1 Presuming Competence and Capability

One of the first steps in effectively treating clients is to understand how our approach influences the therapeutic relationship. The approach we take with clients is informed by our personal preferences, chosen theoretical orientation, mentors, research in the field, a variety of professional experiences, and systemic factors (Erford, 2018). This chapter will specifically review the importance of presuming that our clients diagnosed with autism (ASD) are competent and capable. But doesn't this sound like a given? Absolutely, yes, it should be.

Yet, because of our historically entrenched ideas and inherent biases about ASD and other groups who have traditionally fallen into the "disability" category, it warrants an explicit review of why this is important (FitzGerald & Hurst, 2017). Unfortunately, like most people, mental health practitioners risk holding clients with autism to lower standards of achievement in many areas of their lives. Some may not think they can attain educational, work or relationship goals simply because of their ASD diagnosis (Artman & Daniels, 2012). Our inherent biases cannot be overlooked if we are to be at our best and fulfill our ethical obligations as practitioners to avoid doing harm or impose our own beliefs onto our clients (American Counseling Association, 2014). We have the potential to help significantly or harm depending on our own beliefs regarding autistic people. In one way this chapter serves as a reminder for us all that even though we may think we are presuming competence and capability in our clients, the work of monitoring our biases does not have a stopping point. We owe it to our clients, ourselves and our colleagues to refresh and reinvigorate our love for this work by learning ways to best acknowledge and address our biases.

But how do we move from simply taking on the mindset that our clients are competent and capable, to building this into our treatment approach? Guidelines and recommendations for taking action on how to build this mindset will be reviewed in this chapter. This starts with understanding the value of a strength-based approach and how to navigate the complicated clinical picture of splintered cognitive and behavioral skill sets. The chapter then reviews strategies that can help counselors best integrate these concepts into the treatment approach and provides a case example to highlight how this can be done in practice.

Starting with Strengths

In determining what actions to take in a competency and capability first approach to clients with ASD, this chapter will draw from best-practice, research-based recommendations for the general and ASD population. The first general recommendation is to assess and identify strengths from the start. How this can be approached specifically with ASD clients is discussed in how we can best identify both group and individual talents that will help guide treatment.

In order to implement this effectively we have to be intentional in the content and process of our initial contact with our clients. This can start simply and informally through initial screening and interviewing during which a counselor asks about their values, personal characteristics and aspects of themselves or their lives that they view as resources, and help to improve their mental health. Exploring both internal and external resources will be an essential first step to starting with strengths. It's amazing to witness the surprising encounter this affords clients who are used to starting and engaging in treatment that is typically problem-focused. It is in these clinical moments, that we're reminded about the importance of checking-in with ourselves and our colleagues so that we're delivering the best quality of care.

When considering how mental health professionals can deliver best-practices in care, it is critical to keep in mind that diversity among people diagnosed with autism is just as varied as with any other group of people. Because of this, each client should be treated based on individual experiences, strengths, and challenges. Acknowledging this at the outset of approaching all clients is helpful in order to avoid overgeneralizing or committing the common error of making assumptions about one person based on their association with a group (Sue & Sue, 2016). Therefore, acknowledging individual differences and unique abilities from the start of building the therapeutic relationship is key to success. But in understanding the tripartite development of personal identity on individual, group, and universal levels counselors go a step beyond that to understand commonalities across unique individuals (Sue et al., 2016). Therefore, an awareness of group similarities and characteristics that aid in our understanding of our clients is also important.

The neurodiversity movement is a cultural phenomenon that has shifted the neurological disability paradigm to a humanistic, strengths-based view on people diagnosed with a variety of conditions (Elder-Robison, 2017). As with many grassroots, cultural movements this one began and continues on because of the work of adults with neurodevelopmental and neurocognitive disorders themselves. Within this movement, treating ASD adults and children as a cultural group, much like those of minority race, ethnicity, or gender status, is an approach that honors and respects their experiences as a group that has been marginalized and discriminated against.

Yet the counseling profession has identified in research and clinical experience the importance of acknowledging the complexities of marginalized

groups (Sue & Sue, 2016). This is because many within these groups also hold privilege in certain areas that are vital to surviving and thriving. For individuals with autism, their privileges and strengths lie in many areas. Some examples are an incredible capacity for memorization or an ability to spend long periods of time attending to detail on specialized topics and skills. The criteria that makes them eligible for the disorder can become an asset or advantage when cultivated successfully.

