASD initially had no interest in therapy because he was forced to attend by his parent. She tried really hard to "make our experience still more process oriented" but did not feel a connection to the client until the third session.

After that connection happened, she noticed her client's willingness to share his deeper thoughts and difficult experiences "and I felt that he really trusted me and that he really was willing to do the work at that point and so I think that's when things changed for me and our relationship." Amy shared that she was worried it was something she was doing that caused the client to take a slower pace and then realized, it just took some time for this client to connect to her. Likewise, Isla shared a moment of worry about the pace of session with adults with ASD. She stated,

> where for some, maybe like neurotypicals be like, "Okay, we processed this, we can kind of get over it in so many months" . . . and what's interesting, too, is that like the slow process . . . my professor is in my head going, "Don't shit on yourself" but "you should be a lot further than anything else" but something I've worked with when working with people with autism is that it's so much slower with processing information and how information is taken, processed, dispersed out, all those different things. So, it's kind of like a norm but I also get frustrated like, "Come on, let's go."

In this quote, Isla is feeling conflicted because even though she knows adults with ASD tend to take more time connecting and processing information, she also feels a sense of frustration that she wants to begin working on some of the deeper material. Furthermore, Ella had a moment of worry that she was to blame for the slower pace in sessions with her adult male with ASD. Ella explained that it took a couple of months for the relationship to develop. She said, "you know, it used to feel like, Oh, I'm failing, I'm letting them down" and now, I'm like "Okay, well, this is where they are right now." Ella had learned that people with ASD just take a slower pace in counseling and she has to follow their lead.

Hallie, Dakota, and Cora discussed how slow progress can seem as though there is no progress taking place. Hallie noted,

working with individuals with autism you get to slow progress, it's the nature of the diagnosis. . . . But I think if you have an understanding of your population to the degree that you should you understand that it may not look like that in a Hallmark movie success story. It may be that you can do these basic things and that is progress. You're getting up every day and you're doing this, sometimes that's all.

Here, Hallie was explaining that sometimes progress is viewed as completing the basics, such as getting up in the morning. Progress cannot be viewed as a "Hallmark movie success story" and they have to take it day by day. Similarly, Dakota discussed how progress has to be viewed differently and she has to manage her own expectations of the client's progress. She reported:

I really have learned to check in with the client to see how they're feeling about the process and then also making sure that I'm looking even for the baby steps and really managing my expectations and seeing that there is progress being made even when there is not progress being made, it doesn't mean that there is not work being done as far as progress. And so sometimes progress isn't always able to be seen externally or behaviorally and so I think really understanding the dynamics of what's happening in a relationship and checking in with the client to share their perception of "is this meeting a need for them of some kind?"

In this piece of the interview, Dakota was sharing how she attempts to understand the client's perception of the relationship and how that relates to progress. She tries to find even the slightest point of progress for the client, even if it does not seem to be there. Cora struggled with some of the same thoughts about the perceived lack of progress. Cora reported,

It's like repeating itself over and over and over. I feel like we do the same thing every week, sometimes I feel like are we getting any progress at all? But then when you go back and review data points, you're like, "Oh, okay, something that you saw last for hours, every day may happen once every three or four months and instead of it lasting for hours. So, those are progresses, that's meaningful data."

In this quote, similarly to Dakota and Hallie, Cora was questioning if progress is happening, but when she looks at the bigger picture, she can see that there are tiny changes happening that are hard to initially observe.

Some of the participants noted that they could observe change happening through the client's behaviors. Fiona described how her adult female client with ASD took some time to trust her and the process was slow. She said that she and the client talked about "uncomfortableness, we got to talk in a therapeutic way about how vulnerable that we feel when we have to make eye contact with someone" and the client did not give her eye contact until around the third session. Fiona described that after the third session, the client was able to come into the session and give her better eye contact. At this point she knew that the connection had developed, and the client could trust her. Dakota had been working with her adult client with ASD for over two years and they have an established connection, so she can read his body language. She stated that the connection may look different from the outside than it feels for her on the inside. Dissimilar to Fiona, Dakota felt the connection with her adult male client with ASD, but some sessions he may not share eye contact with her at all. She explains her own gestures and the client's nonverbals:

> But in his case because there is more silence and our pace a lot slower, my gestures, I guess, a little more emphatic or my nonverbals are just more part of my communication and so maybe that part looks a little bit different but I probably are communicating very similar but he's not. So, especially if you're not hearing us and you were just observing just physically, he's looking kind of awkward, he's looking down most of the time. I mean, there are sessions where he won't look at me one time the whole session and there are times when he might look at me maybe two or three times but probably not more than I can count on one hand on average. And so, he looks awkward, he looks anxious, and so it might seem that he looks like he's withdrawn or not engaged but I know him well enough to know that he is. So, I think that looks different. And even when I greet him in the waiting room and I'll say, "Hey, so and so. You're ready to come back?" . . . it's

> just like this awkward interaction and if you didn't know that there was some kind of deficit in social interactions or heightened anxiety or something that was fueling that, you might be like, "You'd expect there to be more of a connection," whereas most of my neurotypical clients, I go out to get them and they're like "Hey, how are you?" like we're connected right from the meeting room, obviously, not talking about anything really important until we get back to the counseling room but still there is an engagement level with them that doesn't typically happen.

In this verbalization, Dakota was explaining how common ASD symptoms play out within the session. She could feel the connection to her client, and she knew he felt the connection too, but her interactions with him may look different than it does with neurotypical clients. Each session may take some time to establish the connection for that day.

Jolette noted the behaviors she observed during the first session. She takes the approach of "getting to know" her client before any true therapeutic work can occur. She stated:

> So, we really have been working a lot of just building rapport and having him get to know to me so it was interesting because he kind of came in as like shoulders were hunched and you could tell he was really nervous, like I was about to be like, "Here's all of these things you should do" and I was like, "Can we just get to know each other?" and so I've noticed just like in communicating with him, because he really didn't talk that much during the intake . . . and so I really just want to get to know him.

Jolette's form of rapport building was informing her client that they were just getting to know each other, so the client feels less pressure about being told what to do. She does not want to be another dictator in the client's life and the client was surprised that she didn't start with directing him towards those behavioral changes. Bryan's style is what he called "fly by the seat of my pants." It took Bryan a lot of time to develop the connection with his adult male client with ASD. Like Jolette, Bryan's client was surprised by the approach that Bryan took with him. He implements "kind of interpersonal stuff of what's

happening at the moment and not as structured" and he "pushes him in those ways of

interpersonally or being more immediate with him or getting him to focus on his anxiety

and experiences it amps it up a little bit more." Bryan used an interpersonal approach in

counseling and attempts to push his client to feel the deeper scarier feelings. He believes

pushing his client to feel those deeper feelings will help the change process. Kaia

described how the change process works with adults with ASD. She said,

> Well, it depends, of course, on the individual but in general, I think because
> people on the spectrum have a hard time with change, change in general in
> therapeutic setting, I mean, would gain a different perspective or gain insight into
> different things happens at a much slower rate with individuals on the spectrum.

Here, Kaia stated that change is difficult for people with ASD, so it makes sense that

changing internal structures would also be difficult and take more time. Although the

process was slow, the connection that she feels with clients with ASD usually occurs on

the first session. On the other hand, Isla describes how the connection takes time

depending on the person. Her adult male client with ASD possessed very low self-

esteem, which made it more difficult for Isla to build up rapport with him. She reported,

> I have a marketing brochure in my office that I use for like play therapy and one
> of them says "We work with people with autism" and it was so hard build a
> connection with him because he was like, "Oh, you work with people with autism
> because we're so messed up, we're so dysfunctional" and "Oh, you put behavioral
> issues on here and high conflict divorce like you work with a lot of messed up
> people and you put 'autism'" and so making that connection. And then having to
> combat that in certain ways and be like, "That's for marketing" and yeah, "I do
> see people with autism and that doesn't define who you are" and all these
> different things, like trying to build up the self-esteem and I think making that
> connection can be really hard.

In this quote, Isla was explaining how the client was implying that Isla was suggesting

that she thinks people with ASD are dysfunctional because she wrote "autism" on her

brochure along with divorce and other issues. It was challenging for Isla to build the

connection with this client because he has such low self-esteem and could not get past his

anger. However, she believes if she validates the client's experience then change can

occur.

Isla and Dakota both discussed the importance of validation. Dakota believed that

teaching the client about their diagnosis and teaching social skills has validity, but

validating the client's experiences can be very powerful. She stated:

> so I'm just supporting them through it like I would do with anyone, being there
> with them, I think especially when their whole world is feeling turned upside
> down and feeling very chaotic, they're feeling very misunderstood, there is
> sometimes even a struggle to understand themselves and so I think one of the
> most powerful things I can do for them in that moment is to help them feel
> understood and validate their experience instead of jump in and try to fix it for
> them. I think that too often we go into fix it mode or "Here, let me teach these
> skills," go into psycho- educational mode and absolutely there is value in that,
> don't get me wrong . . . I think there is a time and place for that for sure but I
> think it's really important to not skip over the being with them part and helping
> them feel validated and helping them feel understood. I think there is a lot of
> power in that, I think that can be very calming for them. They need validation just
> as much as the rest of us do.

Dakota reported that it is troubling to her that other professionals skip over validating the

client's world. She believes every person needs validation and needs to feel understood.

Likewise, Isla believed validation can be influential and she discussed the progress her

client has made once he was in a validating environment. She stated,

> you've got to be validating as much as possible. He's trying to do these things, he
> is doing the best that he can and now my client has got a girlfriend, going to
> college, making straight A's, driving himself, doing all of that and I'm like, "See
> what I mean? When you change the whole environment of like being validating."
> I think it's the number one thing you can do is validate to someone else's
> experiences.

Whereas Isla discussed the significant progress her client exhibited in this

statement, Ella, Hallie, Dakota, Fiona, and Kaia discussed moments of regression with

their adult clients with ASD. Isla also discussed the regression of another older adult

male client with ASD. Hallie talked about how regressions take place in the form of

difficulty in skill maintenance. Hallie stated,

> with adults it's more skill maintenance but it could be something that they learned but just can't maintain if it's not repeated over and over and over. So, with adults it may look like reintroducing treatment goals over and over. It may look like "Okay, remember we did this but let's go back" because if it's not a part of the day to day routine, it's very similar to neuro typical adults. If I don't do something, if I don't ride a bike every day, I can still ride a bike but it's going to be a little bit harder when I get on that bike. If I don't geometry every day, you can show me a problem, I learned how to do that, right? But you show it to me and it's like, "I've seen it but it's foreign" and so that's actually the example that I use. . . . And when you have a neuro development delay that changes how you process and how you learn, with adults if it's not part of their routine, it's almost as if they never learned it. So, it's a lot of what we called an ABA [applied behavioral analysis] maintenance skills. I might go back and see if you can still do that and if you can't I may reintroduce it as a current act or goal and keep that process going.

In this quote, Hallie was discussing how she recognizes and approaches a skill regression.

The examples that she gave display the need for continual practice of skills or they are

lost. She continually revisits treatment goals if she believes the client is not mastering a

particular skill. Fiona described a regression in a similar manner. She gave an example of

the client forgetting about sessions or struggling with depression. She stated, "sometimes

when that depression takes over we're having a bad day, it's harder to use their coping

skills and so maybe there is a week where they just didn't use them at all. So, that's a

simple sign of regression." Here, Fiona was describing how regressions can come in the

form of forgetfulness or loss of using typical coping skills. Ella, Isla, Dakota, and Kaia

described regressions a little differently. Ella talked about how a client "might be doing

awesome and practicing and working on those goals and then for the next three weeks

after that it's 'I don't want to do this anymore' or 'I don't need to do this anymore' so it's

kind of case by case, session by session." In this quote, Ella was describing how she

recognizes a regression by the client's lack of motivation in the counseling room. Isla had

a shared experience in that the client stopped processing during counseling and reverted

back to surface-level discussions. She stated, "it's like 'Well, I'm just not going to talk

about that' and then it was very like service level, like 'I went to work today and I talked

to so and so', 'Okay, well, how did you feel about that?' 'Good' and just regressed back."

The client no longer wanted to discuss more pertinent information. The client's family

member called to inform Isla of the client's decline in daily life, and she became

concerned about how the client became so withdrawn and isolated. All of the information

put together led Isla to believe the client was in a regression.

Dakota and Kaia described regression as the client resorting to a previous state of

being. Dakota's adult male client with ASD had decreased depression, felt happier, able

to socialize without as much anxiety, and managing his life effectively until he lost a

loved one. She reported,

> then all of a sudden [he] became very anxious in social situations, he was very
> depressed again, really struggled to manage his emotions, things around him felt
> very out of control and so it was this major shift in his environment of major
> change in his dynamic in his family relationships and so to him, like his whole
> world changed and then that was really hard for him to deal with and so all of his
> symptoms seem to kind of intensify again.

Here, Dakota was describing how the trigger impacted the client's ability to function, and

the older dysfunctional symptoms increased in intensity again. Kaia also noted that

triggers can cause a regression such as too much stress. Her adult male client who was

experiencing a regression was just in survival mode and "everything is really bothering

him like sounds are really bothering him." Kaia brings up the idea that the ASD

symptoms, such as sensory issues, intensify during a regression. However, Hallie

reported that when a regression is taking place, she goes back to the treatment goals and

starts over to guide the client through the loss of skills. She does this building up skills, such as social skills.

Subtheme: Techniques

Often times in sessions with adults with ASD, participants used techniques to aid in skill development such as social skill building, experiential learning, and psychoeducation. These techniques are used as approaches to help the client develop better life skills. All of the participants discussed using typical mental processing throughout sessions and 10 participants discussed using some form of social skills building, emotional skill building, life skill development, and experiential learning to help the client increase daily functioning. Experiential learning was exhibited in the form of role plays between the client and counselor or other moments during the session time frame where learning occurred with other people in the moment. First, the counselor's experiences with social skills, life skills, and emotional skills will be presented followed by those who practiced experiential learning techniques.

