

Working with Young People with Autism Spectrum Disorder and Comorbid Mental Disorders



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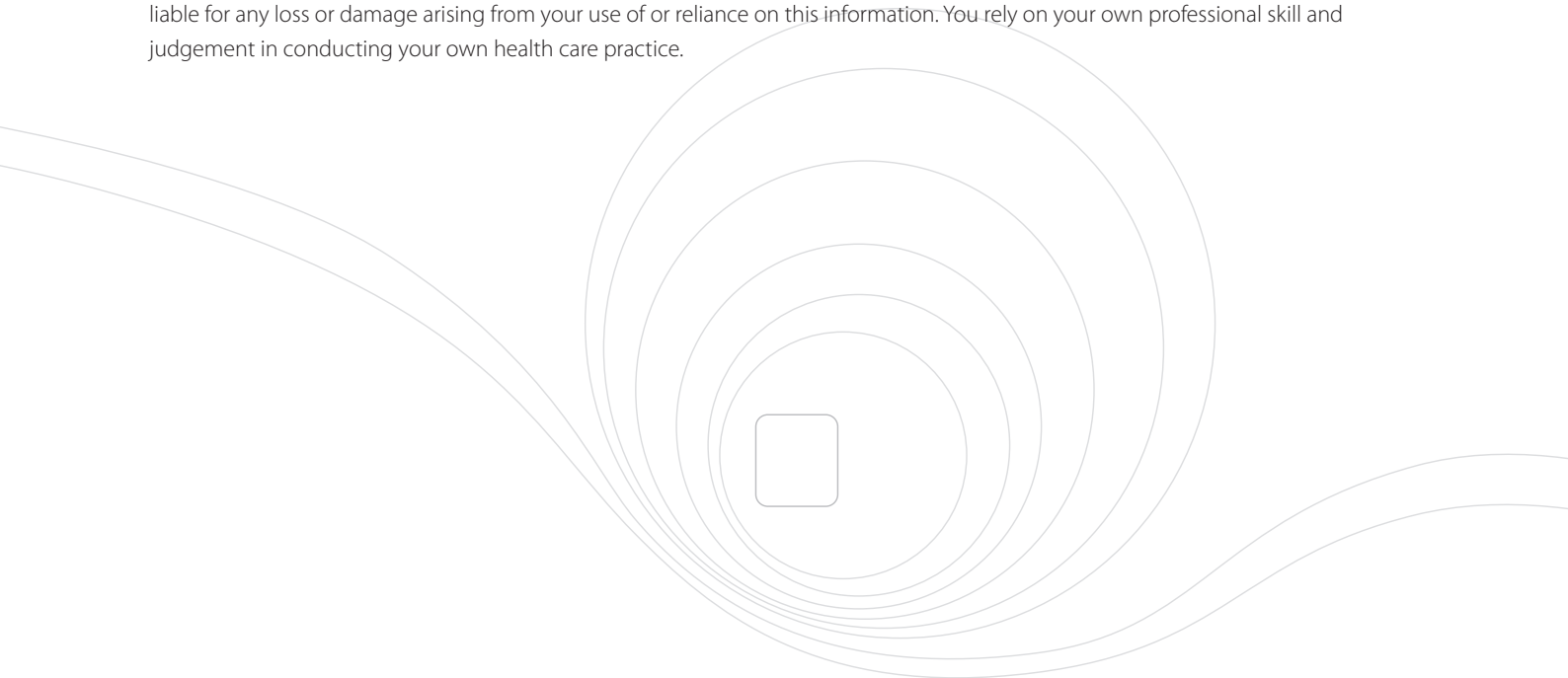


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Introduction

Background

In recent years, reported frequencies for Autism Spectrum Disorder (ASD) have approached 1% of the population, with similar estimates in child and adult samples (Brugha et al. 2011). ASD is associated with higher rates of a range of comorbid mental illnesses. There are various challenges for mental health professionals working with this group – the recognition and diagnosis of ASD where it has not been previously diagnosed; differentiating between features of ASD and symptoms of a co-occurring mental disorder; and providing an intervention that takes into account both the ASD and psychiatric comorbidity.

The Clinical Need for this Manual

Orygen Youth Health Clinical Program (OYHCP) is a public mental health service providing specialist mental health care for young people between the ages of 15 and 25 who live in the north-western metropolitan region of Melbourne, Australia. In 2007 an audit of the prevalence of ASD within the Early Psychosis Service (EPPIC) at OYH showed 3.4% confirmed rate of ASD, 9.6% suspected ASD and a combined rate of 13% total confirmed and suspected ASD (Fraser et al., 2012).

At OYHCP, an audit of clinicians' knowledge and confidence showed that the care of individuals with ASD and psychiatric comorbidity was experienced as challenging. Clinicians reported low confidence in providing interventions, and perceived less progress during episodes of care than when working with neurotypical young people.

The Autism State Plan (Victorian Government 2009) provided resources for additional support of ASD within the Victorian public mental health system. Typically, these resources have been dedicated to the assessment of children and young people. OYHCP has dedicated its resources to working with ASD and co-occurring mental disorders. Whilst the field of literature on intervention with adolescents and young adults with ASD is growing, to our knowledge, this manual is the first to respond specifically to the issue of comorbidity.

There is also a recognised need for visual tools to aid work with young people generally, and those with ASD specifically. The authors have had difficulty sourcing developmentally appropriate visual aids, and this Manual incorporates a number of visual aids developed for an audience of adolescents and young adults.

Background to this Manual

This Manual is intended for mental health professionals working with adolescents and young adults with ASD and comorbid mental disorders.

The writers of this manual aim to increase the awareness and knowledge base of health professionals working with this client group. In the absence of an empirical evidence-base, it is thought that these best practice principles and suggested interventions may lead to a more acceptable response to young people with comorbid ASD and psychiatric disorders. In turn, we hope that this will result in better outcomes across a range of domains, including psychiatric symptomatology and social and vocational recovery.

It is anticipated that there is content of use for all practitioners working with this population. Some understanding of major mental disorders is assumed. Whilst this Manual is intended to be broadly applicable, most of the recommended interventions have been devised and trialed with individuals where there is a degree of intellectual function and language that allows them to engage in some talking-based psychotherapeutic intervention.

Process of Manual Development

These guidelines were developed to address clinical 'best practice' in working with ASD and co-occurring mental disorders in youth mental health services.

The development process involved:

- A literature review on interventions for adolescents and adults with ASD. An 'evidence mapping' methodology was used to search research databases for published controlled trials and systemic reviews (Hetrick et al., 2010).
- Consultation with members of the Victorian Statewide ASD Coordinators Network.
- Focus group consultation with the Orygen Youth Health ASD Interest Group comprising of:
 - › A Clinical Psychologist with more than 10 years clinical experience
 - › A Clinical Psychologist with more than 5 years clinical experience
 - › An Occupational Therapist with more than 5 years clinical experience
 - › A Social Worker with more than 5 years clinical experience and
 - › A Special Education Teacher with more than 5 years experience in Special Education and Mental Health settings
- Review by a Mental Health Speech Pathologist specializing in Autism Spectrum Disorders, with more than 20 years clinical experience.
- Review by a Child Psychiatrist with more than 10 years experience.
- Incorporation of reviewers' comments into the document, and preparation of a final draft.

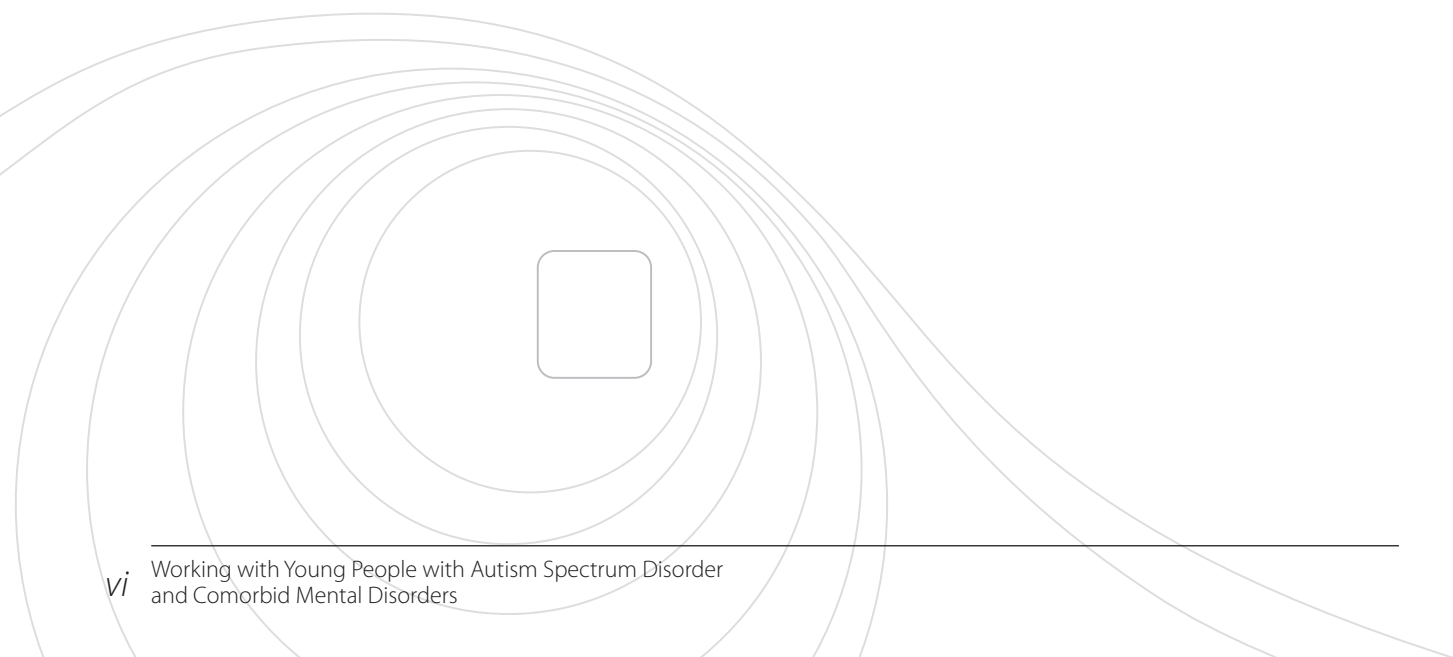
How to Use this Manual

This manual consists of five parts:

- **Part 1** provides a detailed description of the features of ASD as a rationale for recognition and assessment for comorbid ASD in specialist mental health settings.
- **Part 2** outlines important considerations for the engagement of young people with ASD in their mental healthcare, and for the assessment of ASD in young people with a comorbid mental disorder.
- **Part 3** provides recommendations regarding formulation and treatment planning, and includes a rationale for the provision of groupwork alongside individual interventions in the treatment of young people with ASD.
- **Part 4** provides a range of recommendations regarding interventions for specific challenges for the young person with a co-occurring ASD and major mental disorder.
- Finally, **Part 5** incorporates specific resources for use in intervention.

We would like to acknowledge the work of:

- › Tony Attwood
- › Michelle Garcia Winner
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Part 1 : Understanding Autism Spectrum Disorder

The Core Features of Autism Spectrum Disorder

Autism Spectrum Disorder is a neurodevelopmental disorder which causes disturbance in development across a range of areas in the young person's life. These areas include social interaction, communication, repetitive behaviours, restricted interests and sensory preferences. Some young people may be referred for treatment for a co-occurring mental disorder, with a longstanding diagnosis of ASD. In these cases, clinicians will want to understand the features of the ASD in order to understand the young person's overall presentation. In other scenarios, a young person may be referred for treatment with a different primary problem, and a family member, clinician or the young person themselves may suspect ASD is present. Having a sound understanding of the ways in which ASD manifests is a useful tool for clinicians in both screening for further assessment, and tailoring treatment.

Social Interaction

Challenges with social interaction and social relationships may be the most widely known of challenges faced by a young person with ASD. Impairments in social interaction may be exhibited through

- challenges developing friendships at a developmentally appropriate level;
- impaired understanding and use of non-verbal communication;
- problems with social and emotional reciprocity and empathy; and
- impaired ability to take account of context and identify social cues and conventions.

These social difficulties are underpinned by a theory of mind deficit (see Underlying Cognitive Impairment).

Communication

Young people with ASD can often speak fluently and appear to have normal expressive and receptive language. However, they will always have impaired pragmatic language skills. Pragmatic language refers to the use of language in conversation, relationships and getting needs met. People with ASD have

a tendency to be pedantic, have unusual prosody and can make literal interpretations. They may struggle with general conversational rules, such as appropriately gaining and maintaining another's attention, choosing and staying on topic, swapping between the listener and speaker role, and repairing misunderstandings. Some people with ASD may get lost in details and lose the point in a sentence or exchange.

Therapeutic work is verbally mediated. It typically involves the young person recounting their experiences, listening to others' accounts, explaining oneself, describing thoughts, actions and behaviours, and determining solutions. Negotiation, compromise and persuasion also involve language and are key to effective therapeutic work. The young person with ASD may have difficulties in any or all of these areas.

Language issues can impact on therapy without a clinician realizing. The young person may behave in a way that suggests that they understand, when in fact they do not. Pragmatic language difficulties can affect if and how the young person speaks up (initiates) if they're unsure, have not understood, have a difference of opinion or want more information or clarification. Social communication difficulties are also underpinned by theory of mind deficits (see Underlying Cognitive Impairment).

Restricted Interests and Repetitive Behaviours

In ASD, the idea of 'restricted interests' refers to the development of special interests that are unusual in their intensity and focus. It also refers to inflexibility in thinking or behaviour. For instance, rigid thinking patterns or a preference for predictability, routine and consistency, and difficulties managing change. Restricted interests are underpinned by impairment in executive functioning and reduced central coherence (see Underlying Cognitive Impairment).

Repetitive behaviours may include stereotyped motor mannerisms (e.g. hand or finger flapping), repetitive speech or other rituals. The behaviours differ from Obsessive Compulsive Disorder, as they are unlikely to be linked to obsessive thoughts and are not egodystonic, that is, they do not occur against the person's will and are less likely to cause distress.