Another factor of ASD privilege is that, often, the skills they embody are ones that non-ASD adults find uncomfortable, difficult, or even impossible to acquire. This creates a unique opportunity for people with autism to create a niche for themselves in different domains, including educational settings, the workplace, and social groups. For example, people with autism can be particularly skilled in different technological domains. Areas of the world in which prevalence rates of autism are above the norm, such as Silicon Valley – the technology hub of California – could be a result of a cluster of people with autism or the broad autism phenotype (BAP) finding a niche and succeeding in this industry (Van Meter et al., 2010).

Even though each person's strengths should be assessed and identified individually, it's helpful to have an understanding of several identified group strengths (Sue & Sue, 2016). These can serve as a foundation in guiding initial steps in assessment, from written, intake form questions to interview, screening questions used in the beginning stages of treatment. These strengths include but are not limited to those given in Table 1.1.

Early identification of the unique strengths exemplified by clients diagnosed with ASD is part of our responsibility as counselors and mental health professionals. Missing the opportunity to identify and cultivate these will

Table 1.1 Group level strengths of individuals diagnosed with autism

Identified strengths	*Source*
Tendency to be investigative and conventional in approach to work tasks	Lorenz and Heinitz (2014)
Creative, resilient and able to find meaning in life	Wehmeyer (2015)
Detail-oriented, specialized skills in particular area(s), ability to learn or study deeply	National Autistic Society (2016)
Logical in decision-making, independent thinkers, strong visual memory and processing skills	National Autistic Society (2016)
Direct communication skills; loyal, honest and non-judgmental	National Autistic Society (2016)

Sources: this list comprises a collection of common strengths as identified in the autism research, disability literature, and by professional organizations.

likely lead to an ineffective approach, therapeutic relationship and even stagnation in treatment progress. The strengths-based perspective that counselors highlight as part of our professional identity aligns well with this recommendation. It is vital for us to integrate this part of our training into our clinical view and approach in working with ASD adults (Grothaus, McAuliffe, & Craigen, 2012).

From Self-Efficacy to Self-Determination

Amongst the most important reasons that a strength-based focus is successful in the area of adult outcomes are self-awareness, self-efficacy, self-advocacy, and self-determination. Self-awareness is the ability to observe and know one's internal states and characteristics (Goleman, 2005). This at the core of identifying strengths and tailoring treatment for achieving positive outcomes. It is essential to accurately assess and identify the ASD client's strengths and challenges to improve quality of life outcomes (Mason et al., 2018). In clients for whom self-awareness is impaired, they may not have a clear picture of their own attributes, this will be one of the first steps in counseling. This is helpful to introduce by first focusing on one's own strengths and continuing this work by exploring ways that clients can also become aware of their potential for growth. For those who demonstrate higher levels of self-awareness, repeating, emphasizing, and learning how to build on these strengths will be a goal in therapy.

Self-efficacy is the belief one has about one's ability to accomplish or execute a task successfully (Bandura, 1977). A person's measure of self-efficacy often reflects different levels of confidence and capability depending on the context. Among a small sample of college students with ASD, most reported confidence in a few features of self-efficacy, including getting information and other people to listen (Shattuck et al., 2014). But fewer than half of these same students reported being able to "handle most things that come their way", a higher-level self-efficacy skill. Finally, those who identified racially as white and those who had better communication skills reported the highest self-efficacy. Racial minorities in college settings have long faced challenges in getting their needs met in higher education, which seems to be reflected in these results on self-efficacy among autistic students (Sue & Sue, 2016). Self-efficacy is a cognitive determinant that leads to exerting oneself, attaining goals and making decisions and should be a focus of intervention for adults with ASD. It could have far reaching effects in getting basic needs met and is viewed as the first step towards self-advocacy.

Self-advocacy is a person's ability to speak up, stand-up for or represent oneself (Adreon & Durocher, 2007). Without the acknowledgment of one's strengths and capabilities, taking action to effectively represent one's views or interests is a challenge. When a person with ASD is able to self-advocate for accommodations and disclose their needs, this leads to better academic, employment and relationship outcomes (Shore, 2004). By focusing on

strengths and taking action to build them, adults with autism can get their needs met in relationships, at work, and in the community. Without self-advocacy these possibilities are limited.

