CE

CONTINUING EDUCATION EFFECTIVE TREATMENT FOR AUTISTIC ADULTS

BY RACHEL FAIRBANK

For conditions such as anxiety, depression, and some other common conditions, therapeutic needs of autistic adults are not much different from those of anyone else. But many autistic adults report being turned away by practitioners. With minimal additional training and a willingness to learn, practitioners can include these patients in their caseloads.

CE credits: 1

Learning objectives: After reading this article, CE candidates will be able to:

1. Discuss psychological and societal challenges for autistic people upon reaching adulthood as well as for those diagnosed as adults.
2. Identify the basics of working with autistic patients and the importance of understanding their specific needs, instead of automatically referring them to often unavailable specialists.
3. Describe common strengths of autistic patients as well as skills for establishing trust with these patients.

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THE NEED FOR INFORMED PRACTITIONERS

Many autistic patients have reported that finding a practitioner who is willing to treat them for conditions such as anxiety, depression, or post-traumatic stress disorder is often a hard task, as many will refer them to autism experts with long waiting lists rather than accept them as patients. This leads to a situation where many autistic patients are not receiving the help they need, or they end up receiving help from practitioners skilled in working with autism who are not specialized in treating their specific mental health concerns. "They're missing out on cutting-edge, quality, evidence-based care," said Vanessa Bal, PhD, an associate professor of psychology at Rutgers University in New Jersey, whose research focuses on life outcomes for autistic adults.

According to Bal, if an autistic person is seeking out help from a practitioner, one way to approach this scenario would be to ask the question: Is the referral one you would be equipped to handle if the person were not autistic? For example, if an autistic patient is struggling with the loss of a loved one and seeks out a grief expert, or an autistic patient is dealing with a specific phobia and seeks out an expert in treating phobias, these practitioners are likely more equipped to offer them effective treatment than they might get from an autism expert. "Don't use autism as your automatic exclusion," Bal said.

Valerie Gaus, PhD, a clinical psychologist in New York who specializes in working with autistic patients, suggests approaching autism as one would explore any difference that shapes a patient's worldview and social interactions. "You need to know how autism has affected them, so you can understand how it has impacted their view of the world, but you aren't going to turn them away just because you didn't know about that before," said Gaus, author of the book *Cognitive-Behavioral Therapy for Adults with Autism Spectrum Disorder*. "It's the same thing."

MAJOR CHALLENGES FOR AUTISTIC ADULTS

When autistic people reach adulthood, they often face a number of challenges in the transition, such as losing access to the support services available to autistic youth and learning to navigate a new world of adult norms, which can be overwhelming even for non-autistic young adults. Autistic young adults may struggle with deciphering unspoken social expectations in the work environment; having to adjust for sensory differences such as heightened sensitivities to light, noise, or scents; developing and maintaining friendships and romantic relationships; or dealing with the general stress of navigating neurotypical social norms.

As a result of these challenges, burnout is very common in autistic adults, as are co-occurring conditions such as anxiety and depression. Autistic adults have

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a current and lifetime prevalence rate of 27% and 42% for anxiety and 23% and 37% for depression, which is thought to be due, in part, to the stresses of navigating a world that is not built for autistic people (Hollocks, M., et al., *Psychological Medicine*, Vol. 49, No. 4, 2019.) "A lot of this is due to pushing against your natural neurotype, to try and fit yourself into these roles that are expected of you, that leads to issues such as burnout," said Melody Marin, PsyD, an autistic psychologist based in Austin, Texas, who specializes in treating autistic adults.

When treating autistic patients, it is important to factor in the ways that their autism has shaped their experiences and affected how they interact with the world, which includes accounting for stressors such as dealing with stigma and discrimination; the discomfort posed by sensory differences; the confusion of trying to figure out allistic, or non-autistic, social norms; along with the pressure of trying to "pass" as allistic, which often starts at a young age. "Getting to know the person you are serving is going to be really important," said Paula Pompa-Craven, PsyD, a psychologist based in California who specializes in treating autistic teenagers and adults. "This includes considerations such as the underlying basis for specific behaviors, as well as their individual learning style, which can help build rapport."