Hallie, Jolette, Isla, Dakota, and Cora all discussed the use of social skill building with their adult clients with ASD. Jolette's adult male client with ASD presented at intake with his mother, and the client's mother was demanding that Jolette work on money management with her client. After taking the time to "get to know each other," Jolette and her client worked on life skills, including basic financial budgeting. She asked the client to "bring in your budget, let's figure it out" so they could work on management skills. Hallie explained that individuals with ASD struggle with "picking up the hidden rules of society and social rules that we just have learned from observing life is not always that simple and easy for someone on the spectrum." Hallie understood that

individuals with ASD struggle with recognizing nonverbal language and societal norms

organically; therefore, the individual needs repetition and guidance to learn those missed

skills through social skill training. She tried to help the client find systematic ways to

develop those missed skills by creating small manageable goals. She stated:

> let's just say the individual like a lot of adults that are ready to date, right? But underneath dating is how are you honest with someone without hurting their feelings? Let's talk about how sometimes not being completely honest can be a positive thing. Okay, now, your next goal potentially maybe eye contact because we are in a society where we live that is viewed as being respectful and let's talk about drawing attention to communication and language. Okay, let's talk about your body language. Your body language is sending messages that you're irritated and ready to go and so on a date, that may feel that way but in traditional therapy I think the focus is on feelings and processing, what's keeping you from dating? But I think with that example, some adults on the spectrum they aren't conceptualizing that way, they just want a solution.

In this quote, Hallie was discussing the challenges an adult with ASD might face and she

helps the client focus on the targeted goal, such as eye contact, and then works on how

they can improve those goals. She attempts to create goals that are easily accomplished

and do not overwhelm the client and family. She spends less time processing information

and focuses on the skill building. On the contrary, Dakota stated she believed emotional

processing is more important than skill building and spends more of her time processing

with her clients. Adults with ASD need counseling and adding in social or life skills can

increase functioning "if they're oppressive or they're so smelly that they're not going to

be able to get a job because they're not taking a shower." However, Dakota believed the

priority should be providing counseling and attending to their emotional needs. She offers

the choice to the adult client with ASD, if they want to work on some skill building or

focus on the emotional processing needs. She explained:

> he also came in very chaotic, very overwhelmed like not having his life together, like his ADHD [attention deficit/hyperactivity disorder] like I said, was through

the roof and so he would start things all the time, he had trouble holding a job and had these ideas for his teacher and was not really sure how to make that happen. So, certain life skills, job skills, that kind of stuff, I was like, "We can focus, it really just depends on what you need." And I find that a lot with my adults on the spectrum, is trying to figure out what are they coming in needing, I think more so than my neurotypical client. Not that my other clients don't have skill needs. . . . I just find that people on the spectrum definitely need that more, to bring it into the counseling process because they have executive function deficits, I mean, I've never met a person on the spectrum that doesn't. And so, I definitely think there is a big advocate of attending to the emotional piece of them, I think that gets missed a lot. I think there is a lot of great behavioral and skill type programs out there that do meet a need, I just don't think they're holistic. I don't believe that you can help them just manage their anxiety by teaching them a set of skills. I think they need to develop insight into understanding that anxiety and processing what has happened. Most of the time people on the spectrum are walking around in a world feeling misunderstood. they're getting made fun of, they're not fitting in, they're having a hard time feeling filled in relationships, like all of these things and if you like excuse it because of autism, that doesn't make sense. If you took the autism away, anybody else that came in with that set of problems, you'd say, "yeah, we need to process through that, you need to heal from being bullied. And you do need to feel understood and all that stuff" and I'm like, people on the spectrum need those exact same things.

In this statement, Dakota was explaining how adults with ASD need more emotional processing time to develop insight into daily triggers and work through the emotions from trauma such as being bullied. Executive functioning deficits add to the struggle that an adult with ASD copes with daily. She believed clients need to understand their challenges and work through them from an emotional point of view.

Cora and Isla also work on emotional skill building with their clients. Cora uses a paint chip activity to help her adult female client with ASD to feel some sense of control and safety in her life. Cora explains:

so we did like paint chips where we'd say, "Okay, this color means what for you?" and then she'd write it, "What do you need when you're feeling that way?" She'd write it on the back of it and so it was kind of a cue card and she just carried them in her purse with her.

Cora and the client decided to use the paint chips as a way for the client to communicate with her family members. This activity helped the client learn about her own emotions and helped create coping skills. Isla also focuses on emotional skills building in her counseling group. She stated,

> All of your emotional receptors are kept in your eyes right here and so like holding an ice pack over your eyes helps to reduce the sensitivity to emotion stimuli. So, like it's one of the things that we teach them in group and so like we actually bring out ice packs, they're able to do it, they're able to practice it like in the actual group session. And then we ring the mindfulness bell and they take a moment to like breathe and kind of ground in it.

In this piece of the interview, Isla talked about an activity she leads in her counseling group about how to decrease the intensity of emotional stimuli and adds in mindfulness and grounding into her practice. Isla added in the experiential learning exercise so greater learning takes place.

Like Isla, many participants used experiential learning as a tool to support social skill building. Amy, Jolette, Bryan, Ella, Fiona, Dakota, Kaia, and Isla all discussed different types of experiential learning they used with their clients. Amy was building job interview skills with her client and stated,

> was helping him, showing him a career builder website because he didn't know that there are things online that can help you to do that stuff, I pulled out my computer showed him all the resources as to how to you can automatically apply online, apply on the website.

In this moment, she shows the client how to navigate career building websites and access resources that he was not aware of. Jolette's adult female client with ASD that she termed a "shared client" because she was not the primary counselor, but her job was to help the client build additional social and school skills. She stated that she provided the client with tutoring for the General Educational Development and helped with "just a lot of like

understanding other people's perspectives, like we'd go on walks and go get ice cream

and then talk about how to make small talk with a person at the cash register." Jolette

wanted the client to have in-the-moment learning about socializing in daily activities and

giving her guidance on how the client can create socializing experiences, such as talking

to the cashier.

Bryan and Ella both attempt to find avenues for their clients to socialize and gain

social skills. Bryan talked about trying to find experiences for the client to practice social

skills with other people. Bryan stated,

> we have even talked about this of like walking across the street to the grocery
> from my office and like going up to somebody in the detergent isle and being able
> to ask, "What's the best one to get?" He kind of freaks out about that, "It's just
> weird, why would I ask that?"

Bryan shared that his client becomes anxious about communicating with other people and

struggles in initiating and maintaining conversations. So, Bryan created an exercise for

the client so he could practice his skills in a safe place. Bryan stated:

> so I told him, "I want you to come in at the beginning of the session and just kind
> of talk to me like you would any other normal person, not like I'm your therapist,
> but just like try to have a conversation and work on some of the skills that we've
> been working on" and so he was able to do it. And he did a pretty good job and it
> was still pretty brief but it was reciprocal and he shared personal information
> about himself which is hard for him . . . so, he was able to do it and did pretty
> good.

In this quote, Bryan encouraged the client to communicate with him as if they are in a

normal everyday relationship and the client was able to do it. This experiential learning

helped the client become more comfortable and confident with conversations. Ella did

something similar. Ella and her adult male client with ASD practiced social interactions

even though it is a challenge for her client because he struggles with eye contact,

initiating conversations and introducing himself to others. She explained:

> So, I think the last time I met with him, I had another client this week waiting in the waiting room and he was wearing a [university] t-shirt and wanted to connect with him or say something and so he started the conversation we'd practiced and he was able to practice with this other client who also struggles with social aspect of things and they really connected and my client with ASD was so proud of himself and so excited that he was able to do something that he never really thought he could do.

In this moment, Ella and her client were able to practice the skills needed for a conversation with another person in the waiting room. Ella was proud and happy that both her clients were able to practice their social skills with each other in this experiential learning moment.

Fiona created an experiential learning moment for her client using the client's friend. Her ASD adult female client's goal was to have lunch with friends; however, she was anxious about maintaining a conversation. Fiona worked on a mock trial with the client on what the situation would be like to have lunch with friends and what could be discussed. Then they moved on to include the client's friend in the practice trials. Fiona explained that the client

> actually kind of did some practice with that friend, like social interaction practice because it was someone she was really comfortable with and this person knew about her diagnosis and accepted her the way she was and felt it was a really safe person for her to practice some of the social pieces with.

In this verbalization, Fiona encouraged the client to practice her new skills with an outside person to aid in the learning experience and provide the client with some social confidence. Dakota also discussed financial planning and helped the client with self-care strategies with her adult client with ASD including role plays to increase eye contact. She reported:

> And so like having conversations about financially planning or money management or self-care, what does that look like? Eating healthy, exercise, dressing appropriately. We've done some role plays, eye contact is really hard for

him particularly when he feels overwhelmed, like he's able understand the link for himself for like when his anxiety goes up and how he just feels extra, like a lot of sensory stuff and so any time his anxiety is high or he feels overwhelmed, then it's like the world is closing in on him, everything is louder and brighter and he recognizes that and so a lot of his eye contact is related to that and so he won't make it, he'll dart away from it but he knows that's not necessarily like what's going to help him connect to other people. So, we've kind of done some role plays in that or he's involved in a job, kind of hobby thing where he has opportunities to initiate interactions with other people but feels hesitant to do so and so we've had role plays every once in a while to where like, "Okay, if you want to join in a conversation and you see these guys and they're already talking, what can you do?" and we'll like practice things like sometimes. And he would practice it with me and then go out and try it out on his own in the real world and then come back and tell me how it was like and was he able to do it and how different or similar was it to how we practiced.

In this quote, Dakota was discussing the ways that she practices social skill building with her client. She has helped the client with his eye contact and initiating interactions with people through role plays. Isla also uses role plays to help the client "build confidence and generalize the learning to the environment." She shared that she and her adult male client with ASD practice social skills through role plays and acting out several situations where the client wants to interact with others. Kaia discussed similar psychodrama where they act out different scenarios so the client can get build confidence around creating boundaries and coping with friendships. They also role-played job interview skills and how to initiate different discussions with people at the client's place of work. Kaia stated that "sometimes we act things out, it just depends. A lot of psychoeducational stuff." Here, she helps the client learn about ASD and what symptoms are included in the disorder.

Similar to Kaia, three other participants talked about discussing psychoeducation with their clients. Hallie discussed that the client and their family are "feeling a sense of denial and not really understanding the diagnoses or maybe they don't know anyone in

their family that they know of with a developmental disorder which is confusing."

Therefore, she spends a great amount of time discussing the diagnosis and how that

affects the whole family system. Dakota spoke to the realization that newly diagnosed

adults with ASD tended to need more psychoeducation. Sometimes adult clients with

ASD need concrete coping skills after being diagnosed with ASD. Her adult client with

ASD has known about his diagnosis for some time and they do not spend time discussing

education related to the ASD diagnosis. However, those that are recently diagnosed need

more psychoeducation about ASD. She reported:

> whereas others that are coming in with more than one diagnosis, but I notice
> especially those who are more newly diagnosed with autism their treatment tends
> to focus more on understanding autism and what that means for them. It maybe
> skills that more related to the autism piece and so more executive functioning
> skills, life skills, those kinds of things. And then the mood stuff might be a little
> bit more secondary.

Here, Dakota is verbalizing that in the beginning of treatment, a client with a new ASD

diagnosis needs a focus on building coping skills and the mood-related emotional

processing comes at a later point. Ella's client had diagnosed himself with narcissistic

personality disorder and felt very confused about his ASD diagnosis. She stated:

> he was talking about how he's narcissistic because he's always gotten that
> message from society that he's narcissistic because being autistic, some of the
> characteristics, it's hard for him to empathize with others, really understand or
> read other people's emotions, all of these things are hard but he reads articles. So,
> he read an article about being narcissistic and a lot of the qualities that he had,
> that he was possessing. We had a long talk about he is not narcissistic and he
> probably shouldn't take things that he sees on Google on face value. So, I spent a
> whole session processing with him the difference between ASD and narcissistic
> personality disorder. And so, I think that, too, for him was really refreshing, "Oh,
> okay, this is part of my disorder. It's hard for me to read people's facial
> expressions or it's hard for me to get that emotional connection because of how
> my brain is developed and I'm not this narcissistic person who only thinks of
> myself."

In this clip from the interview, Ella's client struggled to understand the differences between ASD and narcissistic personality disorder. She provided some psychoeducation about ASD, and the client felt relief and better understood what the differences were. Overall this subtheme offered the techniques that the participant's used with their adults with ASD such as social skill building and providing experiential learning. Concerns about client suicidal ideation will be discussed next.

Subtheme: Client Suicide
Ideation Concerns

The fourth subtheme is client suicide ideation concerns. This subtheme incorporates the counselor's reactions, thoughts, and concerns about the client's suicidal ideation. Seven of the 11 participants discussed that one or more of their adult clients with ASD had attempted suicide and/or had suicide ideation. Two participants had adult clients with ASD that presented at intake with a history of suicide attempts, whereas five participants had adult clients with ASD who stated that they had suicidal ideation, but no suicide attempts. Three participants noted how different suicidal ideation presented with adults with ASD compared to neurotypical adults.

Isla's ASD adult male client's previous suicide attempt by overdosing and informed her throughout sessions that he continues to have suicide ideation from time to time. She stated that when this client is feeling an intense emotion, then he is thinking about suicide and she struggles to get him to see the situation differently. When the client does think about suicide, it is very rigid as if it was the only option. She has noticed from other clients' behaviors that some self-injurious behaviors may be stimulation seeking behaviors. She stated:

> So, behaviors wise, like talking about like them going to get their medication, them like holding medication. I know a lot of the clients I've had in the past with autism would cheat their mediation, hide it. I had a few that wanted to do self-injury, they'd use whatever they could, it was like that stimulation, like finding that stimulation to whatever is going to work. It's just like the client in our group that talks about the waterboarding, he will purposely put his finger the light socket or anywhere to get some kind of stimulation anywhere . . . just like being at risk for that, seeking like stimulants behaviors and it's just seeking that stimulation and sensory part of it and so I do like art assessments to try and figure out like there are protective factors, like the state of stress, like how much and what's kind of going on.

In this statement, Isla was describing the trends that she notices in her clients: many

adults with ASD tend to hoard medication and self-injury could be a form of self-

stimulation. Jolette also reported that four out of the five adult men with ASD in her

counseling group had attempted suicide. At intake, her adult male client with ASD had

been previously hospitalized a couple of times for suicide attempts, and he was diagnosed

with bipolar disorder and a personality disorder before he recently got the ASD diagnosis.