One of the best outcomes of counseling is when a client gains the self-advocacy skills of taking a stand, making a request and achieving their desired outcomes. Exploring the options from full to partial self-disclosure can open up the client's understanding of how to inform others of their needs. Full self-disclosure usually involves sharing a lot of details about one's diagnoses and medical history with accompanying paperwork in some circumstances (Shore, 2004). This kind of self-disclosure may occur in a workplace or formal setting in which accommodations are legally mandated. Partial self-disclosure is more limited in the amount of information shared and focuses on sharing characteristics about oneself that are important to know in order to get along well with others (Shore, 2004). This approach can be a good fit for clients who either reject their diagnosis or prefer to share more privately or generally about themselves. If a client can learn to disclose in a way that they are comfortable with, then their potential for sustaining a job, romantic partner or friends improves.

Self-determination is our natural ability to motivate oneself to behave in healthy and effective ways (Ryan & Deci, 2017). It allows people to be the cause of their own actions and freely make choices to meet their goals. Once a person experiences self-efficacy and successfully advocates for their needs, self-determination is the final step in building self-competence. Self-determination allows a person to be the change agent in the process of believing they are able to achieve and communicating those abilities (Wehmeyer, 2015). Therefore, the importance for building self-awareness, self-efficacy, self-advocacy, and self-determination will resonate throughout this guide.

In order to best understand our client's level of competence and capability in different domains, I will highlight the cognitive processes and behavioral components involved in a variety of ASD presentations. First let us review common schema presentations that lead an adult with ASD to demonstrate different levels of competence and capability. From there, we'll review the behavioral aspects of these clients that are commonly observed, which will help inform an effective way to approach and form a therapeutic alliance with them.

Cognitive Considerations

Adults with ASD have many years of childhood and adolescent experiences that help shape their cognitive processes. Depending on what occurred during their formative years, including family life, parenting dynamics, experiences in the educational system, and peer relationships, the manner in which they see themselves fitting into adulthood and how others will treat them have a significant influence. As it pertains to one's cognitive competence and capability, it will be helpful to explore the connection between schema dynamics and worldview.

Schema dynamics describe a triadic cognitive process including one's interpretation of self, others and the world. These schema dynamics are often connected to a person's worldview. Worldviews are comprised of one's reliance on internal or external loci of control and responsibility (Sue & Sue, 2016). This generally translates to how a person attributes responsibility and control in their lives, either to their own doing or factors outside themselves. Due to myriad factors, the results of schema dynamics and worldview of a client diagnosed with ASD present in a wide range.

On one end of this range are those who are self-assured, content, and have an exceedingly positive view of themselves and their fit in the world. Their experience during childhood likely involved supportive family members and effective parenting dynamics, academic success and relatively conflict-free experiences with peers. For individuals with these experiences they view themselves as in control and competent, others as helpful, supportive, and trustworthy and the world as a safe, trusting place. This resulting schema sounds like the best possible outcome. Yet, when amplified to an extreme this can lead to problems.

The results of this schema dynamic could lead an autistic adult to be overly trusting of others and be taken advantage of or have difficulty tolerating discomfort if they haven't had experiences that expose them to challenges with peers or in achievement-based settings such as school and work. It can also result in a scenario in which the adult views themselves as more independent than they are and, in some cases, entitled. They may often view others logically and with a purpose as resources who either help or hinder their ability to get what they want and meet certain goals. In my experience, those whose schema dynamics present at this end of the range have often been protected from adversity, which can lead to an inflated view of themselves, in which they are not realistic about their abilities (Lerner et al., 2012). They tend to be naïve about the impact of their interactions with others and the world.

At the other end of the schema dynamics range are adults with ASD who have more apparently negative outcomes. These are individuals who view themselves as helpless and hopeless, others as in control and power-wielding and the world as scary and unsafe. In this case, the adult clients have likely been treated as incompetent or incapable leading them to rely heavily on others for decision-making or guidance and can often minimize their own abilities. These negative views of the self, others, and the world can often lead to anxiety and depression, which can occur in up to 70 percent of adolescents and adults diagnosed with ASD (Lugnegard, Hallerback, & Gillberg, 2011; Hofvander et al., 2009). Many times, the core symptoms of ASD are contributors of these mental health concerns but some researchers posit that the way in which these adults were treated by primary caregivers as children and teens may play a more significant role (Durand, 2011). Both caregiver optimism and parenting or family dynamics will be explored further in Chapter 2.