Sensory Hypersensitivity or Hyposensitivity

People with ASD may be hypersensitive or hyposensitive to specific sensory experiences. They may be overly sensitive to specific sounds, tastes, smells, and sights. They may prefer soft clothing, certain foods or have an unusually high threshold for pain and temperature.

Other

In addition to these 4 areas of impairment, ASD may also include fine and gross motor difficulties (e.g., clumsiness, poor handwriting) and problems with adaptive functioning (e.g. personal care, independent living skills).

Underlying Cognitive Impairment

Understanding the ASD mind and associated cognitive difficulties is essential. The concepts of theory of mind, central coherence and executive functioning should be used consciously and directly with an ASD client and should inform clinicians' approach to intervention (Happé & Frith, 1996).

Theory of Mind

A Theory of Mind (ToM) deficit - also called mind-blindness – is at the core of the experience of young people with ASD. ToM is essentially the ability to put oneself in another's shoes: to take their cognitive, emotional and visual perspective. When in a group of people, it is the difficulty or inability to appreciate the group perspective. ToM difficulties result in the young person experiencing difficulty understanding emotions, thoughts and intentions in themselves and others (Baron-Cohen, 1995).

By adolescence, most individuals with ASD would pass a basic ToM test. They are likely to be aware of the factual information known by another. However, they cannot imagine the ways in which the other person perceives the factual information, or the emotions that they have in response to it.

Impaired ToM can affect social communication in a number of ways:

- Not realising what someone really means. For example, the young person may interpret things literally. They may have trouble noticing or understanding humour or sarcasm.
- Not realising the effect that they have on others' feelings. For example, not pre-empting the impact of their comments on others, not knowing when to keep a thought to oneself, or when to tell a white lie.
- Not realising there are social hierarchies and rules of deference. For example, they may speak to a person in authority the same way that they would to a family member or peer.
- Not understanding that others might have different knowledge from themselves. This can lead to difficulties such as not recognising that others might have useful knowledge to help solve a problem.

- Assuming others have knowledge about them or their experience which they could not have. This can lead to communicating in ways that make it difficult to be understood.
- Having difficulty understanding non-verbal communication (messages given with eyes, facial expression and body language). This can lead to difficulties such as not attending to or responding to others' emotions.

ToM deficits do not only affect social communication. They also impact reading comprehension, interpretation of TV programs and movies, and production of written language tasks.

Central Coherence

Central coherence (CC) is the ability to integrate pieces of information into a whole (Happé & Frith, 1996). With very weak central coherence, a young person with ASD focuses on details without attending to the central meaning. Strong central coherence enables someone to comprehend and remember the gist of a conversation, story or situation and to integrate multiple cues to get a sense of the whole.

Weak central coherence can impact the young person in a number of ways:

- If every detail is important, changes to the environment might be overwhelming. If someone remembers where everything is placed, moving things around the bedroom or house may be a source of distress.
- If every detail is important, a change may result in something that has to be learned new, rather than being understood as something that is essentially similar. Generalising is difficult.
- Challenges to integrating multiple stimuli might lead to difficulty noticing and responding to others' emotions.
- Challenges attending to and integrating a range of types of cues, rather than the 'whole' of a social scene might lead to misinterpretation. Faulty conclusions may lead to inappropriate solutions.
- Being able to attend to details that most of us overlook can also be a gift. It can lead to important new understandings.

Executive Functioning

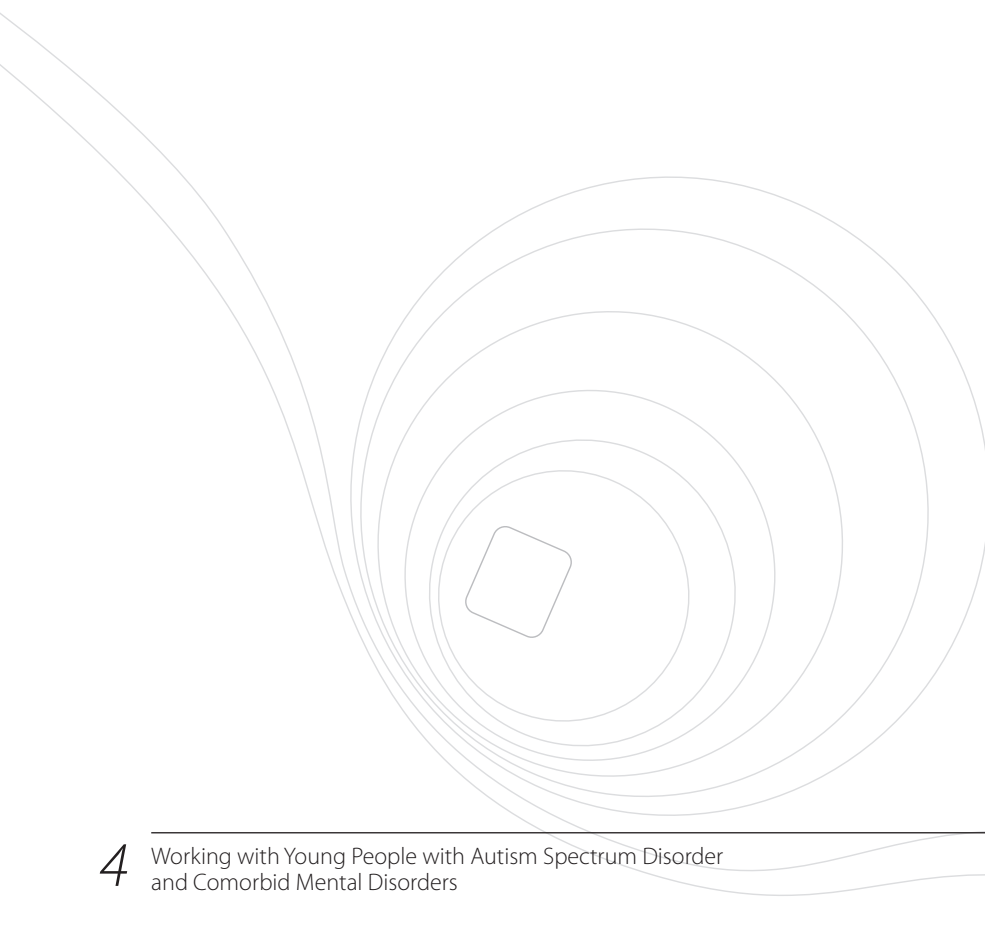
Executive functions (EF) refer to higher-order cognitive processes such as the ability to adapt behaviour to a changing situation, to plan and organise future behaviour, and to think abstractly. As a result of intervention in childhood, as well as family adaptation and individual compensatory strategies, EF difficulties in ASD may become less intrusive in adolescence. There is some overlap in EF, ToM and CC (Happé & Frith, 1996).

EF difficulties in ASD may manifest in everyday life as:

- Difficulty planning ahead and organizing.
- Difficulty concentrating, dividing attention, or shifting attention from one activity to another.
- Impulse control problems – knowing how to start and stop particular behaviours.
- Difficulty adapting to new situations.
- Difficulty getting started with a task or conversation.
- Difficulty reflecting on past experiences and adapting what's worked and didn't work. (This can be too abstract for people with EF and CC difficulties).
- Difficulty predicting ahead and planning to achieve a desired outcome, or avoid a pitfall.

EF difficulties also lead to difficulties in understanding the passage of time. Time issues manifest in a range of ways in individuals in therapeutic settings. Some have trouble estimating time frames. Some lose track of time in the moment and it can be the reason that they may stay on a conversation topic too long. Some have particular expectations about the session starting and finishing on time and may become preoccupied with this in session.

It's important to realise that these areas of cognitive deficit are seen in a number of different disorders and conditions and are not specific to ASD. For example ToM difficulties are seen in young people with psychosis (Sprong et al., 2007), in the 'ultra high risk' for psychosis population (Thompson et al. 2011) and in borderline personality disorder (Sharp et al., 2011).



Part 2: Engagement and Assessment

With knowledge of some of the presenting features of ASD, clinicians will be more able to consider the challenges a young person with ASD may have when seeking treatment. This section briefly outlines issues in the engagement of young people with ASD in mental healthcare. Whilst some young people will arrive at mental health services with a pre-existing diagnosis, in other cases, clinicians will identify some of the features outlined in Part 1, and will need to determine whether further assessment is useful. This section outlines some of the considerations in referring for specialist assessment, before describing the protocol for assessment in adolescence and young adulthood.

Engagement

Engagement is essential before a therapeutic relationship can develop. The initial association with a young person with ASD and their family is often very tenuous because of factors such as the nature of the disorder, the developmental stage of the young person, and the negative stereotypes of both mental illness and ASD. Some important strategies for engagement include:

- Careful explanation of the service context and your role.
- Beginning with what the young person sees as the problem.
- Maintenance of a warm, empathic respectful attitude.
- Careful listening, including taking the individual and their views on the problem seriously.
- Working at a pace that allows the young person to feel safe. For an individual with ASD this may be slower than you are used to and may involve more checking in.

These strategies may be strategies that the clinician would use in their work with any young person. The preceding section, Part 1, outlines why these approaches may be even more vital with a young person with ASD.

Talking about ASD

The later the diagnosis, the greater the likelihood a clinician may face resistance to discussion about ASD with a young person or their family. For a young person, this is most often due to the psychological cost of undoing the way that they've always understood themselves. It may also be due to negative or stigmatising beliefs about ASD. For families, late diagnosis increases the likelihood of blame and shame around

having 'missed' early signs and loss of opportunities for earlier intervention. For this reason it's important to find language that is respectful, non-blaming and reduces the stigma of ASD.

ASD should always be explained in terms of strengths and difficulties. It is important to give the message that Autism occurs on a 'spectrum' and that the difficulties described earlier in Part 1 occur along a dimensional axis. Thus while some young people may be socially aloof, others may be prosocial but socially naive. It may be useful to provide examples of famous people who are thought to have experienced Autism.

Families and young people can be advised that those on the less severe end of the spectrum may not be easily identified in childhood, because the social problems and subtle theory of mind challenges may previously have had less of an impact on their lives. They may have been viewed as quirky but not had unusual interests and behaviours that drew attention to them. Adolescence is a time of change and increased social complexity. It's for this reason features of ASD can become more apparent later in life. It's also common for difficulties associated with ASD to be clouded by other mental health concerns (e.g. social anxiety).

It is also important to communicate that 'labels' or diagnoses do not change who the young person is, and that diagnoses are there to help professionals share information in a convenient way and know how to help. Further strategies to assist with engagement will be considered in Part 3.

Assessment

Screening for ASD

Given the apparent prevalence of ASD in psychiatric settings (Nylander & Gillberg, 2001; Fraser et al., 2012), consideration of a previously undiagnosed ASD in the initial assessment phase may form an important part of overall assessment. Screening tools can be useful in identification of those who may benefit from further assessment. The Autism Spectrum Disorder in Adults Screening Questionnaire (ASDASQ) is a questionnaire which has been used in psychiatric settings, and is a simple and reliable screen for identifying those who may benefit from further assessment (Nylander & Gillberg, 2001).

Why Refer for an Assessment

Assessment can increase self-understanding. Often, people with ASD have known that they have specific difficulties, but haven't been able to explain them. A clear diagnosis can be a relief because it provides an explanation for difficulties. Diagnosis can reduce the experience of self-blame and shame. Without the knowledge of ASD, an individual often fills that void with other more damaging explanations, such as 'failure', 'weird', 'lazy', 'disappointment' and 'not living up to one's potential'.

A diagnosis can help others to be more understanding. Many people suffer the consequences of being constantly misunderstood. When the people close to a young person with ASD understand that there is a reason for the difficulties that they are experiencing, it is much easier for them to empathise and respond in a supportive way.

A diagnosis of ASD can provide the young person with access to certain services and supports (such as educational support and disability and employment services).

Finally, assessment guides treatment. Each individual on the autism spectrum is different. Understanding an individual's profile of difficulties and attributes will assist clinicians to tailor treatment to their specific needs. Where assessment excludes a diagnosis of ASD it may still assist by identifying some of the specific challenges that a young person is experiencing. These might be best explained by another disorder, or might be atypical or idiosyncratic. In any case, they are challenges that are usefully incorporated into the shared formulation of the young person's difficulties and can become targets for treatment.

Important Considerations

A formal assessment is not necessary in every case in adulthood. For some individuals, their own research provides enough answers and the best explanation for their own experiences. Nobody should be forced to seek a label. When people arrive to see a diagnostician against their will, the result is unlikely to be positive.

There are occasions when it may not be appropriate to assess:

- During an acute phase of illness with another mental health diagnosis (e.g. psychosis, depression); or
- When an additional medical label will be further damaging to a young person's self-concept and self-esteem.

Whilst there are challenges to the rigorous assessment of ASD at any age, there are particular challenges to be considered in the assessment of adolescent and young adults.

One significant consideration is the need for a developmental history. An ASD assessment requires multiple sources of information, and the diagnosis requires convergence of information across all sources (Risi et al., 2006). A developmental history is often the point for diagnostic clarification around features that might otherwise be explained by another disorder. Compared with early childhood assessment, where the proximity

of events leads to many parents being able to provide a reliable developmental history, many parents have difficulty providing detailed information about their adolescent or young adult child's early development. Other sources such as journals from childcare, early school reports and home videos may be used to build up a story of the young person's early childhood development.

Assessment Guidelines for Adolescents and Young Adults

Adapted from :

Autism Victoria (2010). The diagnostic process for children, adolescents and adults referred for assessment of Autism Spectrum Disorders. Australia: Autism Victoria.

Young people with a suspected ASD should be referred to a specialist autism assessment team. Initial consultation and screening measures may be beneficial, in order to determine the appropriateness of a formal assessment.


Where assessment is indicated, the young person will be assessed by a multidisciplinary team. At a minimum this team will include:

- a clinical psychologist experienced in the assessment and diagnosis of ASD in this age group, and
- a Pediatrician or Child and Adolescent or Adult Psychiatrist.

Components of an assessment include:

- Collection and review of past assessments;
- A developmental assessment with the parents or carer of the young person (for example, the Autism Diagnostic Interview – Revised [Lord, Rutter & Le Couteur 1994])
- An assessment of social competencies and social communication skills (for example, the Autism Diagnostic Observation Schedule [Lord et al 2000]); and
- Where indicated by the presence of past or current learning difficulties, a cognitive assessment (if one has not been completed in the past 18-months).
- Referral to a speech pathologist where there are concerns regarding the quality of the individual's communicative functioning, and where this has not been previously assessed.