Jolette just started working with this client and has not thoroughly discussed the

complexities of the suicide attempts or thoughts. Bryan's adult male client with ASD did

have some suicidal ideation, but he did not find any differences between suicidal ideation

in neurotypical people and adults with ASD.

Similar to Bryan, Greg discussed that his clients with ASD had informed him

about suicidal ideation, but no suicide attempts. In order to have a safety plan, he stated,

> gone through similar processes that I've gone through with other clients. I'm a little more proactive about making sure they understand what I mean and both of them have had passive ideation with never any intent, maybe a sense of what a plan would be without ever like even considering what it would be like to actually pursue that plan.

He went on to say that he felt secure in the safety planning because both clients were high

functioning and seem to grasp what he was presenting to them. Dakota mentioned that

although she did not have active suicidal ideation in any of her current adults with ASD, many of them did have suicidal ideation as adolescents.

Kaia, Cora, and Hallie all discussed how suicidal ideation was perceived as different than suicidal ideation in neurotypical individuals. Kaia previously worked in a mental health crisis unit with people who were trying to commit suicide or stating that they were going to commit suicide. She remembered that there were 12 people present and two people had ASD. She stated that she realized it was a pretty high percentage. Kaia noticed that adults with ASD have higher incidences of suicide ideation and feelings of worthlessness. She can tell when a neurotypical person is contemplating suicide; however, with her adult female client with ASD, she could not tell due to the client's flat affect. Kaia described her neurotypical male client, "when he was first suicidal and I came in and he was like a walk-in, just a cloud of depression and sadness. You could see it like a mile away and he had a quivering voice, quiet voice, all of those things." She compares that with her adult female client with ASD and stated counselors need to use a scoring system to know how intense the suicide ideation feels to them. She stated:

> but her, you couldn't tell at all so you had to ask and I think that's why I had to assess for a baseline like, "Okay, so from one to 10 how much do you want to kill yourself?" It's matter of fact, like it's the way to them it sounds matter of fact, the language and presentation . . . so, I think you have to be more careful with their feelings to establish those. You can describe the range, what each number means for them and know where they are and ask any time otherwise they could look just like they always do and go home and kill themselves.

In this excerpt, Kaia was describing how it is difficult to determine how serious the suicidal ideation is feeling for a client with ASD and it is important the counselor assesses effectively, or the client could go home and commit suicide. Furthermore, she believes it is imperative that a counselor asks direct questions about suicidal plans such as

"are you going to go home and drink a whole bottle of codeine cough syrup? Are you

going to cut yourself?" so that the counselor and client are clear about what the question

is and what the client's answers are.

Likewise, Cora mentioned that five adult clients with ASD, four men and one

woman, suffered from suicidal ideation. She noted that all of them had suicidal ideation,

but never attempted. She remarked:

> just go in sequence, if you think about it, like you have to plan it [suicide] and
> then you have to figure out what you're going to do and then you've got to get the
> stuff to do it. So, there is like a scope of sequence that I think might be getting
> missed along the way. It's like the thought is there but then what do I do with it?
> That's a high order of thought process, right, that's your executive functioning.
> It's how to organize, how to put it together. . . . Most of the time those that are
> going to talk about suicide ideation have depression as well. Like with my girl
> client, I always know when it's happening because she'll cry more often. Or as in
> session she normally won't cry. But when she is starting to feel depressed she'll
> start crying more often.

In this segment, Cora notices that to carry out a suicide, there are many components

involved that might make it more challenging for a person with ASD that has weak

executive functioning. She also observes that depression is commonly a contributing

factor in those contemplating suicide. She can recognize symptoms of depression in her

adult client with ASD when the client starts to cry more often. Then, Cora knew that she

needed to assess for suicide and usually the client just wants to know if her loved ones

will miss her. Hallie also speaks to the differences in suicidal ideation for adults with

ASD and neurotypical adults. She noted that many of her clients have suicidal ideation,

but no suicidal attempts. She said:

> When I think it is interesting is with my adults with autism is that it's almost like
> more of a "scripted" I guess I could say ideation. Not even sure that they know
> what that is but they have an idea or they've heard about it or they've been bullied
> and so the conversation was introduced. So, it's really getting to the core "Is this
> something that you really want to do?" kind of going through that suicide

conversation like, "How far have you thought about it? Have you attempted it?" so on and so forth. I think has been more of what the dialog looks like with adults because depending on their level of functioning, I think sometimes I don't think it's something that they wanted to do. A lot of my experience has been, "Oh, someone just told me I should" or "I read this article" or "I'm on this video on YouTube" and so I think it's a little bit more difficult with our population to really get to the bottom of that thought process.

Hallie tries to "get to the bottom" of the suicidal thoughts by "looking at numbers, the frequency, how often are they having these thoughts, how far they're getting, and what the triggers are, I try to focus on the triggers because it could be a specific environment, it could be a specific circumstance or situation." Her experiences with clients with ASD suicidal thoughts are that they are usually forthcoming. Hallie went on to say,

I don't even know that with the way that our population processes it, I don't even know that suicide means the same sometimes for our population that it probably would for a neurotypical individual . . . it definitely sounds and looks different than if it were a neurotypical individual.

She reiterated that suicidal ideation is different for adults with ASD and its important counselors are aware of those potential differences or they may miss the signs and end in tragedy.

All in all, the theme counselor approach incorporated the four subthemes: counselor characteristics, therapeutic relationship, techniques, and client suicidal ideation. All of the subthemes make up the nature of the counseling sessions with adults with ASD. This theme answers the research question by providing the counselor experiences in the counseling room with the adult clients with ASD. This theme is the most important piece for counselor educators and supervisions to know and understand, so they can effectively teach and support new counselors who are offering counseling to adults with ASD. Furthermore, it is imperative that new counselors are aware of the

seriousness of suicidal ideation in adults with ASD and take the proper precautions for their safety.

Theme 4: Self-Care

Theme 4, self-care, contains the two subthemes: counselor professional emotional boundaries and support system. This theme incorporates all the ways that the participants take care of their own mental health and responses to the situations in the counseling room with their clients with ASD. The first subtheme, professional emotional boundaries, includes all the thoughts the counselor experiences in reaction to the client in order to maintain empathy and divide oneself from the client. The second subtheme, support system, is the support networks that the participants use to discuss clients and share their own reactions and experiences about their clients to elicit feedback.

Subtheme: Professional Emotional Boundaries

The subtheme, counselor professional emotional boundaries, is a combination of what counselors say to themselves when faced with a difficult moment or challenging client. Professional emotional boundaries are the emotional limits the counselor creates for oneself in order to protect oneself from getting emotionally invested or from allowing the client to tear them down internally. The professional emotional boundary is how the participant separates oneself emotionally from the client and can maintain empathy and genuineness. Nine out of the 11 participants endorsed this subtheme by telling themselves how to cope with a situation or a difficult moment. Many of the participants told themselves a variation of "this is not personal" or "this is not about me." This self-talk also comes in the form of how the counselor recognizes what is happening to oneself internally and how they cope with those reactions and feelings.

Amy thinks that when a counselor works through "a lot of your stuff" then they are more able to separate "where you are and how you connect" from what is happening in the client's world. Amy tells herself "this is not about me, not everything is about me, it's about him and his process" so she can keep a strong emotional professional boundary between her and the client. She takes a few moments after a challenging session to check in with her own feelings and ask herself "so, where is that coming from? What's going on for me?" Dakota used to become intimidated by a client and after some time she learned to say to herself "it's not about me, I can't let that go pretty easy." Dakota is able to separate her own feelings with the client's feelings and can move on without feeling guilty.

Hallie "had to learn not to take it personal when people choose not to participant in the way that you clinically recommend." Although it makes her frustrated, she realized she had to tell herself to cope with the feelings. She stated:

> I had to come to terms working with ASD and I think at some point, especially in this field you have to compartmentalize and I just communicate that "success looks different, progress will look different with your consistent support but I'm not going to be bent out of shape if you refuse to comply. I'm going to do my best in my session, I'm going to continue to provide treatment because it's medically necessary and here are my recommendations and you're more than welcome to join me in supporting this quicker progress when you're ready."

In this quote, Hallie explained to the client that she has the recommended plan that will hopefully improve their functioning in life, but she cannot make them do it. If they chose not to comply, then she is not going to be affected by it. Furthermore, she tells herself that "people are typically always doing the best that they can with what they've got. Sometimes that's the only set of skills I have in my pocket and so that's all I can do." At this point, Hallie realizes that keeping this frame of mind is all she can hold onto when a

situation is frustrating her. Kaia tells herself "that is as far as they can go right now and

we'll just work with what we have" when she becomes frustrated or anxious about a

situation in the counseling room. Isla tells herself "like if he's going to get it, he's going

to get it, it's on his own time." All three of these participants recognize their professional

emotional boundaries and have created statements to help them maintain their empathy

for the client.

Cora shared an experience with an older male client with ASD that was very

distressing for her. She became angry in session and felt rejected when the client became

verbally aggressive. She had to say to herself,

> Okay, this is really about him . . . this isn't about me, this isn't about my lack of
> care for you. This doesn't represent my therapeutic ability to you because I don't
> remember the name of a character in a book that you mentioned for a whole
> minute in a conversation six months ago.

She had to remember that the client's anger was truly not directed at her and her

therapeutic ability was not defined by the client's emotions and reactions. Cora had to

remain strong in her emotional professional boundary. Ella had to do the same when she

described a moment when she became "worked up" during a counseling session. She

reported:

> it's just really keeping my emotions in check, whenever I start getting worked up.
> First off, it's recognizing when I'm getting triggered or worked up and having to
> react quick enough for myself and "Okay, don't sit" . . . so, I'm a person doesn't
> have a filter, I react much more than I should. And that's something that I've had
> to really keep in check for myself, "Okay, this is obviously my crap that I need to
> focus. I can't bring it in here right now because that won't be beneficial to this
> therapeutic process" and so overtime it's just really me just checking myself,
> making sure when I start feeling that getting irritated or worked up or "I know this
> client is lying", just check myself in that moment so that I can continue doing
> therapy.

In a moment that Ella described, she has to keep her anger "in check" and focus her energy on not allowing it to interfere in the therapeutic relationship. She has to tell herself "okay, this actually has nothing to do with me, this is all about them." In this statement, she remembers her professional boundary and can continue with therapy feeling less triggered. When she realized that she was previously being triggered and potentially allowed her anger to breach the therapeutic relationship, she stated:

> Oh, my gosh, I haven't been a very good therapist because I have been personalizing or injecting without even realizing I was doing that" and so I had to go through that whole phase, too, like "Oh, my gosh, what have I done?" to the point to where I just accept it, "Okay, we're all human essentially, of course, I made mistakes, we're humans trying to figure out how to coexist with each other in this therapeutic relationship," and so, in the beginning if they got huffy and puffy and started getting more verbally aggressive it was like, "Okay, I've done something wrong, I've upset them" where over time I'm like, "Okay, no, they need this. This has nothing to do with me, I have to remove myself from this, this has nothing to do with me. I'm just facilitating their session, just helping them guide through it." I think it became better for everybody.

In this quote, Ella started to feel guilty about her previous feelings with clients and had to step back and understand that she was also learning throughout the process. She had to give herself some compassion as well and know that it takes time to learn professional boundaries.

Greg discussed a similar point in that it takes time to build a solid professional boundary. He stated, "I think that definitely comes with time and skill of being able to step out of the door and be like, 'Okay, that's there, now it starts me in my normal life.'" He goes on to describe how he leaves "work at work" and is able to be present while he is at home. He stated:

> but I'm not thinking about like my interventions once I leave. My time for focusing on that work is while I'm in the office before the session, directly after the session, while I'm writing a progress note. But how is it affecting me personally, I leave and I need to leave that at the office. I'm pretty committed to

that so while I may feel disoriented and anxious and frustrated and all of these things I've already said by the time I get home . . . I'm a partner, I'm a parent and I've got other things that I need to move on to like making dinner and working on the bedtime routine, all of that.

Greg knows himself and he understands he has to leave his counselor role at his office so he can stay present and in the moment with his partner and children. Overall, this subtheme, professional emotional boundary is a combination of all the ways the participants maintain their internal emotional boundary including direct statements they make to themselves and how they perceive the difference between work and home. Many of the participants discussed another way that they maintain self-care by using their support system, which will be discussed next.

Subtheme: Support System

This subtheme, support system, is how the participant's harness their support systems to aid in moments of struggle or needing advice. Participants discussed two types of support systems that they used: supervision and consulting with others. Three participants discussed supervision and eight discussed consulting with other professionals. The three participants who discussed supervision are also the counselors who were working towards their full licensure and were required to be in supervision. Therefore, all 11 participants endorsed this theme. Jolette received weekly supervision and she consults with other counselors in the group practice. Amy has two supervision groups that she takes part in, one that is offered through her work location with other colleagues from her office and the second is offered from her direct licensing supervisor. She has fellow interns that she consults with daily and she also speaks with friends from school that she stays connected to. Fiona mentioned the same support system. She has a direct supervisor who is available to her "always just a phone call away" as well as

colleagues that work in her agency that she can talk to. She did say that none of the other counselors or her supervisor work with adults with ASD, she was the only counselor who openly accepted adults with ASD.

Isla shared a similar experience to Fiona in that she is the only person at her group practice that provides counseling to adults with ASD. She stated:

> we have a DBT [dialectical behavior therapy] consultation team so I'm able to staff that with colleagues. The only hard part is I don't have anybody that works with people with autism that I know unless I go to my old company and kind of talk about it that way. But I mean . . . let's see, but honestly, in the several years I've worked here no one understands Autism. . . . Yeah, it's very isolating when it comes to like "Oh, hey, this person is autistic or has autism," so, like I figured that out on my own and was like "Okay, how can I staff in a way that maybe other people might understand or I may just frame it as if they are neurotypical?" So, yeah, it can be super isolating.

Isla feels isolated and lonely in her work with adults with ASD. She has trouble receiving feedback and suggestions that she needs to truly make a difference for adults with ASD because the other counselors don't understand the intricacies of ASD. In contrast, Bryan, Ella, Cora, Dakota, Hallie, and Kaia work in group practices where numerous counselors work with and specialize in working with adults with ASD. Bryan consults with his colleagues and elicits feedback by saying, "how do you deal with someone like this? What do you recommend I do with this guy?" and when he received feedback about his client, he was better able to "manage my own emotion and not be so reactive with him." Ella has several avenues of support including supervision, colleagues in her office, her partner who is also a counselor, and a network of therapists where she can "vent" about her clients. Many of Ella's clients are involved in a multiteam medical approach with the state services due to their problematic sexual behaviors, so there are several therapists she has worked with and become familiar, so she

will just kind of bounce things off each other and talk about stuff that we never talk about with the other team members as therapists kind of thing. And so then that way we can come and be a united front therapeutically and so yeah, I do, I feel like I have a good support system in place for that.