In the first example of how an adult with ASD cognitively processes schema dynamics, the client may be unrealistic about what future goals can be accomplished and may expect others to be more flexible than they are

willing to be. In the latter case, clients can be defeated, untrusting and require additional focus and support to trust themselves and others, which typically involves treatment co-occurring diagnoses. These commonly co-occurring conditions will be reviewed in Chapter 4. Where a client ends up in this range of potential schema dynamics can lead to more and less functional ways of navigating adulthood (Sue & Sue, 2016).

If adults with ASD have been treated or labeled as a person with a disability throughout their lives, they will have faced stereotypes and discrimination that will impact worldview and schema dynamics. Being a part of this minority group, many will have likely faced ableism and mistreatment (whether mild or severe) based on their disability status. Depending on the frequency and intensity of these experiences, adults with ASD can be accustomed to being treated as incompetent or incapable. This is true for the group of autistic adults who do not closely identify themselves as someone with autism or even rejects their diagnosis. In some research this is as much as 30 percent of the population (Shattuck et al., 2014). No matter what the self-identification, it is our task as clinicians to help accentuate the positive and ameliorate the negative to help influence how the autistic adult conceptualizes themselves (Olkin, 2001).

Presuming that individuals with ASD are competent and capable may provide a corrective experience for clients who have faced a range of issues from minor microaggressions to significant discrimination. When counselors and mental health professionals approach their clients by establishing an egalitarian relationship in which the client's personal voice is honored, this may be quite different to how they've been treated by many others in their lives (Sue & Sue, 2016). From those with both good and bad intentions, it could be likely that others have spoken for the person or on their behalf for most of their lifetime. This can be particularly true in the domain of getting psychological, social, and emotional needs met throughout their lives. Depending on the client's internal resources, such as motivation, level of insight and judgement, and external assets such as parents, siblings and others, a confluence of factors occurs that often ends up precluding the person with autism from having their voice heard in these matters. They need to be given this opportunity and being in counseling may be one of their first opportunities for this to happen.

Individuals with autism can be particularly confusing for others because of their clear strengths in some areas and significant deficits in others. This applies to both the behavioral mannerisms and social communication. The next section details how complex the differences in skills can be when examining the competencies and challenges of autistic adults.

Behavioral Peaks and Valleys: Understanding a Splintered Skill Set

One of the core symptoms of autism is the behavioral challenges individuals' exhibit, with restricted or limited interests and repetitive, stereotypic behaviors.

Yet, we all have specific interests which contribute to our quality of life, and behaviors we engage in that are routine and their repetition helps organize our lives. One way to conceptualize the behavioral symptomology of autism, from the stance of presuming competence and capability, is as an intensified presentation of the behaviors many of us naturally display. The extreme male brain theory of autism has found neuroscientific reasons to validate that people with ASD, both females and males, may have accelerated male features (Baron-Cohen, 2002).

In working with our clients we need to be able to understand how their behaviors might be impacting capability and competence in certain areas. One barometer for determining if behaviors are having this impact is when their interests are so limited and behaviors highly repetitive and intense that it interferes with their success in areas of their life where they would otherwise be capable and competent. This can be quite impairing in cases when inordinate hours are spent engaging in an eccentric activity that interrupts arriving at work on time or engaging in family events. But in other cases, these interests can be fairly mainstream and channeled productively in working environments and social contexts that naturally fit well together. Generally speaking, when interests and behavioral patterns are stereotypic and rigid, adults with ASD will likely experience fewer challenges (Garland, O'Rourke, & Robertson, 2013). Yet, within the behavioral presentation of ASD there are complexities due to a splintering of skills that lead to obstacles in life and treatment.

It is helpful to explore and understand the splintered behavioral skill sets that clients with ASD exhibit. Our clients are highly skilled in some areas and stunted in others. How can we best navigate ways to modify treatment to address both the high and low performing skills on splintered ends of the spectrum? The splintered skill set that people with ASD present with, can be naturally confusing for mental health professionals, parents, and others interacting with them (Seltzer et al., 2005). The advanced ability to perform in some areas while having significant challenges in others leads many to make assumptions based on low or high levels of performance that are observed. Most of us expect a more consistent match in performance. Therefore, when a person with ASD excels in academic writing skills and interacts effectively with teachers and older adults, but then struggles with oral presentations and cannot function well with peers, observing these differences in performance can be perplexing.