In Marin's experience, the anxiety and depression that she sees in her autistic patients are often secondary to autism. As a result, many of them will hit a wall in therapy, where they have learned coping techniques but are still struggling. "You are still missing the underlying cause, which might be the pressure to conform or sensory overload or social expectations," Marin said. She finds that it is important to identify and address these underlying factors to help them find more effective relief.



Mindfulness techniques can promote relaxation for patients with autism who may experience sensory overload in certain situations and environments.

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For autistic patients, social anxiety has an extra dimension to it because of their life experiences. "One of the core features of social anxiety disorder is an almost irrational fear of being judged or ridiculed. Most people who have social anxiety disorder haven't experienced those things, but they're afraid of them," Gaus said. "Unlike the neurotypical social anxiety patient, autistic patients really have had those things happen to them. It's not irrational." Instead, treating autistic patients for social anxiety disorder requires helping them understand the ways that autism has shaped their life experiences, including their social anxiety, while also finding ways of helping them navigate tough social situations in an empowering way.

THE DOUBLE EMPATHY PROBLEM

There is an emerging body of evidence to suggest that the communication difficulties found in autism are the result of differences in how autistic and allistic people communicate, with autistic people having the

added pressure of having to communicate with both autistic and non-autistic people. In other words, autistic people are most comfortable understanding and communicating with other autistic people but need to also successfully interact with allistic people. However, allistic people are most comfortable understanding and communicating with other allistic people and have no pressure to also understand and communicate with autistic people.

"It's not that autistic people inherently lack empathy and understanding," said Joel Schwartz, PsyD, a psychologist based in California who specializes in working with autistic adults. "They find understanding allistic people difficult, but allistic people also find autistic people difficult to understand." In this way, the differences between autistic and allistic people can be thought of as a cultural difference, which includes different norms and expectations.

As a number of studies suggest, there are distinct communication differences between autistic and allistic people, with a breakdown in understanding resulting between the two. This includes the ability to accurately decipher facial expressions, identify a person's mental state, communicate effectively, and build rapport (Brewer, R., et al., *Autism Research*, Vol. 9, No. 2, 2016; Edey, R., et al., *Journal of Abnormal Psychology*, Vol. 125, No. 7, 2016; Heasman and Gillespie, *Autism,* Vol. 23, No. 4, 2019; Crompton, C. J., et al., *Frontiers in Psychology*, Vol. 11, 2020).

Some of the differences include the role that eye contact and body language play in communication and the added subtext contained in allistic communication. Practitioners can modify their communication styles for autistic patients by stating at the outset that they will be adjusting expectations for making eye contact. In addition, they should ask direct questions rather than rely on unspoken assumptions, and they should rephrase questions in different ways to facilitate understanding. Taking the time to learn and accommodate these differences can go a long way toward building rapport with a patient and tailoring therapy to fit their needs.

As Schwartz notes, another example of a difference is the role that special interests play in an autistic person's life, which can often serve as a framework for forming their identity while also providing an outlet for them to seek connection with others. "Identity for allistic people tends to be more social; it tends to be based on belonging to some kind of group," Schwartz said. In contrast, "oftentimes the primary identity for autistic people can be based on what their special interest is, which can be the primary way in which they view themselves and connect to others."

In Schwartz's experience, exploring and connecting with these special interests can often be very therapeutic for his patients, as it helps them reconnect with who they are and rediscover some of their strengths and abilities, while also giving them an opportunity to find meaningful connection with others. It is also an aspect of their identity that may have been pathologized in the past when they were encouraged or forced to join teams and clubs instead of having individual hobbies. "The old way of thinking would be to expand their interests and make them mask that," Schwartz said. "Then you have adults who are

KEY POINTS

1. **There is a glaring gap in support for autistic people when the services they relied on as children and teens suddenly evaporate when they reach adulthood.**
2. **Practitioners are often tempted to refer autistic patients to specialists, but if equipped with an understanding of how their patients' identity has shaped their experiences, they can adapt their practice to fit their patients' needs.**
3. **Autistic patients from marginalized backgrounds may have additional challenges that require additional consideration.**



When autistic people reach adulthood, they face a difficult transition to new responsibilities and expectations with few, if any, support services.