Kaia also works in a shared group practice that many of the counselors work with individuals with ASD, so she is able to consult with them when needed. Likewise, Cora is able to consult with colleagues from her group practice and she can process through her reactions and emotions towards a situation and a client. She said:

I think sometimes I think, number one, I'm very glad I'm in a group practice because it's really easy to kind of get drawn into this world and not be able to separate from that and so to be able to go to my colleagues and say, "Hey, this is what's going on, oh my gosh, this is how I felt" and be able to process it through with my peers has been valuable because I think that without that I think it would've been harder to internalize all of these emotions and feelings that she has and then in the sense of protection that I have all on my own shoulders. I think it would be very difficult and so I think as a therapist looking forward to like in year one, like what is that a therapist needs to be able to serve this population. I think they have to have their own strong support system, to almost kind of be able to do your own checks and balances, like "Hey, this is what I offered, what I feel, am I going outside of my sense of responsibility?" or "Is this something I would do for any client, not just this client?" and so it's a constant checks and balances with my emotions, my feelings, my actions. I think it's been invaluable.

In this quote, Cora was appreciative that she has so many colleagues that she can discuss her experiences with, and they understand the challenges when working with adults with ASD. She believes all counselors who work with this population needs a "checks and balances" system. Hallie is in a unique scenario because she is a licensed counselor as well as a board certified behavior analyst and she lives between the two worlds. She has found a licensed psychologist who is also a board certified behavior analyst whom she can consult with. Although this person sees a vastly different population, they understand the struggle that Hallie experiences living in between counselors and behavior analysts.

Hallie mentions she has a "just a community of people I kind of have different people that I reach out to for different things."

While Greg is new in private practice, he works in a building with many other counselors and one of them is a specialist in counseling ASD. Greg stated,

> I did ask for a consult from the guy at the practice that has a lot of experience and we met for an hour over lunch one day and he had a lot of suggestions. I don't have a bookshelf full of resource books that he has but he gave me a couple of quick and easy tools to think about and just some ideas for how to make the structure of the sessions better and so that's helpful.

He was able to seek out someone who could understand the experiences Greg was going through and give some good advice. Dakota shared how working with the ASD population can be draining. She reported:

> I make sure that I am surrounded by people that I feel connected with and so sometimes when I have a really large caseload or a large amount of people on the spectrum on my caseload, sometimes that can be very draining, just as much as like working with a lot of trauma clients can be draining or a lot of anyone specialized population. And so I think making sure that I have people around me be it at the office that I can consult with or debrief with, kind of reconnect with, to kind of get that feedback out of a very extraverted person and so to sit with people who really struggle with connection sometimes can feel draining for me kind of at the end of the day and to be able to jump back into those relationships that feel me up.

In this statement, Dakota recognized her own emotional needs to feel connected and takes the time to "fill up" that need with the people that support her. Overall, this theme provided examples about how the counselor handles professional boundaries by statements that they say to themselves so they can maintain empathy and the support systems that they use to voice their own opinions and emotions. This theme is important because it exemplifies what counselors personally need to care for themselves throughout the counseling process with adults with ASD. This section is important for counselor educators and supervisions to know so they can encourage new counselors to say

connected to fellow colleagues and continue supervision and consulting with others even after the counselor obtains their professional counselor license.

Conclusion

In summary, four predominant themes emerged from the data. Rich, thick descriptions directly from the participant interviews were used to provide examples for each theme and subtheme. The four themes are counselor reactions, previous experience with ASD, counseling approaches, and self-care. Ten subthemes were found. The subthemes are struggles, rewarding, education, personal, counselor characteristics, therapeutic relationship, techniques, client suicidal ideation concerns, professional emotional boundaries, and support system. The first main theme, counselor reactions, includes the range of emotional reactions that the counselor had to the counseling experience with adults with ASD. The subthemes for this theme are struggles and rewarding. This theme answers the research question by providing the emotional experiences the counselor experienced while offering counseling to adults with ASD.

The second theme is previous experiences with ASD, and this theme contained the educational experiences with ASD and the participant's personal experiences with individuals with ASD. The information in this theme was divided into two subthemes: education and personal. This theme answered the research question by providing the participant's background experiences with ASD that lead them to this point in time where they work with adults with ASD in counseling. The third theme, counseling approach, entails all the unique facets on what the counselors do in the counseling sessions with their adult clients with ASD. Four subthemes emerged from the data and they are counselor characteristics, therapeutic relationship, techniques, and client suicidal ideation

concerns. This theme answers the research question by providing the counselor experience while they are in the room counseling an adult with ASD. Lastly, Theme 4, self-care, consists of how the counselor copes with counseling their adult clients with ASD by the statements they tell themselves and the support system they use for voicing their concerns and emotions. This theme has two subthemes: professional emotional boundaries and support system. This theme answered the research question by providing what the counselor experiences after the sessions with the adult client with ASD are over and how they care for their own minds. In the next section, I will discuss the findings and display how the findings from this study connect to the current existing literature.

CHAPTER V

DISCUSSION

In this chapter, I will discuss the results of the study. First, I will discuss my

reactions to the interview and analysis process Then, I will connect the research questions

to the research findings and how they fit into the greater body of literature and discuss the

implications of the findings. Following, I will discuss the limitations of the study and

lastly, I will present direction for future research with counseling adults with autism

spectrum disorder (ASD).

My Thoughts

> In counseling, our self is the central professional instrument. We must preserve
> the self in order to be able to use it for the other. The demand to be attuned, to be
> interested, to be energetic for the other—the other who is often in misery, anger,
> defiance, or hopelessness—and to continue to do it over and over again, defines
> the work of the therapy practitioner. (Skovholt, Goh, Upidi, & Grier, 2004, p. 18)

Throughout the research process, I have learned a great deal professionally and

personally. This quote by Skovholt et al. (2004) really spoke to me because so many of

the participants shared their frustrations, fears, and joys about being a counselor. I believe

so much of our focus lies on the growth of the client and sometimes we forget about our

own growth and emotional processes. During the second interviews, many of the

participants said that they do not sit down and reflect on the work that they have done or

how they felt about it. One piece that stands out to me in this research is the belief that

counselors give themselves to clients over and over again in different forms. We bend our

approaches, our thinking, and our creativity in order to better fit the needs of the client, especially when working with individuals with ASD.

I have provided counseling to adults with ASD and many of the points that the participants discussed resonated with me. I spent a great amount of time reflecting and journaling on my own experiences after each interview and during the analysis portions. For example, when participants would discuss their educational experiences with ASD in graduate school, I felt myself assuming that they would have the same experiences as me. I did not receive any education about ASD besides maybe a short discussion in a class discussing diagnoses. Oddly, when many of their own experiences did reflect my own, I felt disappointed that ASD was being overlooked even in the newer counselors' experiences. When the participants discussed the challenges that they encountered and the rewards they felt while working with adults with ASD, I also felt connected to their experiences. I reflected on adult clients with ASD that I have worked with over the years, and one client with ASD in particular stuck out to me. I provided counseling to him for many years, and I wondered at times if I was doing something wrong because progress was slow and he did not move as fast as I had wanted. I was also more directive with him than I normally am with neurotypical clients. For some time, I felt a sense of guilt about being directive with him. Because I was trained as a non-directive counselor and at the time, I practiced mostly non-directive counseling approach. After working with him, I found that the directive approach worked for me and became confused on who I was as a counselor. I self-reflected often and came to see that I was both non-directive and directive and could switch between the two as the client needed.

As I listened to the participants talk, I felt a sense of relief that I was not the only person to experience the need for directiveness in sessions with adults with ASD and that maybe I was not the cause for slow progress in my client. Similar to some of the participants, my personal experiences with individuals with ASD were mostly coincidence in the beginning. Somehow, I found a passion for working with people with ASD and find it truly inspiring and rewarding. The participants' stories were inspiring to me and encouraged me to continue fighting for the needs of adults with ASD in the counseling profession.

Discussion and Implications

The purpose of this study was to better understand the lived experiences of counselors who provide counseling to adults to ASD. The research question for this study is:

Q1   What are the lived experiences of counselors providing counseling to adults with autism spectrum disorder?

All four themes answer the research question and speak to a different aspect of the participant's experiences before, during, and after a session with an adult with ASD. In the final step of Moustakas (1994) transcendental phenomenology framework, synthesis, he suggested that the data be presented into a "unified statement of the essences of the experience of the phenomenon as a whole" (p. 100). I will discuss the themes and how they tie in together to present the whole picture, how those results connect to the current body of research literature and what that means to the counseling field. I view this research as a complex set of moving parts and although I can break them down into themes, I want to present how the themes play off each other and create a unified view as the whole experience of the participants. This study is the first to explore the lived

experiences of counselors providing counseling to adults with ASD. Some of the results

of this study are corroborated by the research and some of the findings are new emerging

phenomenon. Maddox et al. (2018) proposed that "we know very little about the current

practices and patterns of treatment delivery for adults with ASD and co-occurring anxiety

and depression in community settings" (p. 33). This research study, in many ways,

answered the Maddox et al. statement. We now know more about how counselors in the

field are approaching counseling with adults with ASD. However, this is the first study to

examine counselors' reactions and emotional processes while providing counseling to

adults with ASD. The results of this study impact three main groups within the

counseling profession: counselor educators, counselor supervisors, and professional

counselors working in the field. Each will be discussed.

Counselor Emotions

Theme one, counselor reactions, incorporated the reactions the clients had to their

clients with ASD including the subthemes struggles and rewarding. In the subtheme

rewarding, participants discussed feelings of enjoyment, life changing, humbleness,

passion, empathy, compassion, fulfillment, and decreased judgements about others. These

findings reflect the results from the study by Rabu, Moltu, Binder, and McLeod (2016).

In the study by Rabu et al., they qualitatively examined 12 senior psychotherapists/

counselors who had been providing counseling between 35 and 56 years. They found that

participants thought of their work as a privilege, having a sense of awe, feeling humbled,

grateful, humility, compassionate towards suffering, a blessing, and had a great influence

on their personal lives. Participants in this study echoed some of the Rabu et al.

participants' emotions about their counseling work. Furthermore, individuals with ASD

tend to feel suspicious if counselors are not genuine and truly empathetic (Woods et al., 2013). Participants from this study reported feeling an increased sense of empathy during and after working with adults with ASD.

Participants in the current study shared that they greatly enjoyed their work, "I love it," "it is rewarding," and "couldn't imagine doing anything else." Hallie said, "I think it's life changing and it's constantly changing but it's a life changing experience to work with this population." Hallie views her work as profoundly impacting her personal and professional life. Currently, there is no other research, besides this one, describing the benefits that counselors experience when working with adults with ASD. Werner (2011) examined 42 female students from various university departments including social work, education, nursing, occupational therapy, and speech and language pathology and their attitudes towards working with people with ASD in the future. The participants reported the work was rewarding, even called "holy work" and an opportunity to gain personal and professional growth (Werner, 2011). This was echoed by the participants in this study as an opportunity to develop increased empathy, "suspend judgement," and understanding towards others.

Furthermore, Feather (2017) found that counselors need to have patience, perseverance, creativity, and flexibility when they are working with children with ASD. This study's participants also named patience and flexibility as a key factor in counselors characteristics described in Theme 3, subtheme counselor characteristics. Counselors need to have emotional intelligence, hardiness, good-heartedness, love for others, and a "real desire" to work with people with ASD (Werner, 2011). Similarly, the participants in this study expressed their passion for working with this population, and several of the

participants reported that they primarily work with individuals with ASD. New research

by Camm-Crosbie, Bradley, Shaw, Baron-Cohen, and Cassidy (2019) exhibited the

benefits that adult clients with ASD experienced in counseling. Camm-Crosbie et al.

qualitatively examined 200 adults with ASD without intellectual disabilities and their

experiences of mental health treatment and support. Participants in the Camm-Crosbie et

al. study stated that they credit counseling for life changing treatment that saved their

lives, helped them better function in the world, and decreasing symptoms from severe

mental illness. Overall, both sets of participants, counselors and clients with ASD, were

greatly impacted by the work that is done during the counseling process and have called

the counseling process life changing.

This study highlights the participant's feelings of fulfillment and rewarding nature

when counseling adults with ASD. Many studies focus on the challenging aspects to

counseling adults with ASD and fail to mention the constructive facets when counseling

adults with ASD. This study suggests that although counselors may find working with

adults with ASD as challenging, the benefits outweigh the struggles they encounter. The

participants continue to offer counseling to adults with ASD no matter the frustrations

and insecurities that they experience. Working with people with ASD challenges the

counselor to expand one's skills, perspectives, and understanding of human nature.

Baron-Cohen (1995) stated, "imagine what your world would be like if you were aware

of physical things but were blind to the existence of mental things . . . consider that sense

you could make of human action." This is an example of mindblindness that people with

ASD experience at varying levels. If a counselor attempts to think of the world from this

perspective, it may change how they picture the world. The experience forces the

counselor to approach the process with a new set of eyes, which requires patience,

flexibility, and the ability to have an appreciation for a dimension of difference (Smith et

al., 2008). This is important for counselor educators to understand so that they can relay

this information to counselors-in-training. Counselors-in-training might feel intimidated

or anxious about counseling adults with ASD; however, after some education and

experience, they too can believe counseling adults with ASD can be life changing.

Counselor Challenges

The subtheme, struggles, from Theme 1 discussed the participant's feelings of

frustration about their client, which tied into the Theme 3 subthemes counselor

characteristics and therapeutic relationship. In this study, frustration with the client

seemed to stem from multiple places, including from the perceived lack of client progress

due to a slower pace. Isla had an excellent example that reflects the frustration many

participants experienced with the slower progress made with an adult client with ASD.