Declarative and procedural knowledge tends to be uneven for individuals with ASD, with better reported performance in declarative than procedural knowledge (Bellini, 2008). How this presents itself is that the adult with ASD is often well able to describe a skill but then when required to enact or perform the skill themselves problems arise. Therefore, it is important to keep in mind that even though the "right response" might be given when asked about a particular subject it is likely we haven't gone far enough in our inquiry. An additional step that would require the skill to be demonstrated or

performed will give the most accurate representation of the comprehensive skill that person embodies.

We as counselors can also have declarative and procedural knowledge gaps when we know about the concepts but find it more challenging to act on these in therapy. With a firm grasp on the cognitive and behavioral patterns that autistic adults can present with, let's now move from a conceptual framework of presuming competence and capability to demonstrating it. The following are specific interventions to be integrated into our approach as practitioners to ensure we are clearly communicating that we believe our clients are capable and competent.

Clinical Interventions

There are historical and diagnostic contexts that help explain why adults with ASD have been perceived as less competent and capable than they have the potential to be. In creating a strong therapeutic relationship and corrective experiences with autistic clients there are specific ways to avoid the mishaps we've historically fallen into. At the core, this starts by shifting the clinical mindset to a strengths-based perspective. Yet, to expand beyond a mindset shift there are interventions that can be specifically applied to reflect this. These include the integration of empowerment models of counseling, making intentional language choices and using teaching methods that encourage personal agency and power.

Empowerment Counseling

Counseling and quality of life outcomes are enhanced for people with disabilities by improving self-confidence and empowering the client to actively engage in decision-making processes about their lives (Artman & Daniels, 2010). The concept of empowerment is more complex than it might seem. It both incorporates and goes beyond self-efficacy and self-determination through its incorporation of several steps, ideas, and goals for clients. One definition authored early on in the counseling literature describes empowerment as growth in skills, improvement in understanding one's role in power dynamics, identifying oneself with similar others and participating socially and in the community to empower others (McWhirter, 1991). The complexities identified in this definition involve several of the essential steps in helping adults with ASD increase skills, self-awareness, social belonging, and advocacy. This is one of the reasons that the empowerment model of counseling is a helpful tool in presuming competence and capability with ASD clients.

Building an egalitarian relationship with a client diagnosed with ASD should not differ significantly from the one you would build with clients from other groups who have faced marginalization and discrimination. Addressing the power dynamic between the privileged counselor and marginalized client is one of the first steps to ensuring a culturally competent approach (AMCD, 2015).

This can include at least one question during initial intake and assessment that helps review their experiences, in recent and long-term history depending on one's theoretical orientation, of being a person with ASD. For example, "How has your diagnosis impacted the way that other people in your life treat you?" Or "In what ways does your ASD diagnosis effect your relationships?"

Be mindful that some clients with ASD may strongly identify with the diagnosis in a positive way, in which is it is a point of pride in their identity, while others reject it. For those who reject the diagnosis, it will be important to approach these questions in a manner that gives the client space to have this reaction, and consider their reasons for seeking help as attributed to factors unrelated to symptoms of the diagnosis. Being able to respect the full range of reactions to a client's identity as a person with autism will be helpful in establishing an egalitarian dynamic in the therapeutic relationship. If the client rejects the diagnosis, taking on the position of attempting to convince them that it is important or relevant to treatment is likely to be ineffective. It may also have the counselor engaging in repetition of a theme from the client's lives that will impede productivity within the relationship and, ultimately, in treatment outcomes.

Allowing our clients to make their own decisions, from how they identify with their diagnosis to collaborating on treatment goals, is essential in empowering them in the counseling context. We can also help empower clients by assessing what needs they have that aren't fulfilled and by working through ways of fulfilling them. People with autism may have never been asked, "What's happening in your life that you'd like to improve or change for yourself?" This puts the client in the position of power in deciding what they'd like to improve in their lives and the practitioner can be the guide for how treatment can help them accomplish this.

Language Matters

As we encourage our clients to make decisions and find power, it is important that we model healthy and helpful language choices throughout the treatment process. The choices we make about the quality and quantity of language we utilize with clients can make an impact (Sue & Sue, 2016). In quality it is important as practitioners that we are intentional and deliberate about the kind of language, both verbal and nonverbal, we use with our clients. In quantity a helpful rule of thumb could be "the fewer words, the better". Making oneself clear, direct and concise in how we communicate with our clients will impact the quality and quantity of our language and likely be more successful in our interactions with autistic clients.