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fundamentally disconnected from their passions and what really interests them. Oftentimes, the therapy is working on rediscovering what they are and using them to connect."

DIFFERENCES AS STRENGTHS

One major issue facing many autistic people are sensory differences such as hypersensitivities to certain sounds, lights, or scents. Examples of sensory differences could include a heightened sensitivity to fluorescent lights, getting easily overwhelmed in noisy or crowded environments, developing headaches from certain fragrances, or feeling discomfort from certain fabric textures like wool or polyester. Adults who were diagnosed later in life may not even realize that they have these differences.

"Sensory overload can feel like anxiety," said Karissa Burnett, PhD, an autistic clinical psychologist based in Boston. "Until a person has the permission to think that they even have sensory differences, they might not realize what it is." Burnett was diagnosed with autism herself as an adult (Fairbank, R., *Monitor on Psychology,* November/December 2023).

For practitioners who are treating autistic patients, it can be especially helpful to ask about sensory issues at the beginning of treatment to create a welcoming therapeutic environment. For newly diagnosed adults, it can also help to screen for sensory differences and help them figure out ways of making their environment more accommodating to their needs, as doing so can help improve their overall quality of life.

Practitioners can consider incorporating mindfulness techniques into treatment plans to help promote relaxation when a patient is experiencing sensory overload. In addition, research has shown that mindfulness-based therapies have also been proven to be successful in reducing anxiety in patients with autism (Pagni, B. A., et al., *Mindfulness*, Vol. 14, 2023).

Besides treating sensory overload, it is important to also help autistic patients reframe their perspective so they recognize strengths rather than see only deficits. While heightened sensitivity to sound can sometimes be difficult, research shows that autistic people have greater auditory perceptual capacity than non-autistic people, resulting in, for example, superior pitch detection (Remington, A., & Fairnie, J., *Cognition*, Vol. 166, 2017). Therapy can help identify and build on other abilities common to autism, such as a strong sense of justice and fairness; the ability to do the right thing, even in the face of social pressure; an increased capacity for feeling emotions such as joy and wonder; a strong attention to detail and patterns; and highly developed interests and deep expertise in specific subject matter.

RELIEVING PRESSURE TO MASK

Masking, which is sometimes called social camouflaging, is when autistic people adopt specific behaviors to "pass" as non-autistic. In a world where autism is heavily stigmatized, masking tends to start at a young age. "In many ways, masking is a trauma response," Burnett said. Masking is often a survival mechanism that evolves over time in response to the criticisms of others, whether it is being punished for stimming behaviors, being scolded for asking too many questions, or being mocked for not knowing certain social expectations.

Although masking can help autistic people navigate a world where autism is stigmatized, it comes at a cost, with studies

FURTHER READING

Barriers to healthcare and a 'triple empathy problem' may lead to adverse outcomes for autistic adults: A qualitative study
Shaw, S. C., et al.
Autism, 2023

Mental health challenges faced by autistic people
Lai, M. C.
Nature Human Behaviour, 2023

The neurodivergent friendly workbook of DBT skills
Wise, S. J.
Lived Experience Educator, 2022

A conceptual analysis of autistic masking: Understanding the narrative of stigma and the illusion of choice
Pearson, A., & Rose K.
Autism in Adulthood, 2021

Extending the minority stress model to understand mental health problems experienced by the autistic population
Botha, M., & Frost, D. M.
Society and Mental Health, 2020



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It is important to also help autistic patients reframe their perspective so they recognize strengths rather than see only deficits.

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showing that it is associated with higher levels of depression, anxiety, and burnout (Hull L., et al., *Molecular Autism*, Vol. 12, No. 13, 2021; Arnold, S. R. C., et al., *Autism*, Vol. 27, No. 7, 2023). "It's tricky, because in a lot of ways, masking protects people and keeps people safe, especially if they have multiple marginalized identities," Marin said. "It's adaptive. It's a person trying to adapt to their environment and stay safe." In her practice, Marin will often explore with her patients what it might look like to unmask in a safe environment by exploring moments during their childhood when they began modifying their behavior because of criticism from others. She also helps them honor the role that masking played in their survival.