Components of an assessment may be conducted separately, but always with consultation between all relevant professionals. A consensus is required for a diagnosis to be made. Converging evidence across all components is also required. All reports should include a summary and recommendations section that is jargon-free and can be readily separated for copying. Alternatively a separate jargon free feedback letter should be written to the young person. Psychoeducation and support should be offered to the young person and all family members following the diagnosis of ASD.

 **See Worksheet 1: Core Features of Autism Spectrum Disorder**

Part 3: Formulation and Treatment Planning

Establishing a Support Team

The therapeutic approach to the young person with ASD and comorbid mental disorder should be comprehensive and integrative. As in all mental healthcare, the whole person should be considered in treatment. This is likely to mean including their family (parents, siblings, partners and children) and other support people involved (e.g. school, workplace, educational or training setting, housing, youth justice). A good approach will consider who will support the young person both now and in the future. Whether the future support is a family member or professional, it can be useful to think of assembling a 'Support Team' that may be needed, to respond to difficulties in the following areas:

- Emotional wellbeing/mental health
- Social connection/recreation
- Education/employment/training
- Family and sibling support
- Social communication skills
- Organisation and executive function
- General health
- Assistance with sensory challenges
- Independent living skills/housing

 **See Worksheet 2: The Support Star.**

Formulation

The treatment provided should be formulation-based. Several considerations in the development of the formulation will assist in tailoring treatment for the young person with ASD.

Clinicians will need to determine what aspects of the young person's presentation are best explained by the ASD, and what aspects can be attributed to the comorbidity. Clinicians must also take into account that the features of ASD are often exacerbated by a co-occurring mental health problem and the symptoms of the co-occurring mental health problem may present differently in individuals on the autism spectrum.

Diagnostic confusion can occur because of the considerable overlapping features between ASD and other mental disorders. Some considerations should be made for each of the following disorders:

Schizophrenia Spectrum and Other Psychotic Disorders

Although Schizophrenia and ASD are regarded as distinct disorders they bear resemblance to each other in a number of clinical features (Ghaziuddin, 2005):

- Emotion expression and non verbal communication can be diminished in both.
- Preoccupation with special interests may resemble over valued ideas or even delusions.
- Pragmatic language difficulties can look like a thought disorder, as it's often idiosyncratic, sometimes copied, grammatically odd, irrelevant, socially inappropriate.
- Young people with ASD will often take a paranoid stance due to past negative social experiences and difficulty reading social cues.
- Young people with ASD may experience their own thoughts as voices.
- Finally, neuropsychological deficits in theory of mind and executive function occur in both.

The key to diagnosis lies in the history. History of an onset of deterioration, along with the presence of true hallucinations and delusions will help to determine the diagnosis of a psychotic disorder. Information should be collected from multiple sources, such as schools and caregivers.

Depression

There is considerable overlap in the features of ASD and symptoms of depression, and characteristics of ASD may affect the expression of depressive symptoms (Stewart et al., 2006). Social withdrawal and impaired non-verbal communication behaviours (e.g. flat affect) may be features of both disorders. Impaired emotion recognition and reduced emotional vocabulary may mask the symptoms of depression. For example, individuals with ASD may have difficulty identifying and communicating internal states such as sadness or depressed mood. These internal states may manifest

as irritability or anger. ASD features such as inflexibility and rigid thinking patterns may increase during episodes of depression.

Information about early childhood development and onset of deterioration in behaviour or functioning will aid diagnostic clarification.

Anxiety Disorders

Symptoms of anxiety are common in people with ASD and can manifest as distress at trivial changes to the environment or difficulty adjusting to new people or new surroundings. These symptoms can be conceptualized as part of the ASD however distinct anxiety disorders may also develop (Kerns and Kendall, 2013).

In Social Phobia anxiety may augment social impairments associated with ASD, and poor social functioning may in turn contribute to anxiety. There is some suggestion anxiety may present differently with fears of social evaluation less frequent. Instead it is suggested a young person with ASD fears 'the unknown' – that is they cannot predict or imagine the social environment they are entering into.

Obsessive Compulsive Disorder

In Obsessive Compulsive Disorder (OCD), compulsive behaviour can appear similar to the repetitive behaviour associated with ASD. The difference being that for the person with ASD engaging in repetitive activities, they are not experienced as egodystonic, and are often even enjoyed (Fitzgerald & Corvin, 2001).

Personality Disorders

The relationship between ASD and personality disorders is not completely clear, and there is considerable overlap in clinical features with some personality disorders (Lugnegard et al., 2012).

For instance, research into the relationship between Schizoid and Schizotypal Personality Disorders and ASD has suggested that with such substantial overlap, they could be seen as interchangeable terms that identify the same group of people (Hurst et al., 2007). A careful developmental history will help to differentiate ASD from personality disorders, as onset of difficulties associated with ASD will typically present in childhood.

Establishing Treatment Goals

Treatment goals should focus on the comorbid condition (anxiety, depression, psychosis etc.) and address the features (or impacts) of ASD which effect the young person's engagement in therapy, and which perpetuate the mental illness. A concurrent and integrated treatment of co-morbid conditions and ASD features increases the probability of recovery. For instance, providing treatment for social anxiety may be best integrated with social skills training to enhance social competencies. There will always be some sequencing in treatments and this is based on hierarchical assessment that gives priority to the level of dysfunction, however,

wherever possible treatment should be planned as integrated and responsive to both disorders.

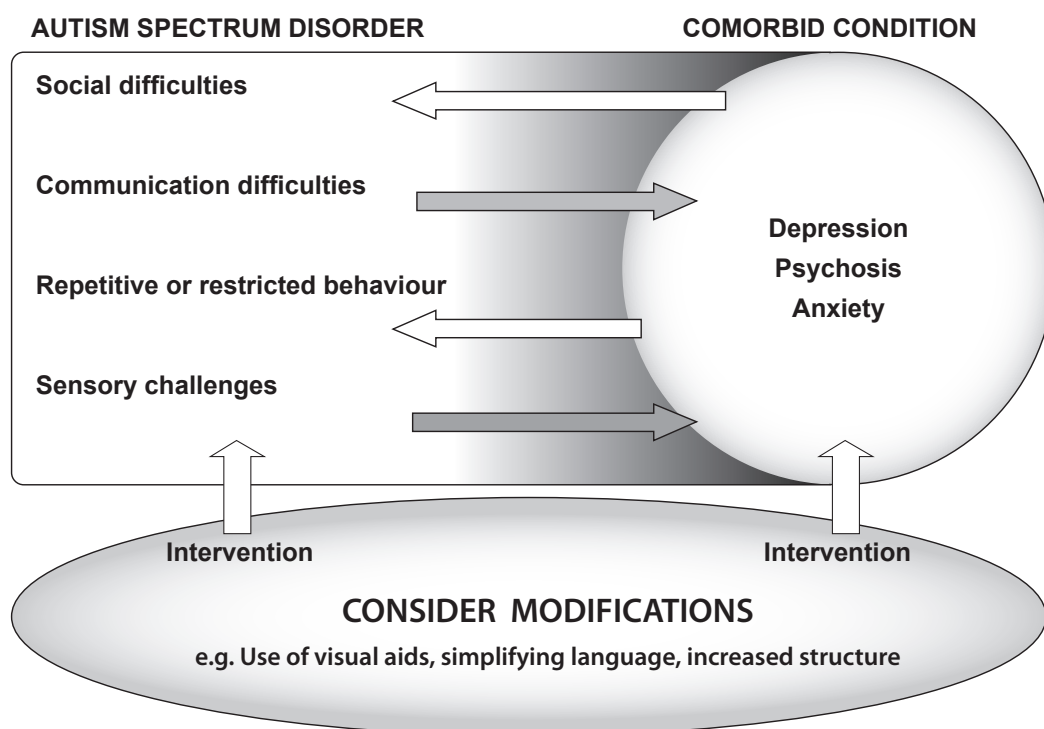
Modifying Psychotherapy for Young People with ASD

There is growing empirical evidence suggesting children and young people have the potential to engage and benefit from psychotherapy, in particular CBT (Sofronoff, K. et al., 2007; Sofronoff, K. et al., 2005) however, it must be modified to meet their cognitive and communication needs (Donoghue et al, 2011). There will be many challenges in building a therapeutic relationship with a young person with ASD. Tailoring therapy in a way that facilitates engagement is essential. There is no 'one-size-fits-all' approach, however, there are a range of modifications and adjustments that may be considered for each young person. Table 1, provides are a number of example modifications. Part 5 of this manual provides specific aids to implementation.

Table One: Example modifications to psychotherapy for young people with ASD

Central Principle	Implementation Examples
Make the abstract concrete	<p>Use visual aids and cues.</p> <p>Provide tangible and specific examples eg: how other young people have coped or managed .</p> <p>Reduce reflective language.</p>
Provide information	<p>Be more specific and detailed than you might ordinarily.</p> <p>Outline how the clinical encounter works, and the expectations on both sides of the social equation.</p> <p>Map and agree to an agenda or broad structure for how the session will unfold.</p>
Provide structure and predictability	<p>Stick to a routine.</p> <p>Have regular appointment days and times.</p> <p>Keep therapy rooms the same. Where this is not possible, give forewarning.</p> <p>Use language such as “sometimes” or “usually” so that fixed views are not developed. eg: “We will usually meet in this room, but sometimes it may not be available”.</p> <p>If there are last-minute changes, check in as to how this has impacted.</p> <p>Discuss and prepare for changes - such as discharge - well in advance.</p>
Support with processing verbal information	<p>Simplify language.</p> <p>Use visual aids to represent complex concepts and slow down discussion.</p> <p>Computers, email, text messaging, art and diagrams may all be useful aids.</p> <p>Provide a range of responses to choose from.</p> <p>Check understanding – don’t assume the young person will spontaneously advise if they do not understand.</p> <p>Explicitly encourage initiation (speaking up).</p>
Capitalise on strengths e.g., intelligence and acquisition of new information.	<p>Investigate a problem together.</p> <p>Set research or data collection projects.</p>
Make use of special interests	<p>Show an interest in special interests and areas of specialist knowledge.</p> <p>Routinely talk about topics familiar to the young person.</p>
Provide opportunities for generalisation and ongoing practice	<p>Include family members and other support people in sessions.</p> <p>Provide a written summary of key points of the discussion to take away.</p>
Minimise sensory distraction	<p>Ask about environmental distractions in the therapy space (e.g. lighting, perfumes, background noise of computers, temperature, airlessness, types of chairs, distracting visuals).</p> <p>Adapt the environment to maximise participation.</p>
Minimise EF difficulties	<p>Schedule shorter sessions.</p> <p>Limit eye-to-eye contact, to reduce the amount of information processing and attention required.</p> <p>Use clocks to manage time together.</p>
Reduce anxiety with distancing techniques	<p>Sit side by side.</p> <p>Use a computer screen.</p> <p>Talk about the problem while taking a walk or playing a game.</p>

Figure One: Intervention Principles



Case Study Andrew

Andrew is a 19 year old school leaver with a childhood diagnosis of ASD referred to mental health services following threats to kill himself after a devastating experience of peer rejection. Andrew learnt via social media his highschool peer group had been socializing without him. His angry attempts to reconcile led to further rejection. Adam was later diagnosed with a Major Depressive Episode.

Establishing treatment goals:

Andrew's treatment involved managing the initial risk of suicide and physical aggression to others. Individual therapy focused concurrently on CBT for depression and social skills training. Andrew was encouraged to attend a group program to develop social competencies and build social confidence. His family were offered support and psycho education. Medical management included anti-depressant medication.

Modifications to psychotherapy:

Modifications were made to Andrew's treatment that considered his inflexible and concrete thinking style, social communication difficulties and ToM deficits. Sessions were held at the same time each week and were shorter than usual. Language was direct and simplified. CBT was modified to include concrete examples. Notes were made and provided to Andrew at the end of the session summarizing key points. The therapist made her own thoughts and rationale for specific intervention strategies explicit.

Considerations in formulation:

The relationship between the ASD and symptoms of depression was considered.

ASD	Depression
Andrew has limited social interaction outside of school and enjoys spending time alone, vigorously pursuing a narrow range of interests (history and video gaming).	His computer game use and time spent alone had increased since leaving school. He was excessively monitoring social media.
Andrew has always had a limited emotional vocabulary and difficulty managing his emotions.	Andrew did not describe feeling sad, but became more irritable and short tempered than usual.
Andrew has inflexible and concrete thinking patterns.	Andrew's thinking became increasingly extreme and inflexible. He repeated demands to his parents "If you don't get me my friends back, I'll kill myself".
Andrew had reduced non-verbal communication (restricted affect and reduced eye contact).	Andrew's affect became increasingly restricted and eye contact further reduced.