She stated:

> I was so frustrated. I was so irritated. I think with the whole thing of just like "I'm
> doing more work than they are" but also like, them needing that support a lot
> more than somebody who is like neurotypical and not needing that "let's break
> down the connection, let's break down what this looks like and how you get this."
> I tell people usually "you're feeling sad, you're feeling anxious, depressed,
> overwhelmed" and it's a lot quicker but if I'm with patients with autism it's just
> long, I mean you really have to be patient and have to be willing to do it and they
> have to be willing to ride it out and so on and so forth.

In this quote, Isla was sharing her frustration that adults with ASD take more time to

connect and process information within the session than a neurotypical client. These

findings are congruent with previous research indicating that therapists who worked with

children with ASD described their experience as challenging and frustrating due to slow

progress (Brookman-Frazee et al., 2012; Feather, 2017; Vulcan, 2016; Werner, 2011; Williams & Haranin, 2016).

One of the findings from the Camm-Crosbie et al. (2019) study was that participants stated they needed time to form a good rapport with counselors and they needed more overall time in treatment. Many of the participants in this study came to the same conclusions. Participants discussed that they took time to "get to know" the client and knew it was going to be a slower process. Greg stated "If we don't have that connection, we're not going to make any progress any way. So, somebody on the autism spectrum I think it might take even a little more time and energy to build that connection." Greg takes more time to build the counselor–client connection because he knows if the connection is not strong, than progress is not going to happen.

More time is needed to develop rapport, build the counselor–client connection and processing information during the sessions is taken at a slower pace. Therefore, when clients are in the working stages of therapy, they take more time to process new information and implement change. Kaia stated, "people on the spectrum have a hard time with change, change in general in therapeutic setting, I mean, would gain a different perspective or gain insight into different things happens at a much slower rate with individuals on the spectrum." Adjusting to change can be challenging to adults with ASD in any setting, so it would be assumed that interpersonal change, changes to thought processes, insight, and other personal changes would also be challenging.

Furthermore, several of the participants stated they had been seeing their adult client with ASD for a long period of time. Bryan reported he had been seeing his client for four years, Cora was seeing her client for two years, and Dakota mentioned seeing her

client for over two years. With the understanding that adults with ASD display a slower pace in each session and an overall slower progress, seeing a client for many years might be more common in mental health practices that have no session time restraints. These results are congruent with previous research, indicating adults with ASD stay in therapy for a longer amount of time, they needed more sessions to feel relief, and attended more frequent sessions (Anderberg et al., 2017; Maddox et al., 2018). Hence, patience is needed in the counselors who are serving their adult client with ASD. However, adults with ASD should be encouraged to continue in treatment even if they do not show immediate improvement; the results will take longer but they can improve with more time (Anderberg et al., 2017).

Another source of frustration for the participants was the involvement or lack of involvement from the client's family members. Research has shown that adults with ASD tend to live with their parents and rely heavily on them for basic needs (White et al., 2018). Furthermore, previous research has suggested that providers should increase parental involvement in sessions so they can aid in the generalizability of treatment goals (Lake et al., 2014; Lake et al., 2015; White et al., 2018). Gaus (2019) briefly discussed the struggle with family members during treatment when a family member does not accept the ASD diagnosis and puts pressure on the client to act normal. However, the research does not detail how parents should be involved, to what extent should they be involved or the impact their involvement has on the counselor or the client. This study found that family involvement can be helpful at times and can be challenging to the counselor. Dakota found that involving the adult client's parents/family members was helpful and aided in perspective-taking for the client. She stated:

> I think when there are primary people involved in the care of that person I think it's really helpful if I'm able to have them be part of the counseling process particularly when they give a perspective that's different than the perspective of the client. Sometimes it can be related to our goals and so sometimes it's hard for me to challenge a client who might really be struggling to understand other people's perspectives. Well, I can't challenge them on that because I don't know any different than what they tell because I'm not with them outside of my office and so I can have a family member come and offer a totally different opinion or experience or perspective then it really gives us some content to really explore and figure out. I think that can be really valuable.

In this statement, Dakota was describing the client's struggle with theory of mind and how it is helpful to her to have another person's opinion on what is occurring in the client's life. While some participants stated parental involvement was useful, other participants found parental involvement during sessions to be a challenge. Participants discussed how they had to balance the needs of the adult client and the needs of the family member. Whereas this delicate balance is common when working with minors, it is a different experience with an adult and their caregivers. Jolette spoke to the counselor's confusing role when counseling an adult with ASD. She stated:

> Emotions of like, "Okay, I want to be respectful of everybody in this room but I also recognize what my job is and I want to respect him as a person. He's not a kid coming in here for an intake" . . . and so I talked with him, "I want you to sign an authorization for your mom and if you would like me to have a conversation in the future with her there" what's billing going to look like, who is going to be paying for sessions, all of those types of things that I don't think maybe like I don't think about those things when I work with an adult without autism. . . . She had very specific goals she wanted him to work on and when he would talk . . . but it was very much like, "Well, you don't know how to do that" and "You need to work on that" and like "be honest, tell her that thing you did," like that kind of stuff. Whereas with an adult coming in, they have a lot more autonomy of what they want to share with me on the front end, because their mom isn't there saying, "Tell her all of the horrible stuff you do" like this is what I'm going to disclose to you at this very moment. And so, yeah, it really struck me in that moment, like this is so different and it is such an important balance here.

In this statement, Jolette was detailing how difficult it is for her to balance listening to both people and respecting the autonomy of the adult client. However, she does have to

keep in mind that the parent was the person paying for services and managing mental health care for this client. Participants described this situation as feeling "disorienting," "confusing," "frustrating," "intense," and feeling "overwhelmed." Greg shared a similar experience when he felt frustrated that a previous mental health provider disregarded the client and focused on the parent's agenda. He said:

> What I tried to do is make sure that I'm giving as much attention as possible to the client, to the person that's on the autism spectrum and I feel like a lot of these people when they've been with providers and things there is so much "talking to my mom or my grandmother about me and what's wrong with me and how are we going to fix what's going on with me" that the Rogers in me is like "We're not going talk about you, I'm going to talk with you and I'm going to include you even if I don't even get responses sometimes. It is very valuable to me that you have a chance to say what you can and I do everything I can to make it safe for you to do that."

In this snippet, Greg is expressing his wish to hear the client's voice and help the client recognize that he wants to understand the client's perspective, not just the parent/caregiver's desires for him. The client becomes accustomed to sitting in the child role and "they're like, 'Oh, here I go again, being treated like a baby because I have a disability. Like I need to be protected, I have to be watched at all times because I can't make my own choices', all those, 'I can't' kind of thing." Adults with ASD may already have low self-esteem; feeling as though they can't add to those feelings of helplessness and depression.

Theme 1 subtheme, struggles, also discussed feelings of inadequacy and doubt which is connected to theme two, previous experiences with ASD, subtheme, education. Participants discussed feeling frustration with other mental health professionals. Many of their frustrations stemmed from other professional's lack of knowledge about ASD and the lack of proper skills. Some participants discussed how other mental health

professionals harmed their client with ASD because of the lack of knowledge about ASD.

Cora's young adult female client was having behavioral problems and the parent took her

to see a psychiatrist before coming to see Cora. Cora stated:

> She had gone to a psychiatrist I guess a few weeks before coming to see me and the psychiatrist had told her that God would be ashamed of her and so from that woman she felt like because she wasn't able to control her behavior, if God was going to be ashamed of her then she started hurting herself. So, she started cutting.

In this quote, the psychiatrist did not have the proper education about the symptoms of

ASD and attributed those symptoms to the client's inability to control her behavior. The

impact of the psychiatrist's words profoundly harmed the client to the point when she

starting to self-harm. Other participants gave examples of how their client with ASD did

not connect or talk to previous counselors and one client had increased anxiety because a

previous counselor expected him to look her in the eye. Isla stated that other counselors

in an agency setting "were just like, 'I don't get it', like I heard a lot of 'she's weird',

'he's strange' like 'why are they thinking that way?'" These examples show the amount

of misunderstanding and judgements about adults with ASD and also show the lack of

education about ASD in the mental health field. Some professionals had negative and

stigmatizing perceptions about the ASD population and may lead to an attempt to avoid

interactions with this population and therefore exclude this population from receiving

treatment (Werner, 2011). Gaus (2019) stated that counselors seem afraid and unsure how

to work with adults with ASD and this was mirrored in the participants' discussion of

other professionals. A participant from the Camm-Crosbie et al. (2019) study stated, "no

ordinary counselor can understand autism" (p. 1435). Counselors need to have training on

ASD so they will have better understanding of the needs of adults with ASD and how to provide more effective assistance.

Change in and of itself can be difficult to anyone, whether or not ASD is present. When change does not occur at the pace the counselor predicts or desires, frustration can be inevitable. The implication for the challenges in counseling adults with ASD is that frustration is part of the nature of working with individuals with ASD. Feeling frustration does not mean change will not or cannot happen, it means the counselor is challenged to change their viewing angle. Many aspects to the counseling process are slow: the client–counselor connection, progress, and the change process. Counselors need to be aware that this process takes time, so therefore they should take more detailed notes, give assessments more often, and ask specific questions each session. Counselors should attempt to find even the slightest changes, such as amount of eye contact, behavioral cues or use of emotional language, to track progress.

This is the first study to discuss the challenge of family involvement in counseling adults with ASD. When a counselor encourages family involvement in sessions there are two emerging perspectives to consider. First, adults with ASD, especially young adults, may have a history of relying on a caregiver/parent for basic daily functioning skills and life managing skills. As we see in the literature and in this study, for an adult with ASD caregivers tend to manage the physical and mental health needs including attendance in counseling. Part of a counselor's treatment goals could be teaching independent functioning skills. Isla, and other participants, described the adult client's perspective as "sitting in the child role" and believing they are unable to take control of their own lives because the parent chooses for them. Thus counselors should be aware of being careful

not to enable the client's potential feelings of learned helplessness. The counselor must balance the needs of the client including empowering the client and meeting the needs of the caregiver/parent.

Secondly, involving family members can be profoundly impactful in counseling for adults with ASD. Including other members of the family in session can give different perspectives on a situation and help the client with theory of mind, emotional regulation, executive functioning, and overall empathy and understanding from all parties. The counselor must treat the adult client as an adult and give all choices for family involvement to the client. Counselors can augment sessions to include more family counseling and parenting guidance with the adult with ASD present. Psychoeducation about ASD should be incorporated into sessions and work out any misunderstandings about ASD. Counseling adults with ASD can be a collaborative process with family members; however, the counselor must keep vigilance about the client's feelings about the family's involvement in counseling.

The last part of the participant's frustrations was surrounding the lack of knowledge about ASD from fellow mental health professionals. This is tied to the lack of education and misunderstandings about ASD. If counselors would receive more education in their graduate counseling programs, then counseling skills with this population might improve. Education about ASD will be deliberated in the next section.

Education about Autism
Spectrum Disorder

All 11 participants stated they did not receive education about ASD in their graduate counseling master's degree program. Four participants remembered discussing ASD in some form while learning about other interventions such applied behavioral

analysis in a class covering counseling theories. None of the participants received proper education about the symptoms in the *Diagnostic and Statistical Manual* (*DSM*), other known symptoms, challenges of ASD and interventions to work with individuals with ASD. Greg stated: "Not much at all and I'd say 99% of the skills that we talked about and theories and in view of the learning experience in the program was not something that feels like it fits well with people on the spectrum." Here, Greg was stating that he did not learn very much about ASD and after working with the population, he realized what he did learn about counseling actually did not work for this population. The overwhelming majority of participants did not have ASD training and if they did, they sought it out on their own time and money. Most of the participants stated they learned how to work with adults with ASD "on the job" and sought out their own forms of education. Participants expressed their frustration with the lack of trainings available discussing adults with ASD. These results are consistent with previous research indicating that mental health professionals are not adequately trained and do not possesses enough knowledge about ASD as reported in the literature from mental health professionals, parents of individuals with ASD and directly from adults with ASD (Brookman-Frazee et al., 2012; Camm-Crosbie et al., 2019; Chiri & Warfield, 2012; Dillenburger et al., 2016; Lake et al., 2015; Williams & Haranin, 2016;).

Trainings about ASD that were provided came from a behavioral-based perspective and did not fit the needs of the counselors. The behavioral-based perspective is missing many important components such as the socioemotional and interpersonal aspects to the person as well as the effects of traumatic experiences. These components are important to the overall wellness of the person. Unfortunately, services for adults with

ASD are missing these components. Counseling is the best place to offer support for the

emotional and psychosocial facets of the person.

Several participants expressed the desire to attend trainings if they were offered,

which are similar to the results of Brookman-Frazee et al. (2012) study. Isla discussed her

struggles to find proper training on providing services to adults with ASD. She shared:

> I'm running into is there is not a lot of training for it. If there is, it's like, "Okay,
> you're going to work with kids with autism," it's not like "How do I work with an
> adult with it, specifically how do I work with an adult with autism who is
> presenting as actively suicidal in the session? What do I do?"

In this quote, Isla has been actively attempting to find better training that is focused on

adults with ASD and suicidal concerns. She can find education about children with ASD,

but education and training about working with adults with ASD is scarce. The deficit of

research and trainings on symptoms, treatments, and services for adults with ASD is

corroborated by previous research (Lake et al., 2014). The body of research, and this

research study, consistently showed that counselors lack knowledge about ASD and ASD

treatment methods.

Participants discussed their feelings of inadequacy and self-doubt. These feelings

were mostly expressed by fairly new counselors; however, other participants shared how

they felt "intimidated" and apprehensive as new counselors who were beginning to work

with adults with ASD. Amy stated: "However, part of me feels worried that as a clinician

I am aware of what I need to be doing to best serve and so I think that there is like this

underlying concern that I have that I might not be delivering the best practices to the

individual." In this statement, Amy, although she felt comfortable with the client, worries

that she does not know enough about counseling adults with ASD to provide counseling

to her adult client with ASD. The feelings of inadequacy and self-doubt potentially reflect

some of the participants concerns that they are not the best fit to work with adults with ASD possibly because they do not have education or training to help them feel more confident. These findings are similar to previous research that showed that the amount of professional education and on-the-job training was a predictor of counselor confidence (Williams & Haranin, 2016). It is possible to conclude that if counselors, including this study's participants, had received more education and training about ASD then self-doubt and feelings of inadequacy would diminish. If counselors felt confident in providing treatment to adults with ASD, then more counselors would offer treatment and more adults with ASD would get the help they desperately need.