ADJUST FOR DIFFERENT THINKING STYLES

One of the primary differences between autistic and allistic people are their thinking styles. For many autistic people, their cognitive processing style tends to be very bottom-up, where they are constructing their knowledge one block at a time. "Every new situation is almost novel, and instead of having these top-down processes, which fill in the blanks, it's almost like they are building up the information from the get-go, with each new situation," said Joel Schwartz. This can lead to a lot of questions about each new situation, which is often misinterpreted as a challenge to authority or criticized as overthinking.

In contrast, allistic people tend to employ more top-down processing, where they extrapolate from previous experiences to predict what new situations might look like. "There are so many cognitive shortcuts that allistic brains make, which makes their processing and ability to process information much quicker, but it's also full of errors and full of biases," Schwartz said. Bottom-up processing often takes a lot longer and won't always produce answers when compared with top-down processing, but it can be more accurate. Both ways of thinking have their strengths.

Although it can feel daunting to start treating autistic patients, it is an endeavor that, when approached with a sense of humility and a desire for understanding, can be effective and rewarding. "Even just the experience of sitting with a person who wants to really understand and validate their true experience, that is a big deal," Burnett said. "That is corrective, that is healing." ■

AMERICAN PSYCHOLOGICAL ASSOCIATION

Enhancing Learning through Commitment to Change

Greg J. Neimeyer, Ph.D.

The rapid proliferation of new knowledge in psychology has placed renewed demands on professional practitioners to keep pace with ongoing advances. Overall, knowledge may remain current in professional psychology for as little as about 6-7 years, with more rapidly diminishing durability in key areas of practice, such as psychopharmacology, child health, forensics, substance use, or neuropsychology, among others (Neimeyer, Taylor & Rozensky, 2014). This means that, in the absence of a commitment to ongoing professional development, many practitioners may begin to experience knowledge obsolescence even while they are still in the early stages of their career (Neimeyer, Taylor & Rozensky , 2012).

BEST PRACTICES

In response, the field of professional psychology, together with other allied health professions, have redoubled their efforts to formulate sets of "best practices" that can enhance learning and the translation of that learning into practice (Institute on Medicine, 2010; Taylor and Neimeyer, 2017). The collective objective of these best practices is to enhance the comprehension, retention, and application of new knowledge in support of ongoing professional competence. Some of these practices focus on the value of adapting the learning strategies to individuals' unique learning styles, presenting information multiple times utilizing different media, and providing opportunities for individuals' input, application and behavioral rehearsal of the material, in addition to receiving peer, or instructor, review and feedback (Neimeyer & Taylor, 2014; Taylor and Neimeyer, 2017).

In addition to identifying current best practices, the allied health fields have long dedicated themselves to the development and evaluation of novel mechanisms for enhancing new learning, as well, drawing from a wide range of literatures with common objectives. Research within the science-of-learning, adult education, and performance enhancement literatures have been particularly productive in identifying and assessing novel methods of learning and facilitating the translation of that learning into practice. *Benchmarking* and *self-assessment* are two examples of educational practices that have arisen as mechanisms designed to facilitate quality assurance and ongoing professional development (Neimeyer and Taylor, 2014).

Benchmarking and Self-Assessment. *Benchmarking* refers to the express comparison of one's own work with the work of other professionals in the field. Benchmarking can be understood as the systematic process of evaluating work based on best practices and using evidence-based practice (EBP) to improve performance. In a typical benchmarking procedure, a psychologist might be given videotapes of peers who are conducting a procedure, such as a substance use screening. The videos are pre-determined to depict varying levels of quality. They might range from depicting relatively poor, informal questioning through more thorough, systematic, structured interviews. The psychologist is then asked to evaluate his or her screenings in relation to those he or she has seen, and given information about key components that are present, and absent, in each of the video "benchmarks." Benchmarking provides an anchor against which psychologists can compare themselves, increasing the accuracy of their self-assessment and incorporating elements of the "higher" benchmarks into their own practice.