One matter of quality in our language pertains to a client's chosen identity. As discussed earlier, the use of person first language is a best-practice, clinical recommendation to decrease the stigmatization of those diagnosed with myriad mental health disorders. Yet, for some clients, their positive association as an autistic person can have mental health benefits and, if this is their

chosen identification, our language should reflect that (Olkin, 2001). These clients will likely prefer identify-first language instead. Asking clients how they would like to be identified in this way, based on assessing their feelings related to their diagnosis is a good place to start. On the other hand, there are clients who experience rejection, anxiety, or depressive symptoms when they learn about their diagnosis (Academic Autistic Spectrum Partnership in Research & Education, 2018). For these clients, using person-first language may be a big leap towards encouraging self-acceptance without taking on the former label of "autistic". We should be able to challenge our own hesitancies about directly asking questions to clients with autism in order to honor their identity and demonstrate our own competence with this population (Olkin, 2001). Ultimately in this linguistic matter, the client's identity should be the determining factor and clinicians can adjust their language accordingly, just as we would for clients with other identities.

In the initial stages of treatment, when we are beginning to understand how clients identify in many ways, beyond their diagnosis, it is helpful to develop a set of interview questions that deliberately allow a client to discuss the areas in which they are competent and capable. These initial interview questions will naturally include, "Tell me more about why you're seeking counseling at this point in your life." Or, "What is the problems in your life that led you to counseling?" Whereupon clients are likely to be problem-focused in their response. The information gleaned from these kinds of questions is an invaluable and standard step in the therapeutic process. Therefore, the addition of strengths-based language in questions will be helpful. This could include "What is your favorite thing to do on the weekends?" Or "I'm wondering what characteristics you have that will make you successful in counseling?" These offer the opportunity for clients to discuss qualities about themselves and their lives they consider positive resources and it provides them with a different treatment experience.

Beyond the intentional focus on how we describe a client's identity and speak with intentionality, it is helpful to make deliberate choices about how our nonverbals impact the ability to demonstrate that our approach presumes competence and capability. The nitty, gritty details of "what we do not directly say" are included here and are often hard to identify in ourselves. These nonverbal communication tools start with wording or phrasing on a professional website or social media profile, initial paperwork and intake forms, and go on to include the body language and facial expressions we use that we are often not aware of.

In order to consistently take a strengths-based approach with our nonverbal language choices, intake forms should include questions such as "What are some good things happening in your life currently?" Or "Please list your top three strengths." Additionally, we should incorporate assessment tools aside from those used to measure ASD symptomology to identify areas of strength. Given the previously identified group strengths (Table 1.1), some potential choices could be the Brief Resilience Scale (Smith et al., 2008) or

The Meaning of Life Scale (Steger et al., 2006). Incorporating assessments that clinicians and clients can utilize to guide treatment that don't focus only on their symptoms or inadequacies, directly communicates to clients that we have a plan to help identify and monitor their positive attributes while ameliorating their presenting symptoms. These two things can and should be done simultaneously to demonstrate that we presume they embody both.

Teaching Methods

A basic counseling skill that most therapists are trained to use early on can be one of the most effective tools in communicating to our clients that we believe they are capable and competent. Socratic questioning, when executed well, communicates to our clients that they have the answers to important questions and the ability to contribute their ideas to the counseling process. But this technique often gets misused or applied superficially, which prevents it from being the powerful tool it has the potential to be.

One necessary assumption for effective Socratic questioning is that the client knows how to come up with a response. Even if the response isn't accurate or what the counselor is looking for, getting them to contribute through co-construction honors their abilities (Sue & Sue, 2016). We need to carefully construct the questions we pose, for a response they are likely to be able to provide and are validated by. The responses that the clinician then provides need to be affirming and encouraging, even if it's not the response we are looking for. This helps the counselor attend to the working alliance and connect the client's thoughts into the counseling process. It does not preclude us from working toward more accuracy when we provide psychoeducation or skill training, but this first step helps us eventually get to providing corrective feedback.