Group Interventions

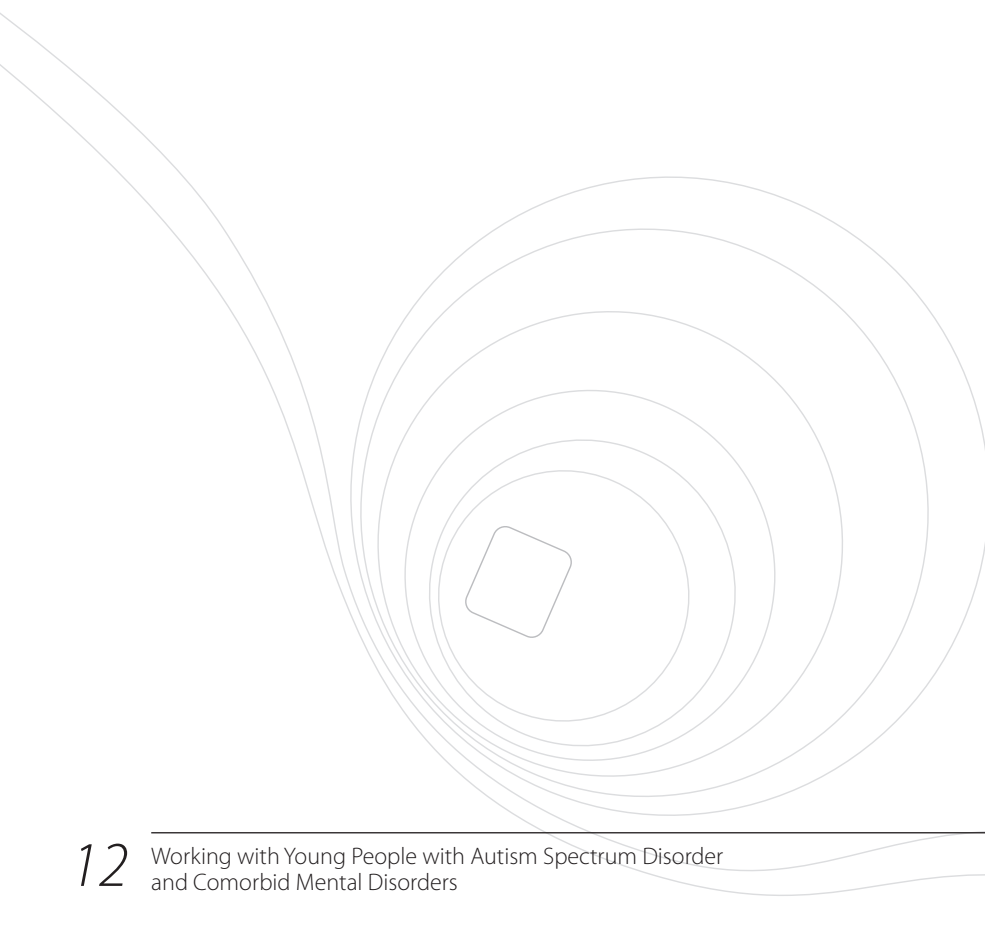
Group programs can be a useful addition to 1:1 therapy for young people with ASD. There are a range of formal social skills training groups described in the literature. Many young people may be reluctant to engage in didactic social skills training. Nonetheless, social skills may be developed or rehabilitated through a range of group formats including activity groups and normative social and recreational youth groups. Groups may be more likely to help a young person notice their special skills and strengths than to highlight their differences or weaknesses.

Groupwork interventions are most successful when the young person shares goals for their group involvement with their primary clinician and the groupworker. Common goals for young people with ASD attending include “making friends”, “feeling less alone” and “doing something different and fun in my week”. Discussion of goals between the groupworker, the primary clinician, the young person and any significant others in the young person’s life can lead to more behaviourally defined goals. In turn, this can lead to consent for the groupworker to support particular behaviours and work with the young person towards extinguishing others.

Groupwork can provide opportunities for individuals with ASD to adjust for ToM deficits. This occurs through the perspective-taking and self-disclosure that is common to lots of groupwork, eg: group rounds, group discussion. In vivo peer feedback often renders explicit the unspoken social rules that young people with ASD may not know or remember. This may be more powerful for the young person than feedback from workers, family, or teachers.

Groupwork can support improved executive functioning. Where the group is designed and facilitated with the specific difficulties of young people with ASD in mind, Young people can be supported to prepare for and manage change; transfer skills across multiple settings; learn new skills; sequence tasks; adjust behaviour according to peer feedback; and make use of emotion recognition and regulation skills learned in therapy.

Perhaps most importantly, groupwork provides young people with ASD with a different social experience from others that they have had. This can then be used to rebuild social confidence, enhance confidence and self-efficacy, and to prepare the young person for other settings. The experiences of peer connection and feedback in groups can support identity development and self-description



Part 4: Interventions that Address Difficulties Associated with Autism Spectrum Disorder

Psychoeducation

Young people presenting to a mental health service may have varying degrees of understanding about their diagnosis of ASD. It is important to begin by exploring their understanding of the diagnosis and feelings towards it. Degrees of acceptance vary from being a “proud Aspie” through to rejection of the label or limited awareness of it. Psychoeducation should also be provided to family members who are often grappling to understand what aspects of the young person’s behaviour can be explained by the ASD, adolescence or other mental health issues.

Special attention to ongoing and collaborative psychoeducation will be essential in the period following a new diagnosis. This may initially be introduced by the specialist autism assessment team, however, should be followed-up by the primary treating clinician.

✂ See Worksheet 1: Core Features of Autism Spectrum Disorder.

Affective Education

Extensive clinical experience and autobiographies show that while individuals with ASD can have considerable intellectual ability, there is invariably confusion and immaturity with regard to emotions. Affective education is considered a stage in a course of CBT that is essential for those with ASD (Attwood, 2003). With neurotypical clients, clinicians often work towards increased understanding of the emotion that is causing a problem. For young people with ASD it may be useful to consider all of the universal emotions. The main goals are to teach why we have emotions, appropriate responses to emotions, and the identification of different levels of emotion. Typically one emotion will be explored at a time (happiness, anger, sadness etc.). If clinicians encounter resistance to a structured program, they may find incidental opportunities to explore and educate about feelings.

Affective education might include:

- Developing a vocabulary to describe emotions and checking in that you and your client share the same interpretation of words to describe particular feeling states. Clinical experience has suggested that some clients with ASD may use extreme statements such as “I am going to kill myself” to express a more moderate level of emotional experience (Attwood, 2003)

✂ See worksheet 3: Feelings Chart

- Using rating scales, feeling thermometers or speedometers to teach range in emotions.

✂ See Worksheet 4: Thermometer.

- For older adolescents and young adults, consider using a pie chart capturing more complex emotional experiences, that incorporate more than one emotion, rather than a linear thermometer.
- Exploring the physiology of emotions.

✂ See Worksheet 5: My Body.

- Using mirrors to identify salient cues for emotions in self and others.
- Using magazines, photos, picture cards to practice emotion recognition.
- Using emotion diaries or a log book of feelings.

Case Study: Daniel

Daniel is a 16 year old male who disengaged from special school 12 months ago due to bullying. Daniel has had longstanding difficulties due to his moderate ID and ASD, but his family report that over the last year his anxiety and depressive symptoms have gradually worsened to the point that he no longer leaves the house, answers telephone calls, nor comes out of his bedroom when visitors are around. Family describe Daniel as looking sad and becoming very upset and oppositional with any encouragement from family to do these activities.

When meeting with Daniel, the therapist observed that Daniel had a very limited emotional vocabulary, and couldn't explain why he no longer performed certain activities except

to say, "I can't", "It's too hard". By selecting emotion cards that incorporated both written descriptions and facial expressions of different emotions, the therapist supported Daniel to identify his feelings about a range of activities. A thermometer chart was also used to help explain the varying strength of a particular emotion (e.g., fear), and Daniel was supported to rate each activity on the thermometer from 'most scary' to 'least scary'. This created a rationale for encouraging Daniel to start gently engaging in graded exposure work, starting with those activities that created less intense fear and rating his emotional responses following each practice. These tools also helped Daniel to keep track of his progress and to understand how practicing certain activities that he disliked was still helping him towards his longer-term goal of getting a job.

Emotion Management

Young people with ASD can often relate to having an emotional 'switch' rather than an emotional 'dimmer'. The development of skills to manage overwhelming feelings will reduce unhelpful behaviours such as aggression and self-harm. It's important to teach the concept that all feelings are permissible, but responses to feelings need to take account of context. Clinicians should start by considering the skills an individual already has in their emotional 'toolbox'. Young people with ASD will often use a special interest to effectively manage difficult feelings (e.g. distraction through video games). By exploring other interests and supporting their development, clinicians can support the young person to increase their repertoire of coping strategies.

Next, help the young person to identify the early warning signs of difficult emotions. A young person with ASD may find it hard to recognize and name the cognitive, behavioural and physiological experiences that accompany a particular event or particular emotion. Spend time investigating the emotional warning signs that can be recognized. For instance you might decide that a stomach ache and decision not to go to school are good enough warning signs that anxiety is taking hold, even though the young person cannot describe the worries or cognitive content that indicate fear or worry.

Emotion management needs to explore a variety of triggers for emotional responses that may not be in the awareness of the young person. This includes considering possible sensory triggers.

Dealing with Sensory Difficulties

Many people with ASD have difficulty processing everyday sensory information such as sounds, sights and smells. This is usually called having sensory integration difficulties, or sensory sensitivity. It can have a profound effect on a person's life.

Intervention might include:

- **Facilitating self-awareness.** Assist the young person to identify their own unique preferences and typical emotional and behavioral responses to various sensory stimuli in their environments. What is experienced as calming? Alerting? Uncomfortable? Family members can also provide helpful information about particular preferences the young person may have. See Worksheet 8: My Sensory Preferences.
- **Exploring and practicing.** Assist and encourage the young person to actively engage in experiential sensory activities, to find out how they may impact on their feelings and behaviour. Consider making a sensory kit for your work. A sensory kit is a collection of objects that can be used experientially with clients to explore their sensory preferences and responses. The kit doesn't have to be large nor expensive, so long as there are objects that stimulate different sensory systems. Many objects can be collected from a supermarket or discount store, and can be stored in a shoe box or plastic tub. Self-rating scales can also be helpful aids.
- **Incorporating identified sensory strategies into daily life.** This may involve environmental adaptation, or assisting the young person to utilize strategies to assist them to better manage the sensory demands within the challenging environment (e.g., classroom). Encourage skill enhancement through practice and self-reflection. Helpful sensory strategies should be documented and communicated to relevant others (family, school, inpatient environments). The young person may develop their own portable sensory kit, to enhance coping in daily situations.



Practical Tip: Consider referral to an Occupational Therapist for completion of a Sensory Profile (Brown & Dunn, 2002)

Example objects for a sensory kit

- Stress balls
- Squishy toys or fidgets
- Elastic bands
- Plasticine
- Scented oils or fragrances
- Sour lollies
- Chewing gum
- Massagers
- Lotions/hand creams
- Eye mask
- Music player
- Rock candy, lolly pops
- Soft toys or fabrics
- String of beads
- Sunglasses
- Heat/cold pack
- Disposable ear plugs
- Postcards of different visual scenes (beach, mountains, etc)

Experiential activities to explore sensory preferences.

- Change of seating (e.g., swivel chair)
- Adjusting room lighting
- Wearing a heavy blanket/doona
- Having a cool or warm drink
- Listening to different types of music and exploring how this influences alertness
- Hot shower/bath
- Aromatherapy
- Different physical activities and exercises (jogging, skipping, swimming, stretches, etc)

Case Study: Sarah

Sarah is new to the service, and her therapist notices that she often presents as fidgeting and distracted during sessions. Knowing that young people with ASD may experience sensory processing difficulties, the therapist works with Sarah to explore how her sensory environment(s) impact on her ability to attend and perform at her best.

The 'My Sensory Preferences' worksheet is used to help Sarah rate how the different senses impact on her level of arousal, and is used as a springboard for further discussion and her family. It is found that Sarah often gets quite over-stimulated and stressed by visual stimuli, such as being in a large store, busy classroom or when a passenger in the car. It is also found that Sarah often feels 'bored' and restless when sitting still, preferring to move about and touch things. To test this out further, the therapist suggests a few adaptations to the counseling environment for Sarah to try out in the following session: sitting in a swivel chair, facing away from the window, and looking through a box of textured and tactile objects that Sarah might like to play with when they are talking. Sarah

picks out a squishy ball and fidgets with this throughout the session, but appears far less distracted and is more readily engaged in conversation. They agree to continue these sensory strategies during subsequent sessions, and discuss how their new understanding might be incorporated into other environments. At school, Sarah starts sitting closer to the front of her classroom as she finds she can focus more on the teacher and is less distracted by seeing the rest of the class. Her teachers agree to invite Sarah to get out of her seat to do helpful tasks such as handing out worksheets when she is appearing restless. Her sensory preferences are also incorporated into her crisis plan so that family and other clinicians are aware of what environmental factors can trigger Sarah's distress and what strategies will be most soothing.

Developing Social Skills and Understanding

Difficulties with social interaction and understanding lie at the heart of the barriers faced by individuals with ASD and often contribute significantly to co-occurring mood and anxiety disorders. Being social is complex and young people with ASD are often referred to as needing 'social skills training'. The term 'social skills' can mean different things to different people. When setting goals for psychotherapy it's useful to have a framework for conceptualizing social skills. Gaus (2007) provides a useful framework that breaks social skills down into three categories; instrumental skills, fund of social knowledge and social cognition skills.

Before beginning social skills training it's important to have shared goals for the work you are doing. Some young people with ASD may not have any desire to change their social life (e.g. have more friends or engage in more social activities). We all have different social needs and this should be respected. However, it's important to explore how social skills are useful to meet other life goals such as finding fulfilling employment or pursuing an interest. Motivational interviewing techniques, such as exploring the pros and cons of developing social skills, can be used to develop goals and prepare for this work.

Instrumental Skills

Instrumental skills are a specific set of behaviours such as making eye contact, greeting with a handshake, turn-taking and starting a conversation. The older the individual the more likely they have learnt instrumental skills. Instrumental skills can be memorized and performed without any knowledge about what others in

the environment are thinking. Instrumental skill teaching might include:

- Using self rating scales to identify instrumental skills that might require teaching and practice.

✂ See Worksheet 11: Conversation Rating Scale.

- Instructing in specific skills, through providing a rationale and strategy. In encouraging appropriate eye contact you would first explore the rationale for making eye contact - others know you are interested and listening. This would be followed by providing a strategy for using eye contact – look at the speaker whenever there is imagined punctuation in the dialogue (pause, comma, full stop).
- Writing scripts to prepare young people for specific social encounters e.g., steps to communicating at your Centrelink appointment
- Practicing instrumental skills in session through role plays.

✂ See Worksheet 10: Ingredients of a Good Conversation and Worksheet 12: Conversation Brainstorm Bubbles.

A major problem for instrumental skill teaching is aiding generalisation to more naturalistic settings. This problem can be tackled through use of the young persons own environment and involving family members.

Case Study: Jeremy

Jeremy, a 17 year old, presented with depression, social anxiety and features of ASD. In an attempt to manage his anxiety in public, he wore sunglasses, kept his ear phones in and wore his hair over his eyes. Jeremy's case manager helped him to understand that communication can be both verbal and non-verbal. Together they considered the impression his non-verbal behaviours might make on others. It was suggested to Jeremy that others may

perceive these gestures as disinterest, and that the unintended consequence may be that others feel nervous to approach him. This could perpetuate his feelings of isolation in social situations. Consequently, Jeremy and his case manager would roleplay small talk scenarios and practice using instrumental skills such as eye contact, using a friendly face, using people's names and initiating conversation.