Research has demonstrated the effectiveness of benchmarking in relation to improving the accuracy of self-assessment, which is a critical pre-condition for evaluating current clinical skills and needs. Lane and Gottlieb (2004), for example, found that when medical residents viewed videotapes of their performance, their self-assessment accuracy increased significantly. And their accuracy increased still more when they watched the videos with a faculty member. Similarly, Martin et al., (1998) found that comparing one's own performance to the performance of others increased the accuracy of self-assessment. In their study, these researchers invited family practice residents to conduct mock interviews with a mother suspected of physically abusing her child. The residents were then asked to rate their performance. Next, residents watched their videotaped interview, in addition to watching four benchmark interviews depicting varying levels of competence. After watching the benchmark interviews, the relationship between the residents' self-ratings and the independent ratings of the supervisor was significantly stronger.

Self-assessment can take many different forms. All forms share in common express efforts to reflect upon, and evaluate, one's own current skills and/or future professional needs and interests. The Quality Assurance Program in Ontario, Canada, is one example of a well-articulated program of self-assessment (Morris, 2011). The Quality Assurance Program requires that each psychologist undertakes a self-review every other year, though the completion of a stipulated Self-Assessment Guide and a Continuing Professional Development Plan. Through a series of questions, psychologists critically evaluate their strengths, growth areas, and gaps in their learning. After conducting the self-assessment, they develop their own personal plan to remediate areas of identified weakness and to enhance their overall professional competence, sharing their plans with a colleague who reviews it and provides input. The Continuing Professional Development Plan is designed to 1) promote continuing competence and quality improvement, 2) remedy gaps in knowledge and skills identified in the self-assessments, 3) address changes in practice environments and workplace needs, and 4) incorporate evolving standards of practice and advances in technology. These Continuing Professional Development Plans are subject to peer review by members of the College of Psychology of Ontario according to stipulated regulatory requirements.

Both benchmarking and self-assessment reflect the considerable effort that can accompany efforts designed to promote professional growth and development. Facilitating new learning, and the translation of that knowledge or skill into practice can be an effortful process, requiring reflection, formulation and deliberate application. Transitioning new learning to practice often requires an individual to reflect on how new knowledge or skills may apply to their own experience and to formulate ways in which the new material can be modified, adapted, or utilized within their own professional contexts or workplace environments. If the value of this effort is justified by the anticipated improvement or outcomes that may follow from it, then individuals are more prone to commit themselves to changes in what they do, or how they go about doing it.

Although some mechanisms for triggering change are designed to be intensive and may require considerable time, others are designed as brief reflective exercises that can occur immediately after, or even during, a learning event. A longstanding literature on the concept of a Commitment to Change illustrates the value of utilizing this simple technique in the service of generating greater learning and the translation of that learning into actual practice (Mazmanian & Mazmanian, 1999).

COMMITMENTS TO CHANGE (CTCS)

CTCs have been the subject of attention for the last few decades, but only recently have they been imported into the fields of allied heath, or more recently still within psychology. CTCs are generally generated following an educational event such as attending a lecture, participating in a workshop, or reading an article (Wakefield, 2004). To complete a CTC, participants are asked to identify a set of possible changes they would like to make in their own practice based on the educational event. They are asked to formulate these changes in specific, behavioral form, which requires them to reflect on the relevance and applicability of the new information, and to adapt its application to their own interests and experience. They are then asked to indicate a level of commitment to each of the changes they have formulated, utilizing a rating scale that reflects their commitment to change, from low (1) to high (5). In the Commitment to Change procedure, participants are often reminded of their commitments 1-2 months later, and asked to indicate if they actually enacted, or attempted to enact, each of their stipulated CTCs and to describe their experience or outcomes.

The effectiveness of the CTC procedure seems to be related to its three steps. The timing of the administration, immediately after the learning event, provides the participant an opportunity to reflect on the most salient elements of the material and to formulate it in terms that are most relevant to their own experience, interests, or needs. Rating the level of commitment provides a concrete mechanism for reflecting on the importance or value of the change, and anchors the individual in a level of expectation about completing it. And the subsequent follow-up provides a sense of accountability and the opportunity to reflect on the translation of the material into practice, or the barriers that may have impeded or prevented that translation.