Effective Socratic questioning is based on the scaffolding of knowledge, so the questions we begin with should be based on what we know about our client's capabilities. Questions can be individualized to the client based on a variety of factors. Yet there are some question stems that you can use as tools to individualize through the client's response. If you use these question stems with repetition your clients will become accustomed to the method and can gain mastery in responding accordingly. My colleague Dr. Liz Laugeson teaches one of my favorite Socratic question stems, which is, "What could be the problem with _____?" Depending on the therapeutic goal or activity, the blank at the end of the question could pertain to any problematic situation you elicit or the client reports. Other Socratic question stems that might be helpful include, "I'm curious about what you positively contributed to _____?" "What did you do well?" Or "What would you do differently next time?"

Encouraging Personal Agency and Voice

The life experiences that an autistic adult is exposed to will lead them to different levels of dependence and communication. Whether it's out of force or by choice, family members often take on the voice of their adult loved one. In some cases, this can be incredibly helpful, while for others it has inhibited them from building and practicing the skill of communicating one's own needs. I've seen this manifest in adults with ASD in verbal and nonverbal communication. Examples of these are frequently responding with, "I don't knows" or just saying "yes" as an easy out of the conversation. Nonverbally this can show up for the client when, in response to a question, they physically look to a family member or support person to step in to share on their behalf.

Given that family members cannot always speak for or advocate on the behalf of adult with autism it's important to provide opportunities for the client to learn about their own decision-making abilities (agency) and how to effectively use their voice. Depending on the client's support system (Chapter 2) the method for approaching this will vary. One of my client's goals in therapy is to tell his parents "Hey, let me talk" so that he can demonstrate his competence and capability of communicating his needs within the family. Due to a history of him shutting down in social situations, his system has gotten comfortable with jumping in to explain things on his behalf, so this shift is significant for both the client and his family members.

As clinicians we need to be comfortable, reflecting our observations of the client and their support system regarding what patterns have developed that can help or hinder personal agency and voice. Several of the steps toward independence (Chapter 10) will directly promote these principles. For some adults it will start by making decisions in therapy, shifting from the counselor communicating with the family and getting the client to directly communicate therapeutic messages to them or setting limits on how much help they receive for different tasks.

Case Example

Paul is a 29-year-old, single, Caucasian, male who lives in a supported living apartment program with wrap-around services, including case management. During each session he presents as disgruntled reporting a lot of frustration with the amount of oversight and lack of independence he is afforded. He has been living in supported residences (with family or professional assistance) for the majority of his life. His interests are music, animals, and riding his scooter.

Some of the challenges that are immediately apparent when meeting Paul is that he has an atypical gait, poor hygiene and stereotypic hand ringing with repetitive arm movements. Unlike many of my clients whose autistic mannerisms present more mildly, Paul's symptoms of autism are moderate and, therefore, make him stand out. Because of traits that are attributed to autism,

his competence and capability is automatically assessed at a lower level. Unfortunately, his challenge with hygiene has led him to losing jobs and volunteer opportunities that he truly enjoyed. He has experienced some behavioral challenges recently during which time he becomes verbally aggressive towards others (i.e., yells demeaning statements to other residents), isolates himself in his apartment and over-eats. This has resulted in the loss of his roommate and a 26-pound weight gain in the last three months. He is seeking counseling and his parents and supported living staff are seeking consultation for ways to best help him. Both family members and support staff at his residence have exhausted their best resources in helping Paul become independent and improve his health with limited success.

When meeting with Paul he reports that "no one is listening to me" and "they won't let me do what I want to do". He explains that the main reason for his recent decline in mental and physical health is due to his recent job loss caused by his hygiene issues. This has resulted in him having to complete, what he considers, menial and "boring" tasks at his residence which he also believes prevents him from getting experience outside of where he lives. He also reports having expressed an interest in attending college "multiple times" and doesn't understand why his parents or coach have not supported this. His goals for coming to counseling are to lose weight, get a job and make friends in college.

During consultation with his parent and coach, they are supportive of his goals but express concern about the realistic nature of them. His weight has fluctuated in the past and they don't trust his ability to self-regulate food intake. They inform me that Paul's mild intellectual disability resulted in the attainment of an alternate high school diploma, which precludes him from seeking a college degree. They're also unsure of how independent he can be in work because of his hygiene problems. The supported living coach echoes these concerns and is additionally worried about how Paul's anger is impacting him and his peers.