Some participants recounted that they did not have other colleagues or supervisors who had knowledge or expertise in ASD. Fiona reported it was a struggle to find someone who had familiarity and skill in working with adults with ASD. She said: "I wouldn't say anyone necessarily more knowledgeable than myself . . . not that I have any special training or anything. I think it's hard to find someone, like I said, that specializes in it in therapeutic ways. So, that's definitely hard." In this statement, Fiona found it challenging to locate other professionals who understand ASD and can consult with her or supervise her. Isla felt similarly when she stated: "Honestly, in the several years I've worked here no one understands autism. . . . I figured that out on my own and was like 'Okay, how can I staff in a way that maybe other people might understand or I may just frame it as if they are neurotypical.'" In this quote, Isla felt alone because no other professionals work with individuals with ASD and during her group supervision, she has to resort to framing the client as if they were neurotypical in order to get feedback. Then, she has to adjust the feedback to fit the situation with her adult client with ASD. The

research displays how the access to consultation with supervisors and colleagues with expertise in ASD is greatly lacking and many counselors are left to figure it out on their own (Williams & Haranin, 2016), which matches the experiences of the participants in this study.

This research study illustrated the need for comprehensive training and education about ASD in graduate training programs, which is consistent with the literature (Brookman-Frazee et al., 2012; Dillenburger et al., 2016; Feather, 2017). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) created counseling standards to "simplify and clarify the accreditation requirements and to promote a unified counseling profession" (section 2). These standards for counseling curriculum require counseling programs to teach courses in social and cultural diversity including "diversity . . .of physical, emotional and mental abilities" (CACREP, 2016, section 2, para. 2). The ASD is considered a mental and emotional disability as evidenced by emotional deficits and by its presence in the *DSM-5*. Nevertheless, very few university counseling programs provide training and knowledge about disability problems (Smart & Smart, 2006). This neglect could be the results of the historical perception that counselors will not encounter clients with disabilities, which this study shows is greatly incorrect. A greater focus on ableism and disability issues is needed in counseling training programs (Smith et al., 2008). Regrettably, disability issues have been ignored as a multicultural problem by the general public and within counselor education (Smith et al., 2008). Unfortunately, this problem is evident by counselors' lack of knowledge of ASD and evident by the lack of mental health care received by adults with ASD.

The results of this study show that counselors need to have significantly more comprehensive education and training in counseling adults with ASD. As stated in Chapters I and II, individuals with ASD are in desperate need of better mental health care. They are walking into the doors at a counseling office seeking the same help as a neurotypical person; they deserve a counselor who is able to help them through their suffering. Participants stated they learned about ASD as it was "sprinkled" throughout graduate counseling courses including a class about diagnoses. The lack of focused time dedicated to discussing ASD and other cognitive disabilities is evident in this study. Students have suggested that the lack of education about ASD may contribute to deciding not to work with the ASD population (Werner, 2011). The ASD could be discussed in depth during a multicultural course when focused on diversity of emotional and mental abilities and infused throughout existing counseling curriculum (Weiss, Lunsky, & Morin, 2010). Counselor educators could not only teach about the symptoms provided by the *DSM*, but also highlight the other challenges people with ASD experience, such as executive functioning and emotional regulation difficulties. Counselors-in-training should be aware of the stigmas that surround ASD and acknowledge their own stigmas about ASD.

Counselor educators could add in discussions about how to use a more direct, concrete approach with modifications and help students understand that progress is slow, but adults with ASD can greatly benefit from counseling. Counselor educators could create a special populations course that covers counseling individuals with ASD and include how to handle the counselor's unique situation of balancing the adult client and the family member's needs in session. Furthermore, Greg and Cora stated that traditional

counseling theories and neurotypical human developmental models may not fit with this population. Disabilities strongly influence how a person lives and interacts with others. When a counselor educator is teaching about traditional human developmental theories and models, consideration needs to be given to how a disability, such ASD, impacts human growth. Additionally, when teaching about counseling theories, suggestions can be made to describe how to use a theoretical model with a person with ASD and how to integrate a counseling theory with the research on ASD about the counseling process with adults with ASD. For example, a counselor can approach counseling from a person-centered perspective and use modifications such as more concrete, direct language in sessions. Counselor educators need to be aware and teach counselors-in-training about how oppression and ableism plays into the daily life of an adult with ASD. Ableism is a form of discrimination against individuals with physical, mental, or developmental disabilities and perception that these individuals must be fixed and cannot be a full member of society because they are considered abnormal (Smith et al., 2008). Ableism impacts personal identity and cause adversity as well as anxiety, depression, and other issues within an individual's life; therefore, it is important counselors are aware and are prepared to address those issues.

Counselor supervisors, whether they are counselor educators or not, also need to have knowledge and understanding about ASD. The research indicated that counselor supervisors are not knowledgeable about ASD and are overall unable to provide feedback and support to counselors (Williams & Haranin, 2016). The results of this study suggest that counselors are feeling frustrated and doubtful when providing counseling to adults with ASD. As found in Theme 4, support system, counselors greatly rely on supervisors

for support and guidance when they are struggling with a client with ASD. If supervisors are better able to understand ASD and the challenges that impact the counseling process, then they will be better able to guide and empathize with the counselor.

One of the biggest issues in the counseling profession is the lack of trainings available about ASD to counselors. Counselors who have been working with adults with ASD need to be encouraged to provide other counselors with training about the challenges in working with adults with ASD. Group supervision/consultation for those working with adults with ASD could be offered so counselors have a place to consult with colleagues who have a thorough knowledge about the struggles in working with adults with ASD. Furthermore, counselor feelings of frustration, doubt and anxiety need to be normalized and accepted as part of the process when working with adults. The lack of education about the ASD issue is evident throughout the mental health field. If counselor educators can start the process of including intellectual disability issues throughout core counseling curriculum, then hopefully by the time counselors-in-training graduate, they will have the knowledge necessary to start counseling individuals with ASD. This will start a chain reaction of knowledgeable and skilled counselors in providing services to the ASD community. Those counselors go on to become supervisors and are better equipped to educate and supervise other counselors on how to counsel adults with ASD. Once this occurs, more adults with ASD will receive the care they urgently need.

Personal Connections

One surprising result of this study was the participants' connection with ASD through their personal histories. Two main branches of previous connections to ASD

emerged: connection through a family member or friend and connection through a

previous job. Four participants had a connection to ASD through a family member or

friend and seven had a connection to ASD through experiences in a work environment.

The participants stated that these previous experiences propelled, inspired and "sparked

an interest" in working with people with ASD. Two participants initially had a negative

experience with a group of adults with ASD, and they both questioned if ASD was a

population that they would want to work with. However, when given the opportunity to

counsel an adult with ASD, they took it and stated that they "greatly enjoy it" and "I love

it." Six of the participants shared that they have a "passion" for working with individuals

with ASD. Currently, the literature does not provide data or information about counselors

who do not or who do choose to work with adults with ASD and their personal histories

with individuals with ASD. No comparison exists; this study's findings are the first. The

intergroup contact theory suggests that personal interaction with members of a negatively

stereotyped group generally decreases negative attitudes towards that group (Allport,

1954). Seo and Chen (2009) reported that people who had regular contact with

individuals with disabilities had more optimistic attitudes towards them. On the other

hand, students showed negative attitudes towards individuals with developmental

disabilities and more positive attitudes towards individuals with physical disabilities

(Barr & Bracchitta, 2015). But, the more contact with a specific disability the person had,

the more positive attitude they had toward that disability. If a person had greater contact

with an individual with a developmental disability it was associated with higher

confidence and lower misconstructions (Barr & Bracchitta, 2015). Sadly, students in

undergraduate psychology programs reported having the least amount of interaction with

and the more negative attitudes towards individuals with developmental disabilities (Barr & Bracchitta, 2015). Strike, Skovholt, and Hummel (2004) found that when mental health professionals have more experience with people with disabilities, then they reported that they felt more competent to work with them. This was reflected in the participants in this study, as all of the participants shared a background of personal connections with individuals with ASD. The participants who had been counseling adults with ASD for a longer period of time reported less feelings of doubt and inadequacy; whereas, the participants who were still in training and new to counseling adults with ASD reported more feelings of inadequacy counseling adults with ASD. I could surmise that if counselors had more education and interaction with individuals with ASD, it is possible to conclude that they might be more willing to provide counseling to adults with ASD.

It is possible that the stigmas, fears, and apprehensions about working with individuals with ASD were extinguished when the participants had personal connections or experiences with someone with ASD. Preconceived ideas about adults with ASD and fear might stop a counselor from accepting an adult client with ASD. The research suggests that contact with an individual with a developmental disability can positively influence the person's perception on them (Barr & Bracchitta, 2015). Weiss et al. (2010) suggested that educators should include individuals with developmental disabilities in in-house clinical experiences and external practicum experiences. With this in mind, counselor educators can also increase counselor-in-trainings' exposure to individuals with ASD through the use of guest speakers, in-house trainings specific to counseling ASD, encouraging students to seek out practicum sites that primarily work with developmental disabilities, and offer extra credit or develop assignments requiring

experiences with individuals with disabilities, including individuals with ASD. Moreover, counselor educators could promote their on-site counseling clinics to organizations that serve individuals with ASD at the university and in the local areas; therefore, more individuals with ASD will attend counseling at the on-site counseling clinic and give students more exposure and experience.

Counseling Methods

Five participants reported that they use a cognitive behavioral approach to counseling adults with ASD, four stated they use a humanistic approach, and one used an eclectic approach. Cognitive-behavioral therapy (CBT) has been shown to be effective for treating youth with high functioning ASD and anxiety disorders (Vasa et al., 2014). The CBT is showing some promise of relief for adults with ASD and co-occurring anxiety disorders (Scattone & Mong, 2013; Spain et al., 2015). The CBT modifications are suggested by numerous research articles to account for the unique needs of adults with ASD. Modifications include use of written or pictorial methods, identification of emotional words, specialized outcome measures, emphasis behavioral changes and skill development, less Socratic style, using role plays, visual cues, using a computer to communicate, structuring time, increasing social opportunities, adjusting session times, making sessions more concrete and practical, directive approach, offering office rules and detailing use of office procedures, teach social skills, coping skills, time management, problem solving, relaxation skills, and assertiveness training (Anderson & Morris, 2006; Gaus, 2011; Spain et al., 2015; Walters et al., 2016; White et al., 2018). Although the participants did not state explicitly that they were using modifications with their adult

client with ASD, they were describing the use of modifications to their process regardless if they used a CBT approach or a humanistic approach.

In the study by Anderberg et al. (2017) counselors reported using a variety of counseling orientations including person-centered, emotion focused, CBT, and acceptance and commitment therapy. The adults with ASD improved just as much in therapy as their neurotypical peers. This suggests that it did not matter what theoretically orientated approach the counselors used, all the adults with ASD improved, and reported fewer distressing symptoms. It is unknown if the participants' clients in this study would report if counseling is helping them or not. Some of the participants discussed success stories. Isla reported that she uses a person-centered humanistic approach to counseling. She recounted a client who is now in college making straight A's, has a romantic partner, driving his own car, and overall doing well. She narrated: "I'm always like curious, I'm like, 'Okay, what was effective? What actually worked?' and again, I remember him telling me I was like, 'Well, what helped do you think?' 'You just telling me that I could do it.'" In this powerful quote, the client needed support and having someone tell him that he could do it helped him heal. Isla believes it was the "validating environment" that made all the difference for this client. Every client story might not have the same ending, but this is an example of how person-centered humanistic approach can improve functioning for an adult with ASD similarly to the study by Anderberg et al. (2017).

Eight participants discussed their style as being direct or "straight to the point." Several described how they structured sessions including Isla who used an "agenda board," so the client could make an agenda for the session thus they could stay focused.

Cora described how she asked concrete statements and asked "clear and precise" questions. Hallie did the same. Hallie said:

> Just because the processing and things like that, generally, an adult with autism is a little bit more concrete, black and white in terms of perspective taking and so a lot of my language is a little bit more concrete, straight to the point, a little bit more clear.

Here, Hallie was describing her use of concrete, clear language when she works with adults with ASD. She uses clear measurable treatment goals so "that they can come into contact with success." Other modifications the participants mentioned were role plays, using diagrams, use of building social skills games and activities, visual cues, agenda boards, using computers to add to skill building, encouraging social interactions and creating opportunities for socializing, teaching life, social and coping skills, giving leniency about session scheduling, relaxation training in the form of mindfulness and grounding, and making sessions practical and using less Socratic therapeutic style. Participants did not mention or maybe they were not aware that they were implementing modifications that are congruent with the literature. Most of them stated they learned through experience and over time and learned what worked and what did not work for this population.

Three participants discussed the use of mindfulness and grounding techniques in their work with their adult client with ASD. One participant, Isla, was trained in dialectical behavioral therapy and used dialectical behavioral therapy skills in her individual sessions with adults with ASD. The dialectical behavioral therapy teaches mindfulness and emotional regulation. Isla discussed how she works with the client to devise a unique plan for practicing mindfulness in their own life. She stated:

> So, I met with him yesterday and he talked about how he liked using mindfulness, like even if it's for a little bit to just be mindful of the experience and just quietful eating, like tasting certain food or getting connected to nature, and he has some sensory issues when it comes to certain things . . . he doesn't like people touching him, very typical, and so I'm like, "What can we do?" and so he said he laid on the floor and felt the coldness on his back and it helped regulate the temperature.

In this quote, Isla had to be flexible in finding the best way for the client to practice mindfulness in the way that fit for the client. Dakota and Cora also used mindfulness, breathing exercises and visualizations with their adult clients with ASD. The use of these strategies in sessions with adults with ASD have been found beneficial in increasing overall wellbeing and decreasing anxiety and depression (Hartley, Dorstyn, & Due, 2019; Kiep et al., 2015; Spek et al., 2013).