Fund of Social Knowledge

Increasing the fund of social knowledge involves providing information about the unwritten rules in social situations. Typically this knowledge is acquired through inference and over time, based on observations of others and deductions made about non-verbal feedback. In contrast, people with ASD need explicit instruction about these norms. Information about social norms and peer culture is vital for a young person with ASD. Unlike teaching instrumental skills, learning about social norms requires an ability to imagine the expectation of others. Many social rules exist in the minds of people in society/culture and are not written down. Therefore increasing fund of social knowledge might include:

- Being explicit with your clients that your role can be as a coach, advisor and interpreter for social situations. Provide a rationale for this – “Our brains work differently – you have a stronger mind than me for facts and logic, I have a stronger mind than you for socialising. I could benefit from you for understanding facts and logic. You could benefit from me for understanding emotions and social situations”. Many clients will want your recommendations about what to say, what to wear and how to handle social situations.
- Using tools such as published social etiquette books.
- Exploring the young person's use of social media to acquire insights into some of the young persons social difficulties and an opportunity to describe social norms (e.g. “If somebody has not responded to you after 3 attempts at contact they are probably not your friend”).
- Provide education on particular social norms in the form of lessons for social success.

Some Lessons for Social Success

1. The Difference Between Friends & Friendly. Highlight the difference between friendly behaviours between acquaintances and attributes of a friendship.

✂ See Worksheet 9: The Friendship Hierarchy.

2. How We Present Ourselves Matters. Explore how presentation (body language, physical proximity, clothes, personal hygiene) affects the impression we make on others and how they respond to us.

3. Different Relationships Have Different Boundaries. Explore how behaviour and communication will be different, depending on levels of closeness.

✂ See Worksheet 5: My Body and Worksheet 7: The Comfort Zone.

Social Cognition Skills

Having instrumental skills and a fund of social knowledge is still not enough for social success. For young people to act socially, they need to be able to think socially. Interventions must take into account fundamental deficits in social cognition. Social cognition refers to the mental operations underlying social interactions, which include the ability to imagine and understand the intentions and dispositions of others. In every social encounter we are required to assess the social context, observe the verbal and non-verbal behaviour of others, infer their mental states, understand what is expected, and behave accordingly. For most of us this kind of social processing occurs in an automatic, flexible and dynamic way. For young people with ASD, this needs to be learned. By adolescence, they may be able to perspective take outside a social interaction – for example, describe the unspoken motivations of a character from a book or a television program or retrospectively notice what was occurring in a particular social situation. However, during a social situation, the young person may lose the ability to track others' intentions, or to carefully plan how to behave.

Developing social cognition can be done through the didactic delivery of commercially available materials, using vignettes and examples (e.g. Garcia Winner, 2007). These tools will provide frameworks for retrospective discussions about encounters the client has had between therapy sessions. CBT also lends itself to enhancing social cognition through practice with interpretation of the social environment. CBT can include;

- recognising the difference between social facts and guesses;
- understanding the influence mood has on social guesses;
- appreciating multiple interpretations of ambiguous situations and;
- practice with gathering and testing evidence for conclusions.

✂ See Worksheet 6: Thoughts and Feelings.

The therapeutic relationship is another opportunity for developing social thinking that should not be missed. For instance, engage in a discussion about the communication issues or social mistakes taking place in the sessions, rather than continuing to listen and express interest and curiosity when you are getting bored or feeling offended. You will need to establish rapport first and provide a rationale for feedback. It's best to warn early on that the client might be interrupted in order to ask questions or provide feedback about a particular communication style (e.g. monologues) and you may like to devise a signal. At times it's helpful to include emotional reflection in your feedback (e.g. I feel x when y).

Developing skills in social cognition may also be done through guided conversation that explores the mental operations of your client and others in any social encounter.

Guiding Conversation to Facilitate Social Cognition

Be curious about the mental operations of your clients

"Tell me about what you were thinking?"

"What made you have that thought?"

"How were you feeling?"

"I can see you getting very tense/crying...tell me about what you are feeling?"

Be curious about the mental operations of others

"What effect did that have on the others?"

"What might they have been thinking or feeling?"

Be transparent about your own thoughts and feelings as a therapist

"When you said that I had this thought..."

"I have just been reminded of another conversation we had..."

"I felt quite sad to hear about that experience..."



Practical Tip: Consider referral to a Speech Pathologist who has specialist skills in teaching social communication

Case Study: Trent

Trent, aged 22, has been attending for several sessions and is troubled by anxiety and obsessional thinking about current work relationships and the prospect he may lose his job. You notice a pattern of Trent monopolizing the conversation, speaking over the top of you and providing too much detail that's difficult to follow. You decide it time to address this with compassionate feedback.

Therapist: *Before we begin Trent I want to point out a pattern I've noticed developing in our sessions. It seems your anxiety has you talking so much when we are together that I sometime find it hard to keep up and contribute to the conversation. Do you think this could be a problem?*

Trent: *yes, yes, I'm sorry I know I talk too much...*

Therapist: *What affect might it have on me or other listeners?*

Trent: *Well people get frustrated with me...or bored...*

Therapist: *And what is the consequence for you when this happens?*

Trent: *People get sick of me and don't want to be around me...I also feel like I'm not getting anywhere...I never get the answers I'm looking for.*

Therapist: *So shall we try and do something different in our sessions together?*

Trent and his therapist developed a plan for dealing with the "over talking" as he named it. Trent practiced noticing facial expressions that indicated the therapist wanted to interject and had something to say. He used imagery of a tennis match and stop sign to increase reciprocity and gave permission for the therapist to interject with a time out signal when "over talking" crept in. By following this plan he reflected that the conversation felt more helpful and began to apply some the same principles to relationships outside of therapy.

Case Study: Tom

Tom is a 23 year old man who is yearning to find a girlfriend. He arrives at your sessions and informs you that he was at a work trial over the weekend at a pizza restaurant. He met Sue, a waitress and they had several conversations. Following this he feels excited by the prospect he's met "the one" and can't wait to ask her out and begin the relationship. He seeks your advice about how to proceed.

Therapist: *You seem very interested in Sue. Do you think she has the same feelings for you?*

Tom: *She knows some of the same people I do, she's Greek like me and she shared lots of information about herself to me (like where she lives and which footie team she barracks for).*

Therapist: *They are good signs that you have some things in common and she's a friendly person! How might you figure out if Sue is interested in pursuing a friendship or romantic relationship with you versus being a friendly work colleague?*

Tom: *If I asked her to my birthday party in a few weeks time and she declined it may mean she's not interested. If we continue having friendly conversations over several weeks it might mean she is interested. If she seeks me out for conversations, rather than me seeking her out, it may also mean she's interested.*

Therapist: *These seem like great hypotheses to test out before deciding if Sue is really "the one".*

Sex, Intimacy and Romantic Relationships

Adaptive expressions of sexuality and the development of healthy intimate relationships are important part of social skill development. Young people with ASD will often face confusion about the "unwritten" rules of intimate relationships and sex. Impaired theory of mind and misinformation (e.g. use of internet pornography) can lead to misunderstanding, confusion and inappropriate sexual behaviour. A clinician should be routinely asking about sexuality and supporting the development of adaptive skills for healthy sexuality (Henault, 2006). This may begin with providing social skills training and include information and guidance around topics such as puberty, dating, sexual knowledge and identity, and intimacy. It is important to consider the young person's physical health and ensure they have adequate information about sexual safety and sexual health.



Practical Tip: Consider referral to a specialist counsellor or sexual health nurse

Managing Social Anxiety

More often than not, young people with ASD will experience social anxiety. It can make social skills appear worse than they are. For young people with ASD the fear can often be about what they don't know, as well as fear of negative evaluation. Intervention for anxiety should always be accompanied by social skills training.

Intervention might include:

- Providing concrete details about what to expect in specific social situations. Having fewer things to 'predict' can help alleviate anxiety.
- Rehearsing potential social encounters through preparation and role-play, to maximize likelihood of enjoyment or success.

✂ See Worksheet 12: Conversation Brainstorm Bubbles.

- Using modified CBT incorporating graded exposure.

✂ See Worksheet 7: My Comfort Zone.

- Highlighting competencies – develop and 'tune in' to stories about doing social things in the face of anxiety, and express curiosity about what made this possible.

Case Study: Vince

Vince was a 16 year old man who had disengaged from school and spent most of his time in his bedroom playing video games. Vince worked with his case manager to visually represent the activities he felt most comfortable with (playing video games) and then began to explore other activities, in order of increasing levels

of discomfort. Using a CBT framework to manage anxiety, Vince began to make small steps outside his comfort zone, like speaking on the phone, and noticed that after the initial discomfort came some rewards. He was able to return a phonecall that lead to a traineeship opportunity!

Exploring Identity and Developing Self-Understanding

Identity is a tricky thing for adolescents in any case, but ASD complicates the issue - some of the tools that are normally used to construct self-concept are missing or low-functioning. The sense of self and worth is generated through noticing and interpreting how others respond. For a person with ASD, many of the cues and signals that feed the identity and self-esteem machine are difficult to understand. Some ways to explore identity include:

- Using genograms
- Using timelines to create a sense of self across time
- Creating mock social media profiles to explore interests, preferences, likes and dislikes.

✂ See Worksheet 13: Personal Profile.

- Using exercises where answers to concrete questions are used to elicit more abstract values

✂ See Worksheet 14: Values

- Identifying roles models (e.g, family members, teachers, sporting stars, fictional characters) and explore the attributes of these individuals.
- Consider group programs which enable specific feedback to the young person about their attributes

Transition Planning

Times of change and transition will be especially stressful for a young person on the autism spectrum. It is essential to consider:

- Preparing early for discharge from your service
- Early referral to, and engagement with, community supports.
- Delivering intervention in a variety of naturalistic environments (e.g: Macdonalds, TAFE). This helps with generalising skills.
- Naming skill sets and using visual diagrams to show similarities between environments (e.g., clinical setting, school, TAFE), and how those skills might be used in different settings.

✂ See Worksheet 15: Now and Later.

- Assist in preparing for work and career with stepped plans, calendars and timelines

Pharmacological Interventions

There is no established evidence for the use of pharmacological interventions to address the core features of ASD. They may be used to address challenging behaviour when psychosocial or other interventions cannot be delivered because of the severity of the behaviour. Pharmacotherapy may be also be considered for treating co-existing mental disorders. Refer to the current National Institute for Health and Clinical Excellence (NICE) guidelines for Autism for further guidance on medical management (<http://guideline.nice.co.uk>).

Part 5: Tools for Clinical Work

Worksheet 1: Core Features of ASD

Worksheet 2: Support Star

Worksheet 3: Feelings Chart

Worksheet 4: Thermometer

Worksheet 5: My Body

Worksheet 6: Thoughts and Feelings

Worksheet 7: The Comfort Zone

Worksheet 8: My Sensory Preferences

Worksheet 9 The Friendship Hierarchy

Worksheet 10: Conversation Ingredients

Worksheet 11: Conversation Rating Scale

Worksheet 12: Conversation Brainstorm Bubbles

Worksheet 13: People Profile

Worksheet 14: Values.

Worksheet 15: Now and Later

References

1 Core Features of Autism Spectrum Disorder

Target

To develop a shared understanding between the young person, clinician and young person's family of how ASD impacts on them.

Use

This is a tool to describe or explore the features of ASD in language that is respectful and easily understood. However it's still important to check in for level of understanding and seek to provide specific examples for the young person. The list includes both difficulties and qualities. You can use the worksheet check boxes or create your own list using a whiteboard or paper. The 'qualities' are often considerable strengths (e.g. attention to detail). It's important to include as many strengths as possible to your list. The qualities or attributes might also be both helpful and unhelpful depending on the context, this can be a useful thing to explore (e.g. enjoy spending time alone – when is this helpful? When is this unhelpful?).

1 Core Features of Autism Spectrum Disorder

People have a range of strengths and difficulties in different areas. Everyone is different!



Social

- ☐ Difficulty using eye contact
- ☐ Difficulty guessing another person's perspective (eg: how they might be thinking or feeling)
- ☐ Difficulty understanding "social rules" (eg: how to behave in different kinds of situations)
- ☐ May find social situations confusing
- ☐ Difficulty making or keeping friendships
- ☐ Can easily enjoy time spent alone



Communication

- ☐ Difficulty holding conversations (eg: may not know what to say)
- ☐ Difficulty getting involved in group conversations
- ☐ Misunderstanding some things (eg: jokes)
- ☐ Difficulty reading emotions in other people
- ☐ Difficulty noticing and describing own emotions
- ☐ Having a strong vocabulary
- ☐ Can easily talk a lot about 1 or 2 special topics
- ☐ Difficulty noticing 'non-verbal' cues (eg: body language) and/or responding to them the way that people expect



Behaviour

- ☐ Very focused or intense interests
- ☐ Very determined about values and morals
- ☐ Preferring things to stay the same, or having a routine
- ☐ Habits or rituals (eg: collecting things, or doing things a certain way)
- ☐ A good ability to follow rules



Body

- ☐ Sensitive to certain sounds, tastes, smells or feelings on your skin
- ☐ Difficulties with coordination or clumsiness (eg: trouble with some sports)
- ☐ Difficulty with handwriting
- ☐ Feeling changes in temperature or pain more or less than others
- ☐ Difficulty with sleep
- ☐ May not care much about fashion or 'grooming'



Thinking

- ☐ Logical thinker
- ☐ Good with facts and figures or details
- ☐ Good at visualizing things
- ☐ Specialist knowledge in certain areas
- ☐ Good at research – curious and inquisitive
- ☐ Difficulty with abstract ideas (eg: 'the future')
- ☐ Like having things written down to help remember

1 Core Features of Autism Spectrum Disorder

People have a range of strengths and different cultures in different areas. Everyone is different!



Social



Communication



Behaviour



Body



Thinking

worksheet

2 Support Star

Target

To introduce the concept of a support team and prompt clinicians and families to consider the wide range of needs in a young person with ASD.