THE BACKGROUND ON CTCS

CTCs have been the subject of attention in relation to the organizational change literature for several decades, as a tool for facilitating critical shifts in organizational structure, processes or style. Within the allied health literatures, medicine was among the first to explore the utility of CTCs as a mechanism for facilitating the translation of new knowledge into actual clinical practice. Within this literature, the actual performance of CTCs varies widely, from 47-87% (Wakefield, 2004), based on a number of identified factors. These factors include the extent to which individuals feels as if the CTCs are relatively easy to do, and the extent to which they feel as though they have personal control over completing them (Fidler et al., 1999, Lockyer et al., 2001). The greater the environmental or institutional constraints, the less likely individuals are to be able to follow through on their commitments and accomplish the behavioral changes they have formulated (Parochka and Paprockas, 2001). A number of studies have demonstrated that the CTC procedure can trigger actual changes in practice-related behavior, including the specific prescriptions that physicians write following educational programs (Wakefield et al., 2003), and the specific interventions utilized by occupational therapists over the course of their work with their clients (Lowe, Rappolt, Jaglal, & Macdonald, 2007).

The precise mechanisms involved in triggering this translation into practice are not fully known, but recent work has begun to address them. Herbert, Lowe and Rappolt (cited in Lowe, Hebert & Rappolt, 2009), for example, wondered whether reflection alone at the end of a new learning experience was sufficient to promote practice change, or whether the express formulation of a commitment of change was an essential element. Reflection has long been a key component of ongoing professional development programs, as reflected in the Mann et al., (2009) systematic review of reflection within continuing medication education courses. In their study, Hebert et al. (2009) asked half of their participants to complete CTCs while the other half were prompted to reflect on the workshop using the Critical Incident Questionnaire (CIQ). Two months following the workshop, there was a modest difference favoring the CTC group over the reflection-only group. The percentage of those who demonstrated significant change was significant in both groups, but it favored those who had formulated specific commitments to change. Overall, 67% of the individuals who used CTCs made changes in practice, compared to 50% of those in the CIQ group who reported doing likewise.

A recent study of the relationship between reflection and behavior change in continuing medical education provides further evidence in this regard (Ratelle, et al., 2017). In a cohort study of attendees at a national hospital continuing medical education course, 223 participants provided reflection scores for each presentation they attended, and formulated commitment-to-change statements at the conclusion of each course. Reflection scores consisted of ratings, on a 5-point scale, about the extent to which the presentation had prompted reflection, re-consideration, deliberation or critical re-evaluation of their practices. A 3-month post-course survey was conducted to determine whether planned CTCs were successfully implemented, and whether they were related to higher levels of reflection.

Overall, participants indicated that 65.5% of the CTC statements were implemented. Reflection scores correlated significantly with the number of planned CTC statements ($r=.65$, $p<01$), suggesting the potential role of the CTC procedure in enhancing reflection and, potentially, translation into actual practice. In addition, higher reflection scores were related to the greater availability of opportunities for audience response and the use of clinical case illustrations. The researchers concluded that, "we found that reflection strongly correlates with CTC" and that "continuing education "curricula that stimulate reflections may actually promote positive patient care behaviors" (Ratelle et al., 2017, p. 166).

SUMMARY

Educators or learners who are interested in enhancing learning, and the translation of that learning into practice, may increase the retention and translation of material by incorporating CTCs into their programs. Although the overall effectiveness of CTCs as a tool to enhance the integration of new learning into practice is still under study, the current evidence is promising. The incorporation of simple reflective questions into a learning experience may itself be useful, as when the psychologists asks, "How can I use this new knowledge?", "How does this apply to my practice and to what I do?", or "What might I do differently based on what I have learned today?" Although simple reflection itself appears to facilitate both learning and the translation of that learning into practice, the express formulation of potential changes and a commitment to those changes may add further value (Lowe et al., 2009). Overall, the formulation of CTCs represents a relatively simple mechanism for promoting reflection, anchoring expectations regarding adoption, and leveraging new learning into novel practice behaviors. Simple extensions to the CTC procedure that may provide additional benefit include conducting surveys of post-course behaviors to assess compliance with the CTCs, encouraging reports to colleagues or other peers regarding CTCs in order to build in additional elements of accountability, or establishing timelines for the completion of CTCs. With continued utilization and examination, Commitment-to-Change procedures may join the ranks of other processes, procedures and techniques that jointly constitute what has increasingly come to be recognized as the set of "Best Practices" in the field of ongoing professional education and continuing professional competence.

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