One of the first steps approaching Paul and his support system in presuming competence and capability will be to hone-in on identifying his internal strengths and external resources to build self-efficacy and work towards self-advocacy. In order to do so, individual time to assess and develop goals with Paul, without his support system present, is important. As we meet individually, Paul talks about how much he loved his position with the local animal shelter and how much he misses it. He also reports being motivated to lose weight because he thinks girls won't like him because of his weight. Lastly, he does seem to understand that college will be a different experience for him than it is for his sister (who is seeking a degree from a large university), but he'd still like to try it out. He is more insightful about his strengths and limitations and motivated to change than even the counselor has presumed.

The next step is to collaboratively develop some ideas and goals to later present to his support team. The first is that he can begin to earn money working in a nearby retirement community by dog walking and pet sitting.

He plans to go to apartment buildings to post flyers offering his service and charge a competitive fee that we research in session to determine. Regarding his weight, he's willing to enroll in a weight loss program that will help him track his food intake and incorporate mild to moderate exercise into his routine. He is also interested in participating in his residence's local garden to learn more about vegetables and to get physical exercise. Lastly, because he knows he is not eligible to pursue a college degree, we discuss the possibility of auditing one college level course in music, a special interest of his, at a local community college. Each of these goals was originated by him and modified in counseling through Socratic questioning so that his personal agency and voice is honored.

In the next phase of treatment, Paul and I join his support team including his parents and supported living coach to get their feedback. The reality is that in order to meet these goals he needs his parents and coach to buy-in so they can support him emotionally, financially, and energetically. During this session, Paul presents his ideas, in a way in which he behaviorally rehearsed in individual sessions leading up to this, yet during many moments he finds himself at a loss for words or the skills to express himself.

There are some helpful tools for helping to promote his self-efficacy (he's at a loss due to his belief that he can't communicate with them effectively) and self-advocacy during this joint session with the family. One way to apply Socratic questioning in this session will be to minimally help facilitate reminders of his upcoming points. This is to ensure that reliance on the counselor or other supports is avoided and his independence is encouraged. For example, the counselor asks, "Paul, I wonder how you think you'll try and meet that goal?" The experience of successfully communicating his plan as independently as possible can influence his belief that he can do this effectively.

Paul is accustomed to other adults in his life speaking on his behalf or even, at times, over him. This leads to frequent redirection during the family session because Paul and his family tend to focus their attention back to the counselor and supported living coach. For example, when Paul blanks in explaining his plan, he looks in our direction in the hope that we might take over this part of the discussion. This requires patience and more time in planning sessions to allow for this adjustment, which aims to promote Paul's self-advocacy. The clinician needs to be comfortable using nonverbal responses to redirect Paul to answer questions himself. This can be done through a hand gesture (i.e., pointing to him or patting the table in his direction) and preventing sustained eye contact or reinforcing attention to the dependence on others to respond for him. Verbally the clinician may encourage by saying "You got this" or "It's up to you".

Once his sense of personal agency and voice are more strongly developed and demonstrated, it'll be important to focus on improving behavioral challenges that are negatively impacting him. Since he has been fired from work due to hygiene issues this is an important treatment goal. Collaboratively, Paul and his support develop steps that he can follow in the shower to be sure

he achieves cleanliness. The counselor assists in creating a visual aid and a plan for how much time he spends cleaning different areas of his body during a shower. Paul decides on favorite verses of Pink Floyd songs he can sing to, to make sure he spends about 30 seconds cleaning the most important parts of his body (i.e., armpits, genitals, hair). He also decides on songs he can play while he's in the shower that will help him with the total time he should spend thoroughly cleaning himself. The same is applied to toothbrushing. After a couple of weeks implementing this visual support and auditory plan for timing, Paul's hygiene improves. He still needs reminders to use dandruff shampoo, as his flakiness is an ongoing work in progress and potentially a next step in treatment once he masters current hygiene goals.

In the next steps in therapy, Paul exercises self-determination as he sets his own goal to lose weight. He decides to make changes to his diet and begin exercising in a serious attempt to become physically healthier and takes action quickly. A plan is co-developed with the treatment team but Paul leads the charge and demonstrates a high level of motivation for change on this particular goal. Through a scaffolded process of Paul believing in his abilities to succeed in different areas (self-efficacy) and self-advocating for what he needs in various settings he finally reaches the ultimate goal of being his own change agent. His family does not have to prompt him like they have in the past to motivate him to make changes and this shift in the dynamic is a positive treatment outcome when aiming to improve competence and capability. The reality is that when we treat our clients from a strengths-based perspective that honors their competence and capability, the potential for becoming more competent and capable in different areas of their life is possible.

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