Use

Add the names of current or prospective support people to each arm of the star, representing different domains in the young person's life.

worksheet

2 Support Star

Name each arm of the star with an area of your life (eg. Friends, Family, School, General health, Recreation, Emotional wellbeing). Now consider who might support you in each area, and how they might help.

A seven-pointed star is centered on the page. Each of the seven points of the star has a short vertical line extending downwards from its tip, intended for labeling the different areas of life. Surrounding the star are several sets of horizontal lines for writing, organized as follows:

- Top-left: 5 horizontal lines.
- Top-right: 5 horizontal lines.
- Bottom-left: 5 horizontal lines.
- Bottom-right: 5 horizontal lines.
- Left side (between top and bottom): 5 horizontal lines.
- Right side (between top and bottom): 5 horizontal lines.

Mr Potter

Helps organise assignments

Time out cards

Catches up with mum

sensory kit

Education

Example

✓

V

$$\frac{1}{v}$$

Jane

Picks me up for soccer

Bob

Helps me with soccer

Fun

✓

3 Feelings Chart

The Feelings Chart can be a good starting point for a number of interventions, and can be used in a variety of ways.

Target

To assess emotional awareness and emotional vocabulary

Use

Look at the chart together and ask the young person to identify which emotions they are familiar with. Invite the young person to suggest different times where they may have felt different ways. Take note of which emotions are known and familiar to the young person and which are more unfamiliar.

Target

To improve awareness of own emotions and expand repertoire of emotional language

Use

Look at the chart together and identify how the young person is feeling. This can be a helpful "check-in" at the beginning of each session, to keep communication about emotions a part of the routine. Considering an event that the young person has described, invite them to indicate how they were feeling at the time of the event. Encourage them to identify the emotion initially rather than begin with their actions.

Invite them to consider how the other person may have been feeling at the time of the event. Encourage them to consider how the person looked, and what they did.

Target

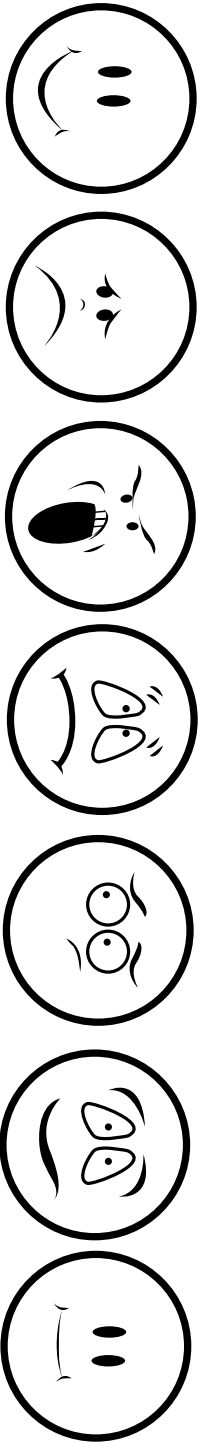
Improve understanding of mixed emotions

Use

Invite young person to consider that it may be possible to feel multiple emotions at once, and that this may be confusing. Working together, using a specific example, name the different emotions that the young person was feeling.

worksheet

3 Feelings Chart



Intensity	Happy	Sad	Angry	Fearful	Ashamed	Confused	Safe
High	thrilled	miserable	furious	terrified	humiliated	bewildered	serene
	elated	agonised	enraged	petrified	embarrassed	torn	tranquil
	joyful	hopeless	mad	panicked	bashful	mixed up	peaceful
	excited	heartbroken	agitated	anxious	awkward	foggy	calm
Medium	cheerful	unhappy	frustrated	worried	silly	split	relieved
	glad	down	annoyed	uneasy	self-conscious	uncertain	comfortable
	satisfied	disappointed	irritated	nervous	uncomfortable	undecided	content
Low	OK		bothered	cautious			

4 Thermometer

Target

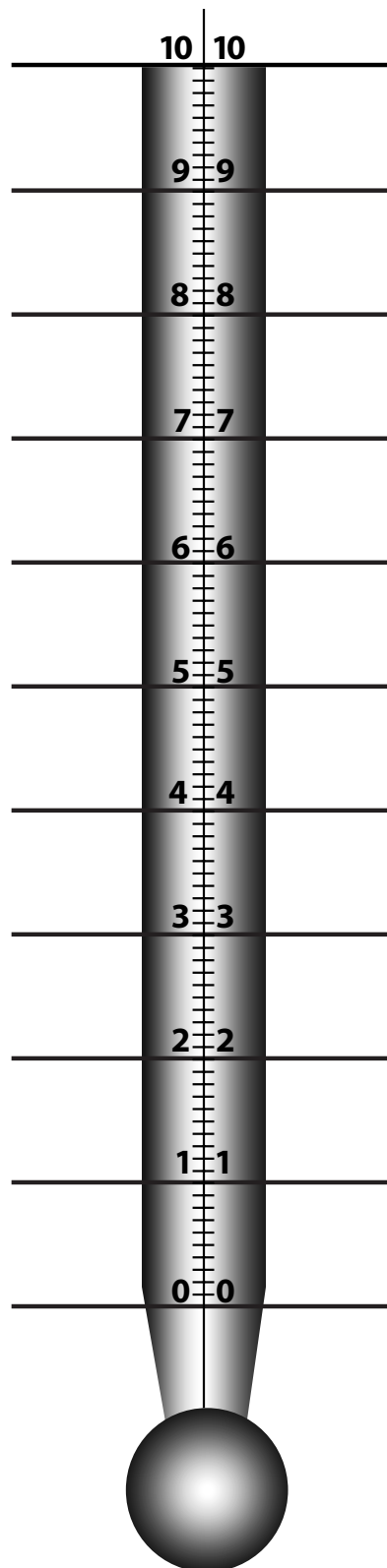
To improve awareness of the range of emotional experiences.

Use

This activity may be either didactic or young person-lead and should be used in a way that matches the developmental level of the person you are working with. For instance, a younger adolescent or someone with an intellectual disability may benefit from use of the tool in a concrete way – as a worksheet for rating their own feelings. With other clients it may be used more as a discussion point for exploring their experience of feelings and how/whether they differ in range or intensity. For example, a young person who exhibits externalizing behaviours when highly aroused may benefit from being asked “can you show me how angry you were when Travis wouldn’t share the video game? And now can you show me how angry you were when the teacher didn’t notice you putting your hand up?”

worksheet

4 Thermometer



5 My Body

Target

To improve awareness of the physiology of emotions

Use

Invite the young person to annotate the body outline with sensations that they experienced whilst feeling the specific identified emotion, or whilst in a particular situation. Work towards linking the physiological experiences with the emotion 'name'. A series of different outlines might be developed for different emotions.

Target

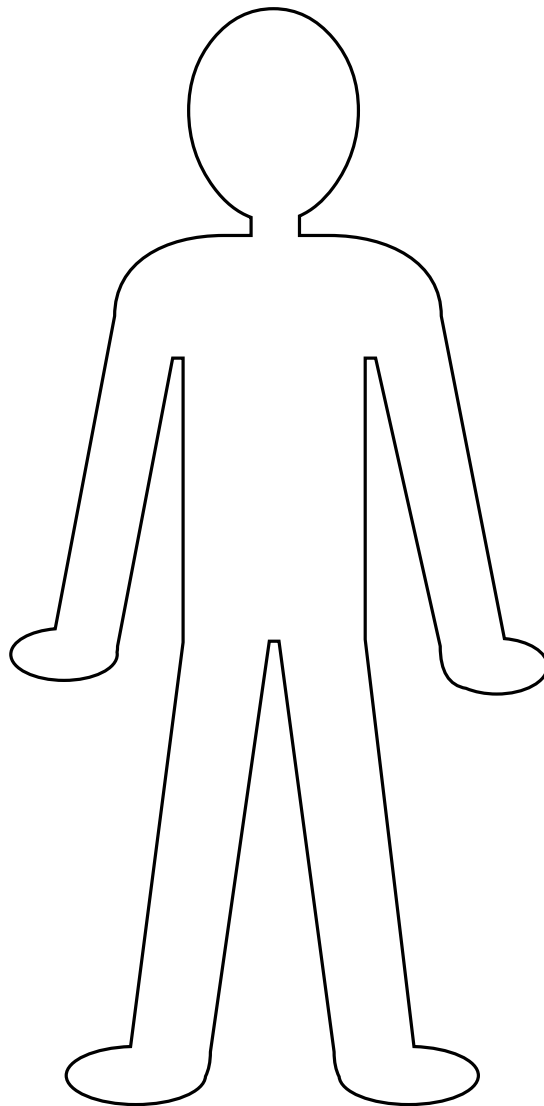
To teach about physical boundaries and limit-setting.

Use

This may be either didactic or young-person lead. Discussing a specific social relationship, mark on the body outline either the areas the young person can touch on the other person or the areas on the young person that can be touched. You may want to use two different outlines – one for the young person, and one to denote the other person in the relationship.

worksheet

5 My Body



6 Thoughts and Feelings

The cognitive demands of CBT must be modified to meet the cognitive needs of someone with ASD. For this reason, the clinician might take a more directive approach (instead of socratic questioning), provide concrete examples and explore alternative ways of thinking supported by logical evidence. Visual aids are also important.

Target

To demonstrate that there are alternative interpretations of an experience and more than one way of thinking about something; to build skills in making alternative interpretations.

Use

This worksheet can be used to provide a visual example of alternative ways of thinking and the linked feeling and behaviour. The worksheet may initially be used to 'teach' the concept. Subsequently, the young person may be invited to consider an event in their own life and generate alternative thoughts, feelings and consequences.












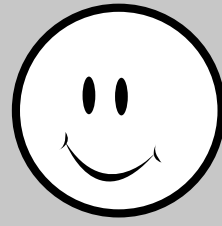
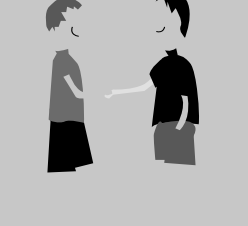
Target

To demonstrate that mood or emotions influence the social guesses we make in any social encounter; to build skills in identifying the influence of particular emotions on social encounters.

Use

Examine the comic strip together. Ask the young person to imagine entering the scenario already feeling angry/depressed/happy/anxious. Consider which social guess they might make. Invite the young person to consider a social event in their own life. Get them to imagine themselves in different mood states and generate thoughts for each.

6 Thoughts & Feelings

A ntecedents Event/Situation	B eliefs Thought	C onsequences Feelings	D o Actions
 <p><i>"You see an old friend across the street and they walk straight past without saying hello"</i></p>	<p><i>He ignored me totally, no one ever likes me</i></p> 		
<p><i>"You see an old friend across the street and they walk straight past without saying hello"</i></p>	<p><i>He's got a lot of nerve, ignoring me like that, I can't believe he treated me this way</i></p> 		
<p><i>"You see an old friend across the street and they walk straight past without saying hello"</i></p>	<p><i>I want to say hello to him, but I will probably just make a fool of myself again</i></p> 		
<p><i>"You see an old friend across the street and they walk straight past without saying hello"</i></p>	<p><i>He's probably distracted and just didn't see me and I know he is pretty shy</i></p> 		

7 The Comfort Zone

Target

To support an understanding social anxiety and graded exposure

Use

Encourage the young person to write down places/situations/people that they feel comfortable and confident with on the 'couch'; and conversely those that are currently outside their comfort zone, but which are important to them, in the relevant outer circles. Filling out the different sections can create a hierarchy of anxiety-provoking situations that could form the basis of a graded exposure therapy intervention. Explore strategies for approaching activities or places outside of their comfort zone.

Target

To identify coping strategies

Use

The 'couch' items may be discussed as safe helpful coping strategies that can be used in difficult situations.

Target

Identify goals and facilitate change

Use

Express curiosity regarding how the young person learned what things were inside their comfort zone. Express interest in the activities outside the comfort zone, and whether the young person wants to pursue these at any point.

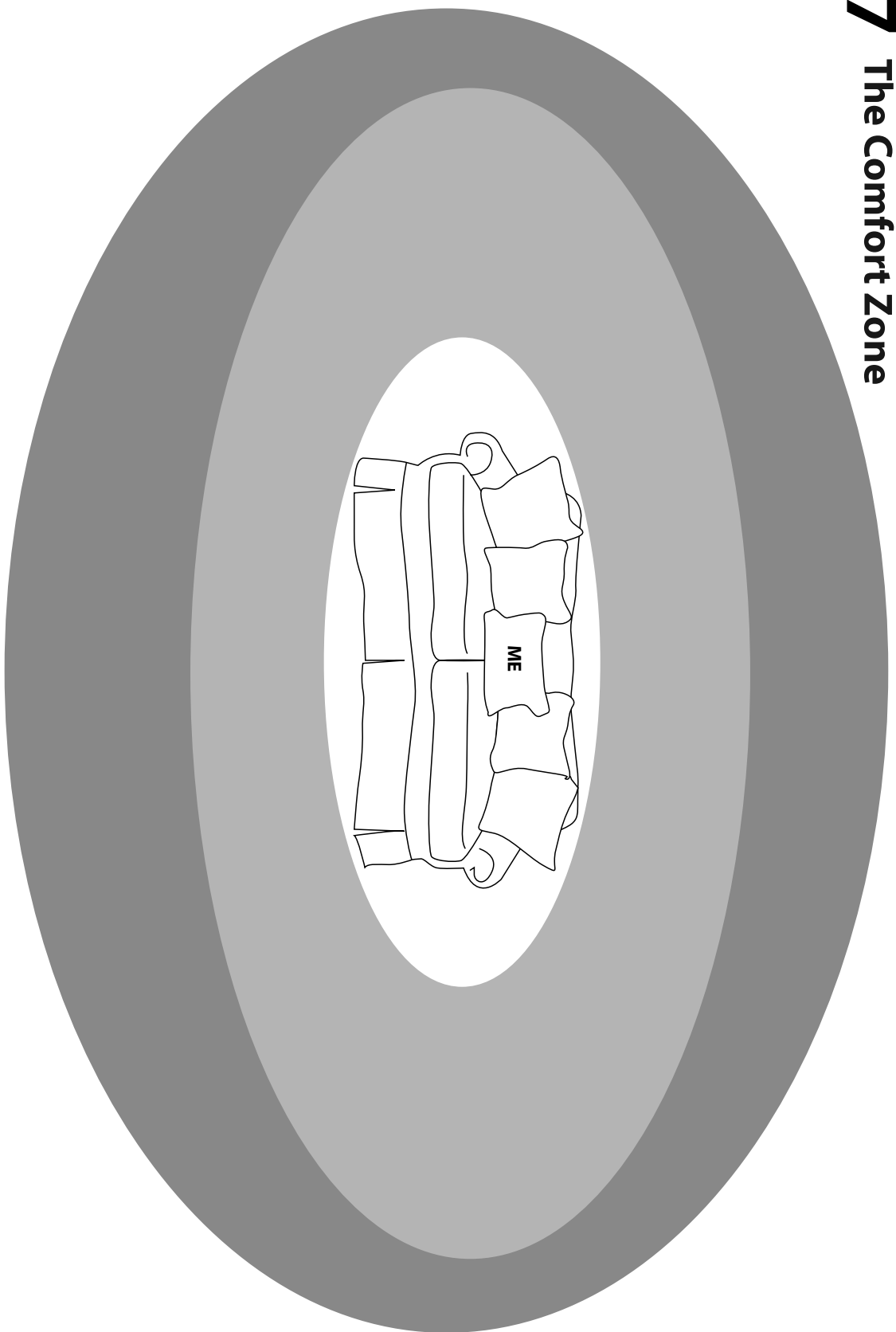
Target

To identify interpersonal boundaries

Use

Label the concentric circles progressively outwards from the people the young person is closest to, such as family members to those they know distantly, such as acquaintances. Targeting either behaviour or verbal communication, work with the young person to 'brainstorm' the different ways they interact with the people they know, depending on closeness.