Adults with ASD have high rates of anxiety disorders and depression (Hollocks et al., 2018). All 11 participants discussed their clients' comorbid diagnoses. Anxiety and depression was the most commonly discussed disorder, but other participants said that their client was diagnosed with a variety of other mental illnesses such as social anxiety, attention-deficit hyperactivity disorder, conduct disorder, bipolar disorder, and/or personality disorders. Jolette led a counseling group for adult men with ASD and sometimes the group members try to decipher the differences between ASD and depression. She stated: "they are really trying to understand 'What's autism?' and then 'what's me?' and 'what's depression?' and so every other week it's like, 'Oh, this is my autism' and then somebody else in the group is like, 'No, it's not, that's you.'" In this statement, the members of the group question where the lines are between ASD, depression, and who they are. The other members recognize that sometimes the behaviors are just the person and have nothing to do with ASD or depression. The mixture of ASD and other mental illnesses with personality traits can be very complex and can be difficult

to know where to focus goals and treatment. Counselors have to decide where to start. Cora explains how she starts a session with an adult with ASD with comorbid disorders. She reported:

> So, I always try to meet my client where they're at and so if they're anxious, I'm going to focus on that more so than the depression or the ADHD or the autism. So, whatever they're presenting with, that's what I'm attending to and if it is anxiety or if it is depression, I try to use terms that doesn't require so much like thought process and so I try to talk it down and tell them what I think they can understand. So, instead of saying, "You're feeling depressed today" or "What are your triggers?" I would say "You look sad today, what happened?" so come in, redirect it in a way that they're able to talk about it and be able to process it.

Here, Cora explained how she augments her word choices, so the client is better able to respond to her. But she has to concentrate on where the client needs attention first, sometimes it is the ASD symptoms and sometimes it is other mental health diagnoses symptoms. Even though comorbid disorders were not part of the research questions for the interviews in this study, all 11 participants shared their clients' struggles with other mental health diagnoses. These results support a large pool of research that shows comorbidity in ASD and other mental illnesses, primarily anxiety disorders and depression (Ghaziuddin et al., 1998; Gillott & Stranden, 2007; Hollocks et al., 2018; Maddox et al., 2018; Russell et al., 2005; Spain, Sin, Linder, McMahon, & Happe, 2018; Sterling et al., 2008).

As found in this research, counseling adults with ASD is different than working with a neurotypical adult. Counselor educators can teach counselors-in-training that typical counseling processes with neurotypical clients may not appear the same process with an adult with ASD. Modifications need to be made to the counseling approach to better fit the clients' needs. Counselors will need to teach social and coping skills, as well as life skills such as managing basic finances and job searching. Regardless of theoretical

orientation, adult clients with ASD showed improvement. This suggests that the therapeutic relationship is just as powerful with adults with ASD as it is with neurotypical clients. Participants in this study stated that they learned about ASD during courses that discussed applied behavior analysis and behavioral therapy. This shows a misperception that individuals with ASD can only be helped through a behavioral paradigm. Counselor educators can incorporate modifications to counseling with adults with ASD during discussions of other counseling theories and paradigms. Awareness needs to be brought to the high rates of anxiety and depression in adults with ASD. Counselors need to be assessing for comorbidity in any adult client with ASD including frequent suicide assessments.

Suicide Concerns

Research suggests that adults with ASD are at a high risk for suicide ideation, attempts and completed suicide than the general population (Hedley et al., 2018; Hirvikoski et al., 2016). Individuals with a high-functioning ASD diagnosis are at an even greater risk of suicide (Zahid & Upthegrove, 2017). Suicide ideation concerns were a main topic discussed by some of the participants. Seven out of the 11 participants discussed that their clients had suicidal ideation or had previously attempted suicide. Most of the participants' clients had not attempted but had suicidal ideation with no plan. Cora stated:

> I think it's more of the suicide ideation is coming in, I think they're feeling sad and so if they're feeling sad and they feel lonely but they don't really be able to identify it and so it's like "I'd be better off dead." I think that goes back to that executive functioning sequence. Most of the time, those that are going to talk about suicide ideation have depression as well.

Cora knew executive functioning was a common struggle with individuals with ASD and so creating and executing a suicide plan could be more difficult for adults with ASD. Therefore, many adults with ASD might have suicidal thoughts but do not create a plan. She noticed that many of her adult clients with ASD who talk about suicide also have trouble with depression. This statement is corroborated in the literature that individuals what ASD with comorbid depression are more likely to report suicidal ideation (Cassidy et al., 2014; Hedley et al., 2018; Zahid & Upthegrove, 2017).

Many of the participants noted that suicidal ideation presents differently in adults with ASD than it does in a neurotypical client. Kaia commented about her adult female client with ASD:

> I wouldn't have guessed but in other people I can tell in your neurotypicals, I can kind of tell. But her affect was so flat anyway I couldn't tell that she was anymore upset than normal or how depressed they are and what that means. Hers was high and so I would've known that way but I couldn't tell by the way she presented or talked or anything else.

In this quote, Kaia realized that in neurotypical clients she can observe their intense depression through their body language and speech. However, in her adult client with ASD, she could not tell that the client was having intense feelings of suicidal ideation. The client's affect was flat, and she did not show outward signs that she felt so depressed and wanted to die. Hallie also described how suicidal ideation may appear different in adults with ASD. She stated:

> I don't even know that with the way that our population [adults with ASD] processes it, I don't even know that suicide means the same sometimes for our population that it probably would for a neurotypical individual . . . be really careful of that but it's definitely sound and looks different than if it were a neurotypical individual.

Hallie had noticed that adults with ASD may be perceiving suicide in a different manner than a neurotypical person. Several of the participants commented that they use specific direct questions when assessing for suicidal ideation such as "are you going to go home and drink a whole bottle of codeine cough syrup?" Ella asks the client how the thoughts feel in their body and attempts to help the client discuss the suicide feelings from a physical approach. Isla found that for her adult client with ASD, his suicidal ideation was "very black and white thinking." The client had a negative experience and automatically thought "I just have to die." She felt frustrated that the client automatically jumped to suicidal thoughts and spend many counseling sessions working on helping him recognize other options when he his emotions are dysregulated.

A core deficit in ASD is social difficulties and disconnection. A couple of the participants noted that their clients were lonely. Bryan felt a sense of sadness over the "emptiness" in his client's life. He stated:

> I do often have a lot of sadness for him just because he is so lonely and his life is really kind of empty. I had him do a sandtray once, "just show me your world" and he literally put three things in there, like a building for his house, a building for school and a car and that's all that was in there. And I think that's a pretty accurate representation of what his life is like.

In this quote, Bryan felt sad that his client has such deep loneliness in his life. High levels of loneliness in adults with ASD have been indicted in the research. Depression and loneliness paired together are linked with higher rates of suicidal ideation (Hedley et al., 2018; Mazurek, 2014). Symptoms of depression and suicidal thoughts are exhibited differently in adults with ASD such as impulsivity, aggression, irritability, agitation, substantial emotional dysregulation, and anger (Chen et al., 2017; Kato et al., 2013). Two

of the participants discussed verbally aggressive clients who also showed significant

depression. Cora stated:

> I think he could really become angry and so there was always this built in
> awareness with me, like I was always keeping temperature on him because "Is he
> getting too mad, is he getting too aggravated?" because he had anger issues, and
> so I'm in the room with him and so I just scheduled when I wasn't the only one in
> the building and so we do like protective measures.

In this moment, Cora felt uneasy about the level of anger the client was exhibiting. Anger

and aggressiveness can be paired with depression (Spencer et al., 2011).

This study adds more evidence to the grave concerns of suicide in adults with

ASD. Counselors must be checking and assessing for suicide in every adult client with

ASD using direct, concrete, and clear questions. Using less open-ended questions, using

the physical body as a means to explain their feelings, visual scales, colors or pictures,

and charts are ways that a counselor can assess for the depth of the client's suicidal

thoughts and plan. Sometimes it is difficult to decipher if a client with ASD is having

suicidal thoughts, so a thorough assessment needs to be completed regardless if the client

is or is not showing external signs at the beginning of each session. Counselor educators

need to be aware the seriousness of suicidal ideation in adults with ASD and teach

counselors-in-training how to address and assess for suicidal thoughts and plan.

Counselors-in-training need to be vigilant about the client's feelings of suicidal ideation

masked under anger or aggression. Furthermore, if the adult client with ASD was

previously diagnosed with depression and/or discusses feeling lonely, than assessing for

suicide is even more imperative as these factors increase the suicidal risk. Overall, more

research needs to be completed to understand suicidal ideation in adults with ASD.

However, the research suggests suicide is a significant problem in adults with ASD and

counselors need to be the front line in assessing for suicide and providing interventions that decreases the client's suicide risk.

Counselor Self-Care

Two self-care strategies were identified in this research: professional emotional boundary and a support system. Self-care is an act of the prevention of burnout and impairment by caring for one's mental, emotional, physical, and spiritual wellbeing (Friedman, 2017). Nine out of the 11 participants expressed an emotional self-care boundary through self-talk by stating a variation of "this is not personal" or "this is not about me." These statements were designed to protect their inner thoughts and feelings from enmeshing with the client and the client's world. For example, when a client became verbally aggressive with Bryan he stated: "it wasn't personal and that there was a reason or a function behind his behavior towards me, his interactions with me." In this statement, Bryan was using an emotional professional boundary to understand the client's behavior and keep his personal feelings separate from the situation. These statements seem to be used as a strategy to protect their inner emotions, self-esteem, perception about others, and who they are from the potentially harshness of the client's dysfunction. Although this phenomenon has been discussed previously in other forms, the use of a strong professional emotional boundary is important with this population because of the potential blunt nature of adults with ASD. Many participants mentioned instances when the client criticized them in some form, not intending to be rude, but stating a fact or pointing out something. This population sometimes can use more forthright words and a counselor must have strong emotional boundaries to maintain positive regard for the client.

Counselors' internal emotional boundaries is similar to Skovholt's (2012) idea of empathy balancing when a counselor must "enter the world of the other" while simultaneously living in their own world (p. 140). The empathy balance is the counselor's skill of being present with the client yet separate and possessing the ability to fluidly move between the two during a counseling session. This study's findings show how the counselor is using an internal boundary as a tool for self-care.

Self-care for a counselor also includes seeking consultation from other professional support systems. Ethical standards encourage the use of case consultation when a counselor needs to seek out support (American Counseling Association, 2014). Consulting with other professionals and supervision is a form of counselor self-care (Bradley, Whisenhunt, Adamson, & Kress, 2013). Three participants discussed the use of supervision and eight discussed consulting with other professionals. Amy struggled to have empathy for her client's mother whom she described as constantly complaining about the client. Amy stated: "It's an area of growth for me and so I had a hard time understanding where she was coming from and so we talked about in supervision and in the group, so we talked about it a lot, to better understand her world." She was feeling frustrated, helpless and anxious, so she realized that she needed help from her supervisor and her supervision group. Ella described consulting with others as "venting" about the frustrations she feels during session. Previous research has indicated that case consulting with colleagues can decrease feelings of counseling exhaustion (Ducharme, Knudsen, & Roman, 2008). Consulting with others was one of the 10 essential resiliency tasks for counselors as outlined by Skovholt (2012) to prevent counselor burnout. Cora stated:

"I'm very glad I'm in a group practice because it's really easy to kind of get drawn into this world and not be able to separate from that."

Cora noted that having colleagues to talk to about her struggles with adults with ASD has helped her mentally and emotionally. The participants from the Rabu et al. (2016) study reported that supervision and consulting is something that is greatly needed throughout a counselor's life, not just for new counselors. Any type of self-care, especially using emotional boundaries and seeking case consultation, is the best remedy to prevent counselor ineffectiveness and harm to the client.

To my knowledge, this is the first description of the professional emotional boundary with this population. Working with individuals with ASD can be difficult, and counselors have to create a wall or a boundary to cope with the frustrations of the population. The use of emotional boundaries may be a tool used as a way to combat or prevent burnout by taking themselves out of the place of responsibility over the client's change process. When the counselor is no longer responsible for the client's choices, responses, emotions, and situation, then he or she is better able to respond with compassion. If the counselor is emotionally invested in the client's change or choices, then it is logical to conclude that the counselor may be suffering with burnout. Supervision is an ideal environment to discuss these emotional boundaries. Counselor supervisors should be aware of the existence of the professional emotional boundary and help strengthen those boundaries in their supervisees who work with adults with ASD. Furthermore, counselor educators can use the professional emotional boundary to teach new counselors-in-training that they are not always responsible for what occurs in the

counseling room. Counselors cannot take everything as an attack or against them, sometimes it is "not about me."

All in all, many of the themes and subthemes of this study could be tied to the current body of literature. However, some subthemes, such as the counselor emotional boundary, were a new emerging phenomenon. Research, education, and training about ASD are greatly lacking and the field of counseling needs to give more attention to the needs of adults with ASD. Counselors who work with adults with ASD need to be aware of the slow process and slower progress of these clients. Furthermore, the use of modifications into the counseling process is greatly useful for helping client progress.

Future Research

In this section I will describe some suggestions for future research. This research study answered the research questions; however, after examining the results more questions have arisen. The literature shows a lack of knowledge about two main populations: counseling professionals and adults with ASD. Currently, there is no research in the literature that examines what and how counselor educators are teaching about ableism, disability issues, and ASD to counseling students. Furthermore, it is also unknown what counseling students know about ASD; therefore, it is difficult to determine the extent of counseling student's knowledge about ASD when they graduate from their counseling training programs. Education about ASD in counseling program curriculum needs further exploration and refinement. A question that needs to be answered: How do counselor educators teach the skills necessary to provide counseling to adults with ASD? In turn, this also asks the question: How can supervisors be better skilled to provide supervision to counselors who counsel adults with ASD?

An area that warrants future research is counselor experiences who offer counseling to adults with ASD in other mental health settings such as government funded agencies, non-profit agencies, and hospitals. The participants in this study could be described as experts in the field of ASD and some actively recruited individuals with ASD to their practices. Therefore, they are a unique population. Future research could focus on counselors who are not experts in ASD and possibly are required to work with any client, such as an individual with ASD, even if they feel uncomfortable and unsure. Lastly, a gap exists in the experiences of counselors who provide any care to individuals with ASD, adults and youth. This research filled a small hole in the understanding of counselors who work with individuals with ASD; however, how counselors emotionally cope with counseling adults with ASD in other areas of the United States or in other countries is unknown.

The last area for future research for counseling professionals is the idea of professional emotional boundaries with adults with ASD that was discovered in this research. Professional emotional boundaries need to be fleshed out and examined in all counselors who work with different populations and in different areas. How do emotional boundaries work, and how do they differ depending on the functioning of the ASD population, setting the counselor works in, number years in the field, gender, etc.? Can better professional emotional boundaries be taught and if so, how?