worksheet
7 The Comfort Zone



worksheet

8 My Sensory Preferences

Target

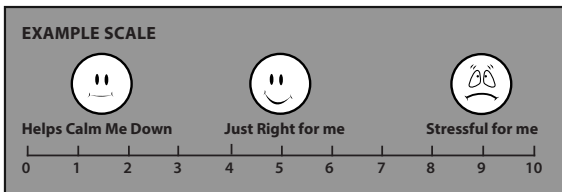
To explore a young person's sensory profile. It can assist in identifying strategies to manage sensory overload and add to a young person's repertoire of coping strategies to manage difficult emotions (distress, hyperactivity, depression etc.)

Use

An initial screening tool to identify sensory sensitivities that may require further assessment (a full sensory profile can be administered by an OT).

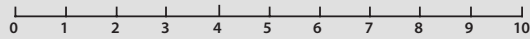
8 My Sensory Preferences

Every day we encounter a range of sensory stimuli, such as sights, smells, sounds and tastes. These can be experienced as calming (help us to feel relaxed), energizing (give us energy to feel alert) or distressing (really uncomfortable or even painful).

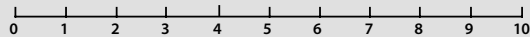


Visual (seeing)

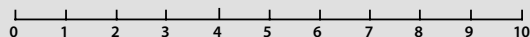
Watching a fast paced movie or TV show



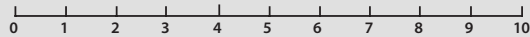
Seeing lots of movement around me



Looking at nature (clouds, the ocean, stars)

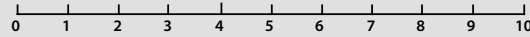


Looking at something colourful

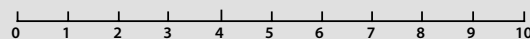


Auditory (hearing)

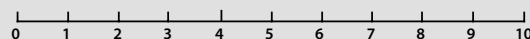
Listening to nature sounds



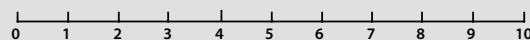
Listening to music (what type?)



Being somewhere noisy (lots of talking)

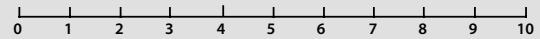


Hearing the voice of people I know

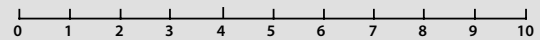


Touch

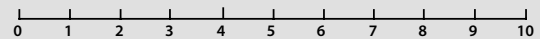
The feeling of brushing my hair or teeth



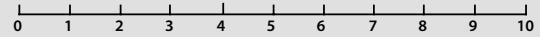
The feeling of unusual food textures in my mouth



Having my back rubbed

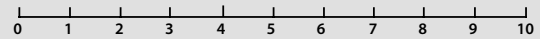


Sitting or standing very close to others

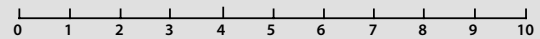


Movement

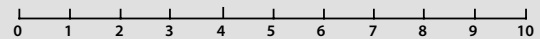
Sitting in a rocking chair or swivel chair



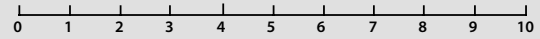
The feeling of being in an elevator or escalator



Going on rides

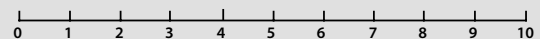


Sitting still

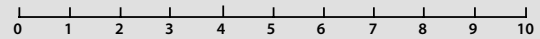


Smelling and Tasting

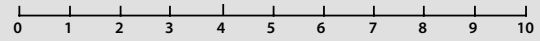
Scented candles (what type?)



Other people's perfume



Eating a strong tasting food



9 The Friendship Hierarchy

Target

Recognize that there are different levels of friendship and factors that facilitate or prevent progression through each level.

Use

Consider the different levels of friendship from stranger to close friend. What is the difference between a friend and somebody you go to school or work with? Where would an online friend sit on the friendship hierarchy? Encourage the young person to identify where the various people they know might sit on the hierarchy. Explore the different ways you might progress from one level to the next. Explore the barriers to progressing from one level to the next. For example, moving from associate at school to hang out friend might require initiation or making invitations and this can be hard for some people.

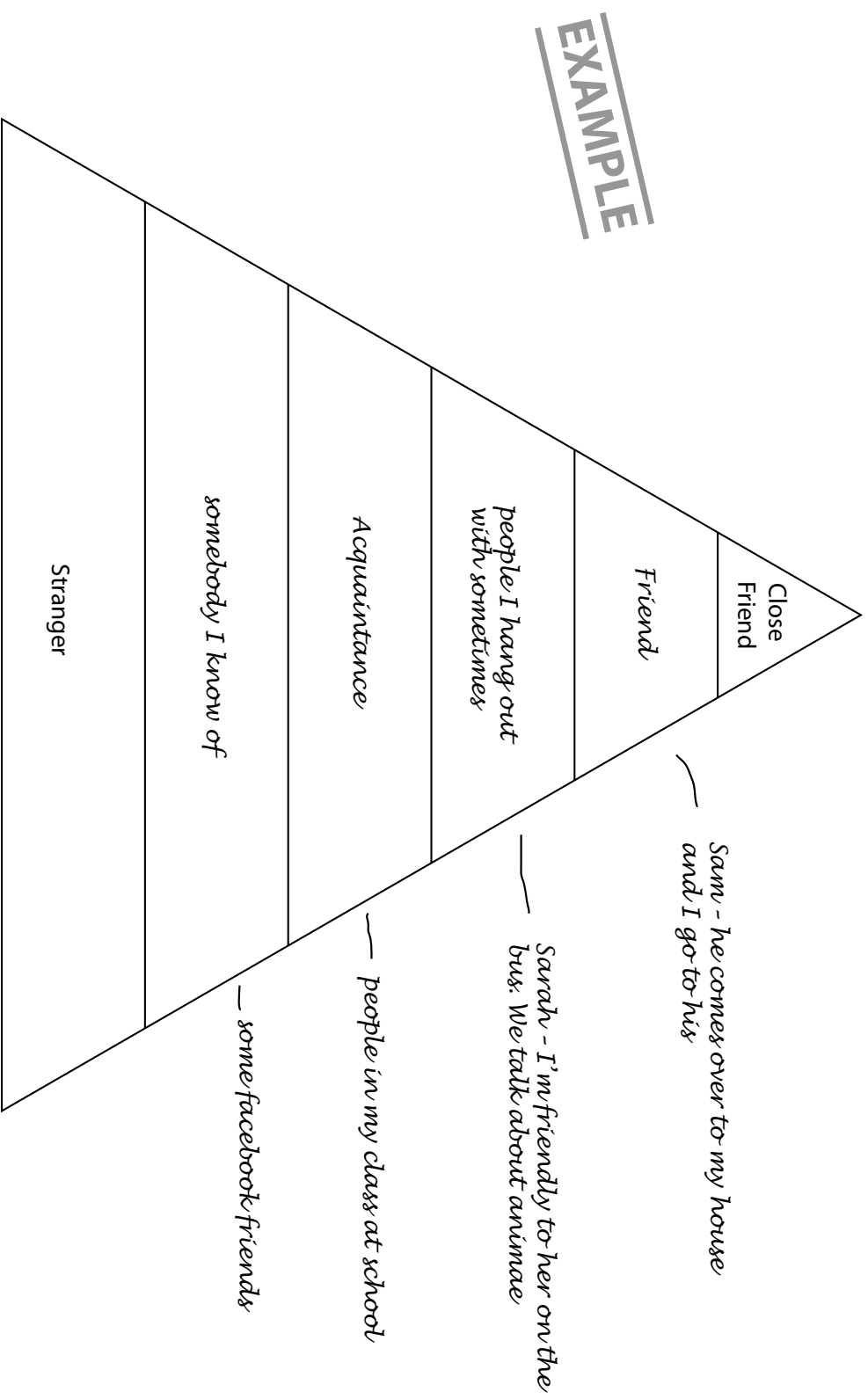
Target

To recognise the difference between friends and friendly.

Use

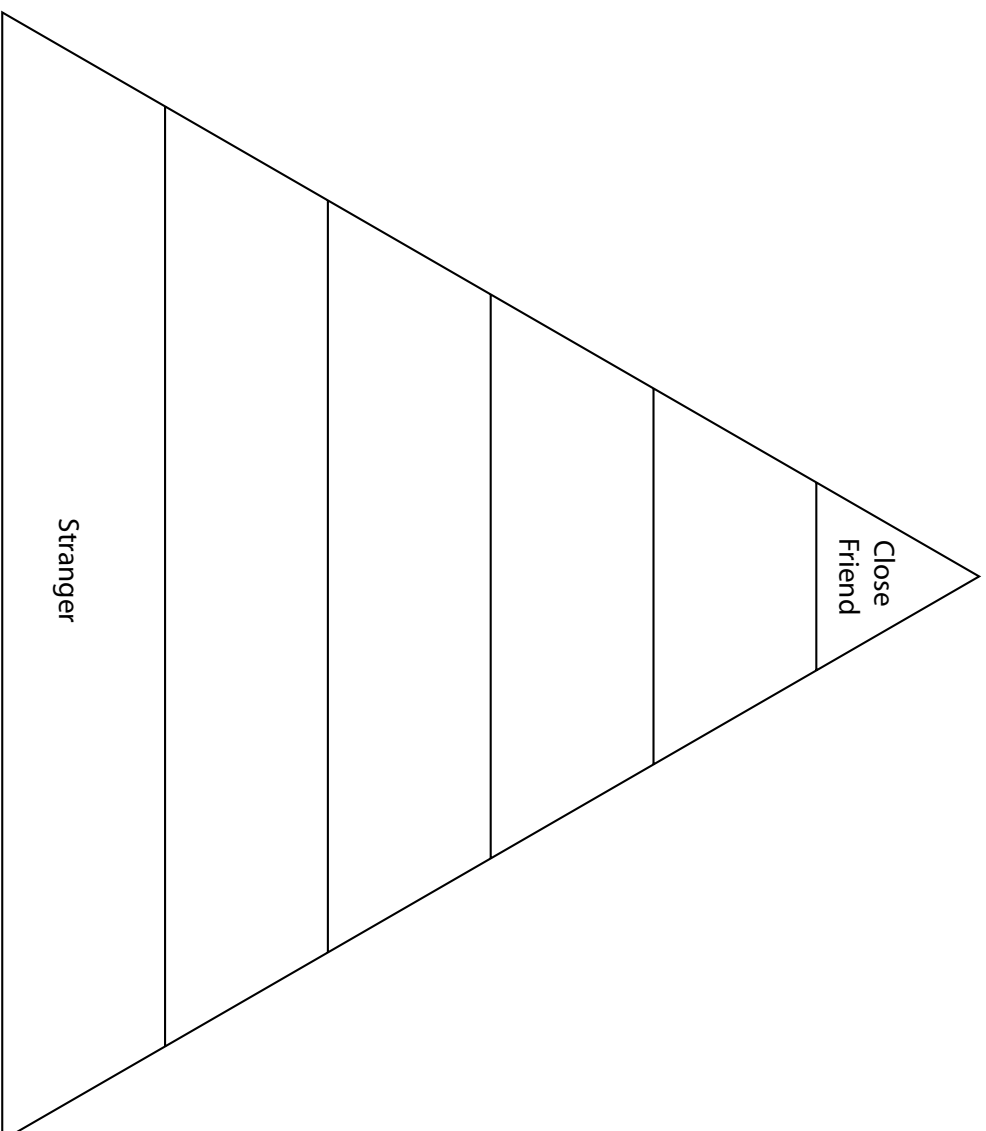
Explore the kinds of behaviours one might expect at each level of friendship. Highlight the difference between friendly behaviours between acquaintances (greetings, small talk) and attributes of a friendship (enjoying activities together, sharing of more personal information, make efforts to keep in touch)

9 The Friendship Hierarchy



worksheet

9 The Friendship Hierarchy



worksheet

10 Ingredients of a Good Conversation

Target

To provide education and increase knowledge about the elements that make up a successful conversation. This includes both verbal and non-verbal communication.

Use

Can be provided as a handout or worked through in session. Check in for level of understanding and seek to provide concrete examples for the young person. Use your own experiences of conversation with the young person where appropriate.

10 Ingredients of a Good Conversation

Practical Tips

1. Look towards and ideally make eye contact with person when speaking.

People usually like you to look at them. It indicates you're interested and paying attention (try not to stare).

2. Use the persons name when you start speaking to them.

It's more personal and shows that you are interested in the other person.

3. Use body language to indicate you are interested.

This includes friendly facial expressions, nodding to show you're interested and leaning slightly towards the speaker.

4. Notice the other person's facial expressions.

They may indicate the listener's interest level. Whether they are enjoying, bored by or even upset by the conversation. Facial expressions also indicate if the listener is understanding or confused.

5. Sharing the conversation equally.

Having a conversation is a bit like a tennis match. You can take turns at serving (a bit like taking turns at introducing topics). Don't hog the ball. If there is more than two people imagine a piece of pie and attempt to divide speaking time evenly among you.

6. Stay on topic over multiple conversational turns.

Changing topics too quickly can confuse a person. Staying on a topic too long can also bore a listener. It can be tricky getting it just right which is why tuning in to facial expression is so important. When you change topics, use a 'lead in sentence' to let the listener know what the new topic is.

7. Avoid personal or controversial topics.

Do not discuss politics, religion or personal issues with people you do not know well. Some people may feel uncomfortable sharing this type of information

10 Ingredients of a Good Conversation

Elements of a conversation.

1. Greetings and farewells:

These are the ritual openings and closings we use. When entering a conversation, greetings are not designed to discuss anything of substance but serve as 'icebreakers' and show interest and an intention to start conversing. Greetings include: "How are you?" "How's it going?". When leaving a conversation, farewells are not used to introduce new topics but to 'close' the conversation. Farewells can include: "See you," "See you next week" and "It was good to catch up".

2. Questions:

allow you to get to know a person and shows that you are taking an interest in them. They are essential to keep a conversation going. When we talk to others about their interests, they may be more inclined to talk with us about our interests. These 'baiting' questions are a bit like going fishing and can help you keep a conversation going. Remember to wait for the response and continue the 'tennis match' over several turns on that topic.

"What did you do on the weekend?"

"Where do you live?"

"Do you study or work?"

3. Facts:

In early conversation exchanges, each person tries to find out if there is enough to share to make a conversation worthwhile.

"I live with my family in Sunbury"

"I'm studying hospitality at TAFE"

"I saw the latest Fast and the Furious movie on the weekend"

4. Opinions:

Give people a more personal view of you. They tell what you think and feel and about something. The listener might continue the conversation by asking more about your view, or sharing something about their view.

"I hate seeing action movies. I prefer comedies"

"I love cooking and want to work in a kitchen"

"I would prefer to live closer to the city"

5. Supporting Comments:

These are the sound bites we use to let the speaker know we are paying attention and affirm how the speaker is feeling and what they did. We need to try to match our facial expression and tone of voice to the sound bite.

"really?", "cool", "what?", "awesome", "so true", "totally", "OK", "great", "oh no!"

11 Conversation Rating Scale

Target

To increase a young person's awareness of their own strengths and areas for improvement with social communication. It will enable clinicians to develop goals for improving social communication.

Use

Invite the young person to complete the checklist. This may be most relevant immediately following a specific social encounter. Explore self-identified strengths and difficulties. Come up with examples that may have manifested in your work together. Emphasise that nobody is a perfect communicator.

Target

To increase awareness of the impressions communication behaviours will have on others.

Use

Explore each communication behaviour and ask the young person to identify some responses it may elicit in the listener. For instance, during a conversational interchange, when somebody refrains from making eye contact, what might others think, feel and how might they respond?

11 Conversation Rating Scale

Below are some things you should watch out for when you're around others. It should help you figure out what impression you make on others. If you're not sure, consider asking somebody you trust for feedback in each of these areas.

Situation:	I do well at this	I am OK at this	Room for Improvement
Looking at others when I speak to them			
Using a persons name when I speak to them			
Using friendly body language Posture Facial expression Tone and volume of voice			
Judging expected personal space for situation			
Noticing facial expressions The other person is interested The other person is uncomfortable, confused or bored			
Staying on topic			
Choosing appropriate topics			
Sharing the conversation equally			
Greeting and farewells			
Asking questions			
Sharing facts			
Giving opinions			
Supporting comments			
Other			

12 Conversation Brainstorm Bubbles

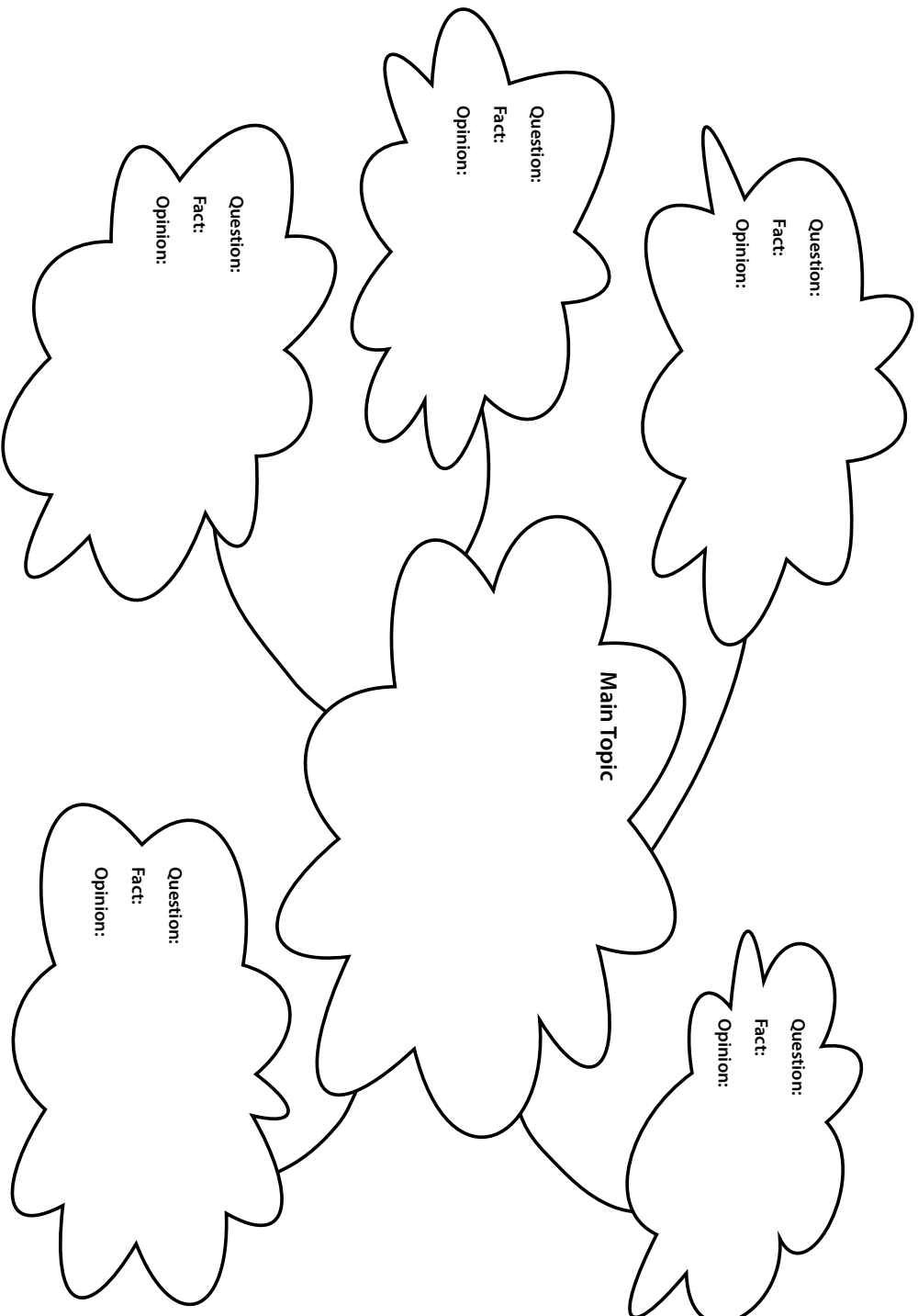
Target

Development of conversational content and maintaining a conversation.

Use

In preparation for a social situation, with the young person, identify a likely 'topic' for conversation. Write the topic in the central bubble, then spend time considering sub-topics or related information which could be included in a conversation on the topic. Be sure to include each of the elements of a conversation – questions, facts and opinions. This activity is usefully followed by some form of rehearsal.

12 Conversation Brainstorm Bubbles



13 People Profile

Target

To meaningfully explore how a young person perceives themselves, and/or how others may perceive them.

Use

Develop a 'Facebook'-like profile together in session. Selecting a profile picture can support the client to talk more about how they want to be perceived by others. Look for information that might help to elicit values. For instance, Why is that particular movie one of your favourites? What did you like about the main character? What does that say about what's important to you?

Target

To develop rapport through exploring interests and perceived strengths, rather than just the difficulties that have brought them to therapy.

Use

Developing a profile with the client 'in the room' together. Notice and validate interest or preferences that seems particularly important.

Target

To educate about healthy use of social media

Use

Use the imaginary profile to facilitate conversation about what is appropriate content to share online. Identify how the information and pictures shared will influence how they are perceived.

Target

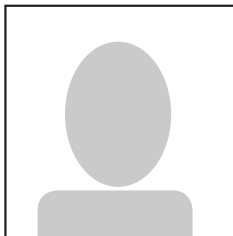
To demonstrate the importance of storing personal information about others

Use

Complete the profile in session for other people the young person knows. Look for gaps in information to identify future conversation topics. Teach the young person that remembering personal details about others helps with conversation starters and shows that we are interested.

worksheet

13 People Profile



Name:	
Suburb:	
Female <input type="checkbox"/> Male <input type="checkbox"/>	Birthdate ____/____/____
Languages:	
Friends and Family	
Relationship status:	
Family members:	
Friends:	
Education and work	
High school:	
TAFE/ university:	
Work:	

13 People Profile

Philosophy	
Religion:	
Political Views:	
People who inspire:	
Favourite quotations:	
Art and Entertainment	
Favourite Music:	
Favourite Book:	
Favourite Movies:	
Favourite Television:	
Favourite Games:	
Sports	
Favourite Sports:	
Favourite Teams:	
Favourite Athletes:	
Activities and Interest	
What do you like to do?	
What are your interests?	

14 Values - What is Important to You in Life?

Target

This worksheet aims to help the young person to develop greater self awareness and sense of identity. The prompt of asking the young person to describe how they would spend a million dollars if they won the lottery is a concrete way of eliciting what is important to them.

Use

Use the pie chart to visually depict how the million dollars will be spent. This can be a springboard for exploring what and who are important to them. These values can then be articulated and written in the spaces provided in relation to different parts of their life.

Target

This worksheet may also be useful in developing short and long term goals that are consistent with their values. This could complement ISP goal setting.

Use

Complete a second pie chart mapping the translated goals.

Other hypotheticals could be used in a similar way, such as asking the young person to imagine it's their 80th birthday and someone gives a speech about their life. This involves the young person thinking about what they would like the person to say about what they have done in their life.

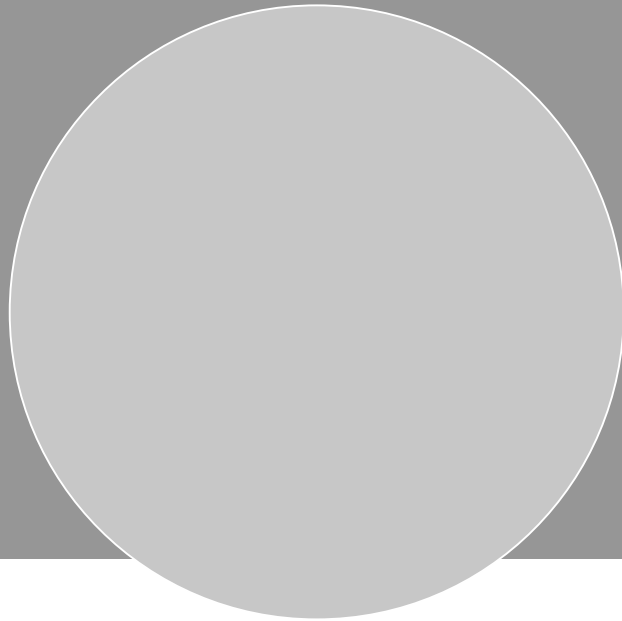
worksheet

14 Values - What is Important to You in Life?



If you won the lottery how would you spend a million dollars?

Divide the Pie graph and label how you would spend the portions of money.



What does your answer tell you about what is important to you?

Family: _____

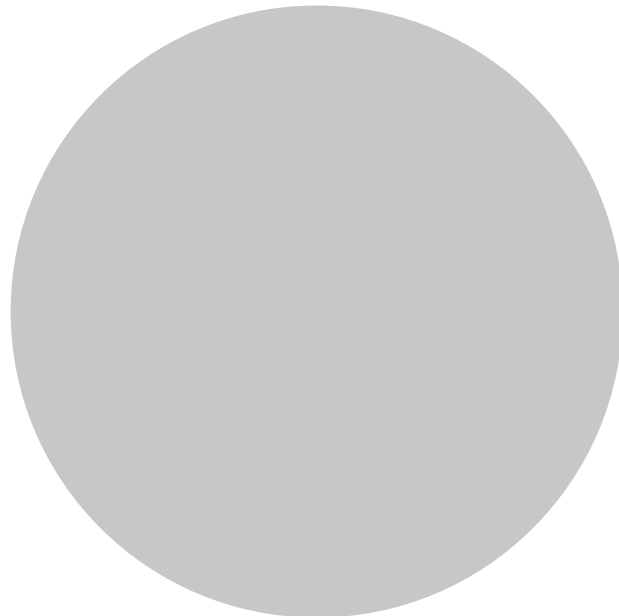
Friends: _____

Community: _____

Leisure: _____

Work/vacation: _____

Other: _____



How might these values be translated to short-term and long-term goals?

worksheet

15 Now and Later

Target

This worksheet prompts clinicians to acknowledge the difficulties these young people have with change. It is most useful when the young person is making a significant transition eg: educational setting, therapist/care team; living situation. It aims to increase central coherence and reduce anxiety over transition periods.

Use

Working together, identify those things that are similar or the same across settings, and those things which will be different. Explore feelings towards the changes.

worksheet

15 Now and Later

Now	
Name the current situation eg. my school situation or living arrangement	
Later	
Name the future situation eg. new school or home	
What will be the same?	How do I feel about that?
What will be different?	How do I feel about that?

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