Lastly, another area of research that needs an enormous amount of growth is the experiences of adults with ASD. A large portion of research focuses on children and adolescents with ASD and ignores the needs of adults with ASD. More studies are needed examining the lives of adults with ASD, specifically their experiences with

suicidal ideation and attempts. Counselors cannot know how to prevent suicide in adults with ASD if we do not know how adults with ASD are experiencing suicidal ideation. Studies need to look at suicidal symptoms and how they differ from neurotypical suicidal symptoms. Furthermore, future research needs to examine the effects of humanistic counseling on depression and anxiety symptoms in adult with ASD. Many studies look at CBT with anxiety; however, there is minimal information about the outcomes of humanistic counseling with adults with ASD.

Limitations

A few limitations existed in this study. Great lengths were taken to make sure this study was rigorous; however, limitations are a natural part to the research process. Limitations included geographical location, participant demographics, limited places of employment, and my own influences on the study. The first limitation is the participants' geographical location. Although a handful of clients were located across the United State, the majority of the participants were located in and around two major cities in Texas. Extensive recruitment methods were taken to find a varied population with experience with adults with ASD; however, snowball sampling and network sampling were used that attracted participants from the same region. This limitation could mean that participants possess similar backgrounds in education, training, and experiences. Furthermore, they have the same access to local trainings about ASD. Consequently, experiences might greatly vary for counselors who live in different regions of the United States. This limitation is important to consider when transferring the results to other counselors who provide counseling to adults with ASD.

The second limitation is due to the demographics of the participants. Two out of 11 participants identified as male. Additionally, in 10 out of 11 participants ethnic identity was White. One person identified as Black/African American. Counselors who identify as other ethnicities providing counseling to adults with ASD might have different experiences than the participants in this study. All of the participants reported working between one and 15 years in the counseling field. Experiences might differ for counselors who have worked with adults with ASD longer than 15 years and also might possess different educational and training backgrounds.

The third limitation is the restricted variety of participant employment locations. Although I attempted to recruit participants from varying locations, nine of the participants worked in a private counseling practice. Two out of 11 participants reported working in an agency setting, and one person worked in a private practice and a hospital setting. All of the participants who worked in a private practice setting worked in a group private practice along with other counselors. Counselors who work in other counseling environments might have diverse experiences providing counseling to adults with ASD and different opportunities for trainings focused on ASD. Some of the participants could be described as experts in the field of ASD as they actively sought out training and recruit clients with ASD through marketing. Many participants worked in a private practice setting and, most of the time they have more flexibility to accept the clients they want. The participants are passionate about working with individuals with ASD and, therefore, may have different perspectives on working with the population than other counselors who are given a client with ASD and do not want to work with them.

The fourth limitation is my own influences as I identify as a counselor who provides counseling to adults with ASD. The majority of the participants, and myself included, approach counseling from a process-oriented mentality. Although I attempted to bracket my preconceptions, my thoughts and beliefs could be viewed by the way in which I interviewed the participants. A counselor with a different approach may have opened up dissimilar discussions and followed up with questions leading the interview in a different direction. This study was also my first time to conduct a study; therefore, other mistakes could have been made without my knowledge.

Conclusion

Through a phenomenological exploration of the experiences of 11 counselors providing counseling to adults with ASD, four main themes were found, counselor reactions, previous experiences with ASD, counseling approaches and self-care. Each one of the themes answered the research question by providing an in-depth examination of the counselors' experience while providing counseling to adults with ASD. This study contributed to the body of literature by providing information about counselor's thoughts and feelings. Important findings illuminated from this study are listed below.

- Counselors are aware and sometimes feel frustrated with slower progress, the slow client-counselor connection and overall more time needed during the counseling process.

- Counselors struggle with how to balance the needs of the adult client with ASD and family members who are involved in sessions.

- Counselors believe they are not provided enough education and knowledge about ASD during their graduate counseling programs and lack trainings focused on counseling adults with ASD.

- Counselors who have a personal connection to individuals with ASD seem to be more willing to work with individuals with ASD.

- Regardless of the counselor's theoretical orientation, CBT or humanistic, similar modifications were used in counseling adults with ASD.

- Suicide is a significant concern in the adult with ASD population and signs of suicidal ideation may appear different than the neurotypical population such as through aggression.

- The emerging idea of the professional emotional boundary as a tool to safeguard the counselor's internal self-esteem, emotions and used as a self-care strategy. This is an important concept when working with the adult with ASD population to maintain empathy for the client.

This study's results presented that counselors feel frustrated and insecure at times, but they also really enjoy their work with adults with ASD. Participants also had previous connections to people with ASD and many did not have educational background or training in working with adults with ASD. These experiences highlighted the overall need for improved and more thorough education about ASD and support for those who already provide counseling to adults with ASD. This study explored the counseling approaches used and found that counselors find progress and general processing is slower with adults with ASD, social skills and experiential learning was used often, and participants found themselves being more direct and concrete with the client. This study also found a new

concept, professional emotional boundaries, and participants discussed this as a self-care mechanism to separate their own feelings from the client and the client's world.

Overall, this study found results that support the current literature and new information about counseling adults with ASD. This study outlines the benefits and empirical support to include more in-depth education about ASD into graduate counseling programs. I was profoundly impacted personally and professionally by carrying out this research project. I was in awe of the participants' dedication and passion about working with individuals with ASD. Even when they felt frustrated, angry, anxious, and doubtful, they continued to give what they could to their clients. I am very grateful to my participants for giving up their time and speaking their truth. This research has given me better insight into myself and helped shape my future professional goals. As I close, I want to end with a powerful statement a participant, Amy, said:

> I really try not to let the autism be the only lens that I look through and so I try and look through the lens of other things that he's describing but use that as maybe a clarifying one. . . . So, I allow that it [autism] to be more of an informant rather than a label.

Autism is the informant, not the label. It is not the sum of who they are. It is only a piece of information.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

DATE: June 11, 2019

TO: Jenna Mack, M.Ed.
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [1439543-2] Lived Experiences of Counselors Providing Counseling to Adults
                    Diagnosed on the Autism Spectrum: A Qualitative Phenomenological Study
SUBMISSION TYPE: Revision

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS
DECISION DATE: June 11, 2019
EXPIRATION DATE: June 11, 2023

Thank you for your submission of Revision materials for this project. The University of Northern
Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB
regulations.

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Nicole Morse at 970-351-1910 or nicole.morse@unco.edu.
Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of
Northern Colorado (UNCO) IRB's records.

APPENDIX B

INFORMED CONSENT DOCUMENT

UNIVERSITY OF
NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Lived Experiences of Counselors Providing Counseling to Adults Diagnosed on
the Autism Spectrum: A Qualitative Phenomenological Study

Researcher: Jenna Mack, M.Ed., LPC-S, RPT
Phone: xxx-xxx-xxxx   E-mail: jennamackmed@gmail.com

Research Advisor: Vilma (Betty) Cardona, Ph.D., Applied Psychology and Counselor Education;
Phone: (970) 351-1627

Purpose and Description: The primary purpose of this research study is to understand the lived
experiences of counselors who are providing counseling to adult client diagnosed with Autism
Spectrum Disorder. Participants will be asked to participate in two separate face-to-face
interviews or online Skype interviews. The first interview will be approximately one hour. The
second interview will likely take less than one hour. Furthermore, participants will be asked to
review initial findings to verify their appropriateness. No more than 3 hours of your time will need
to be spent on the entirety of the research participation. Upon completion, you will be given a
$15.00 gift card to Amazon. Counselors, counselor supervisors and counselor educators will be
the populations who will most benefit from the results of this study.

Risks to you are minimal. The risks inherent in this study are no greater than those normally
encountered during everyday discussions with colleagues. As with any discussion of experiences,
you may feel anxious, sad or frustrated during the interviews. I encourage you to seek support
from supervisors or a consultation group as needed. Costs include travel expenses to and from
an in-person interview and time spent in the interview or reviewing data themes. The benefits to
you include gaining self-awareness and aiding in finding better counseling methods and
techniques to better serve adults with Autism Spectrum Disorder.

I will take every precaution in order to protect your confidentiality. I will assign you a pseudonym
and your name will not be included in any reports of the data. The individual interviews will be
audio recorded for transcription purposes using a handheld digital recorder. Your recorded
answers will not be identified with your name and will be erased after data analysis. Only the
lead investigator will know the name connected with the pseudonym and when the findings will be
published, your name will not be used. Data collected and analyzed for this study will be kept
behind in a lacked cabinet in the office of the principal investigator.

The only potential exception to confidentiality is if you disclose to me a behavior or action that 1)
violates ethical guidelines according to the American Counseling Association (ACA) Code of
Ethics, and 2) has substantially harmed, or has the potential to substantially harm a client.
Congruent with ACA guidelines, I will do my best to address this concern with you before
informing the appropriate entities (such as the state licensing board).

Participation is voluntary. You may decide not to participate in this study and if you begin
participation you may still decide to stop and withdraw at any time. Your decision will be
respected and will not result in loss of benefits to which you are otherwise entitled. Having read

the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact Nicole Morse, IRB Administrator, Office of Sponsored Programs, 25 Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

_____

Subject's Signature   Date

_____

Researcher's Signature   Date

APPENDIX C

DEMOGRAPHICS SURVEY

Participant Demographics Survey

1. What is your age?
   a. 20 and younger
   b. 20-30
   c. 31-40
   d. 41-50
   e. 51-60
   f. 60 or older

2. What is your Ethnicity?
   a. White
   b. Hispanic or Latino
   c. Black or African American
   d. Native American or American Indian
   e. Asian/Pacific Islander
   f. Other

3. What is your Gender?
   a. Male
   b. Female
   c. Other
   d. Choose not to answer

4. What is your employment status?
   a. Part-time (20 hours) or less
   b. Part-time (20 hours)
   c. More than part-time and less than full-time (40 hours)
   d. Full-time (40 hours)
   e. More than full time

5. Where do you work?
   a. School
   b. Private practice
   c. Agency
   d. Hospital
   e. Government
   f. Multiple settings
   g. Other: _____

6. What is your educational background?
   a. Master's Degree
   b. Ph.D.
   c. Other

7. What is your counseling license? _____

8. How many years have you been a counselor in practice?
   a. Less than 5 years
   b. 6-15 years
   c. 16-20 years
   d. 21 or more years

9. How many adult clients are you currently seeing with Autism Spectrum Disorder?
   a. 1
   b. 2-5
   c. 6-15
   d. 16 or more

10. How many clients do you currently have on your caseload?
    a. Less than 5
    b. 6-15
    c. 16-25
    d. 26 or more

11. How many hours of training did you receive about Autism Spectrum Disorder in your graduate program?
    a. None
    b. 1 hour or less
    c. 2-5 hours
    d. 6 hours or more

12. How many hours of training did you receive about Autism Spectrum Disorder after graduation?
    a. None
    b. 1 hour or less
    c. 2-5 hours
    d. 6 hours or more

13. How many years have you been offering counseling to adults with Autism Spectrum Disorder?

a. Less than 5 years
b. 6-15 years
c. 16-20 years
d. More than 21 years

14. What is your primary theoretical orientation?
    a. Family Systems
    b. Cognitive Behavioral/Behavioral
    c. Humanistic
    d. Psychodynamic
    e. Eclectic
    f. other

APPENDIX D

RECRUITMENT E-MAIL

Hello! My name is Jenna Mack and I am a doctoral candidate in the Counselor Education and Supervision program at the University of Northern Colorado. I am seeking participants for my dissertation study exploring the lived experiences of counselors who provide counseling to adults diagnosed with Autism Spectrum Disorder.
Participant criteria:

- Graduated with a master's degree/Ph.D. from a CACREP accredited university
- Hold a state counseling license (ex. LPC, LPC-Intern, LPCC, LCPC, etc.)
- Currently providing counseling to an adult diagnosed with Autism Spectrum Disorder

Participants will be asked to participate in two separate 60-minute interviews either conducted face-to-face or through online video communication software, Skype. Participants will also review initial themes during analysis to check for accuracy by e-mail. Involvement in the study will take no more than 3 hours of your time. Participants will receive a $15.00 gift card to Amazon.com upon completion of the study. Currently, our field is greatly lacking knowledge about counseling adults with Autism Spectrum Disorder. This study's results will aid in understanding counseling practices and how counselors can offer better mental health care to adults with Autism Spectrum Disorder. If you are interested in participating, or if you have further questions, please contact the primary investigator, Jenna Mack at Jennamackmed@gmail.com or (xxx) xxx-xxxx. Furthermore, feel free to forward this e-mail to any individuals you think may fit the criteria of this study and would like to participate.
Thank you for your consideration!

Sincerely,
Jenna Mack

APPENDIX E

INTERVIEW GUIDE PROMPT

Disclosure: I will be asking you to discuss experiences with a client with ASD. Keep in mind confidentiality is paramount, so please omit identifying information about the client.

I understand that discussing relationships can be difficult and at times distressing. If at any moment you are distressed, we may take a moment to slow down or take a short pause. You have the power to stop this interview at any time. Listen to your emotions and let me know what you need.

Prompt: Think back on a session you had with a recent adult client with ASD that stands out to you that felt as though there was some movement in the relationship. Imagine you are back in that moment- relive your internal and external experiences. Be in that moment.

1. Tell me about this experience.

2. What were you thinking?

3. What were your emotions?

4. What bodily sensations did you experience or notice the client experienced?

5. How did this experience impact you professionally?

6. How did this experience impact you personally?

7. Have you shared everything that was important about this experience?

APPENDIX F

INTERVIEW TWO QUESTIONS

Interview Follow-Up Questions: Interview Two

1.   Tell me about your thoughts and reactions after the last time we met.

2.   Tell me about your experiences with your client with ASD from the last

time we talked.

APPENDIX G

INITIAL THEMES SENT TO MEMBERS AND
PEER REVIEWER

Research Question: what are the lived experiences of counselors providing counseling to adults diagnosed with ASD?

1. **Counselor Emotions**
    a. Positive emotions
    b. Negative emotions

2. **Previous Experience with ASD**
    a. Education
    b. Personal experiences

3. **Counseling Approaches**
    a. Counselor characteristics
    b. Therapeutic relationship
    c. Counseling style
    d. Unique aspect

4. **Self-Care**
    a. Self-talk
    b. Support system