Psychotherapists' experiences of working with adult clients with a diagnosis of Asperger Syndrome/High Functioning Autism (AS/HFA): An Interpretative Phenomenological Analysis (IPA) study

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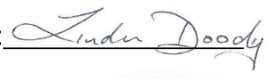
Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Psychotherapy (DPsych), is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed: 

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Glossary of Terms

Adaptive Functioning: The ability to effectively navigate through the everyday demands that one routinely encounters.

Attention Deficit Hyperactivity Disorder (ADHD): a neurodevelopmental disorder characterised by difficulty maintaining focus, and/or hyperactivity, impulsivity, and acting without concern for consequences

Aetiology: the cause, or set of causes, of a disease or disorder

Asperger's Syndrome (AS): an autistic condition at the milder end of the autism spectrum (sometimes referred to as "High Functioning Autism")

Autism Spectrum Disorder (ASD): a neurodevelopmental disorder characterised by social/communication difficulties, and restricted and repetitive patterns of behaviours

Autism Spectrum Condition (ASC): a term used in more recent times to refer to Autism Spectrum Disorder

Broader Autism Phenotype: a subclinical manifestation of autism found in the general population

Cognitive Empathy: the ability to decode (read), interpret and understand another person's emotions/mental states and intentions

Double Empathy Problem: the mutual difficulties that neurotypical and autistic individuals experience reading/understanding each other

Emotional Empathy: the ability to share another person's emotions/mental states and respond appropriately

Epidemiology: a branch of science concerned with the incidence and prevalence of diseases and disorders

Executive Dysfunction: difficulty with planning, organising and switching back and forth between different tasks (multitasking)

High Functioning Autism: an autistic condition at the milder end of the autism spectrum (sometimes referred to as "Asperger's Syndrome")

Homogenous Sample: a group of participants who share the same or similar backgrounds, characteristics or traits (e.g., participants who are all accredited psychotherapists and have experience of working with a particular client group)

Impaired Theory of Mind (ToM): difficulty empathising with other people

Interpretative Phenomenological Analysis (IPA): a qualitative research approach/methodology

Neurodevelopmental Disorder: a disorder characterised by abnormal brain development which leads to difficulties with various aspects of cognitive/psychological functioning

Neurodiversity: the view that many neurodevelopmental and psychological conditions are not inherently pathological, and as such should be reconceptualised as "differences" rather than disorders

Neurotypical: a person with a normal neuropsychological profile (i.e., someone who does not have a neurodevelopmental disorder)

Pathogenesis: the biological mechanism that leads to the presentation of a disease.

Phenomenology: a branch of philosophy concerned with consciousness and subjective experience

Weak Central Coherence (WCC): poor cognitive ability to fit pieces of information together into a coherent whole.

Abstract

Psychotherapists' experiences of working with adult clients with a diagnosis of Asperger Syndrome/High Functioning Autism (AS/HFA): An Interpretative Phenomenological Analysis (IPA) study

Linda Doody

The aim of this study was to gain an in-depth understanding of psychotherapists' experiences of working with adult clients with a diagnosis of Asperger Syndrome/High Functioning Autism (AS/HFA). People with AS/HFA are very susceptible to developing mental health issues, most notably depression and anxiety. With a greater awareness of AS/HFA in recent years and increasing rates of diagnosis, more adults with AS/HFA are now presenting for psychotherapy. However, to-date there appears to be no qualitative research exploring the experiences of psychotherapists who work with this client group. Thus, the current Interpretative Phenomenological Analysis (IPA) study aimed to address this gap in the literature by interviewing nine therapists who work with adult clients with a diagnosis of AS/HFA. Analysis of the data identified three superordinate themes: (1) "Being in a One-Sided Relationship", captures the participants' feeling that they were in a one-sided or non-reciprocal relationship, (2) "Feeling Frustrated and Inadequate", reflects the participants' frustration and their sense of inadequacy experienced when working with this client group, and (3) "Needing to Adapt", captures the participants' experiences of adapting their approach and/or suppressing part of themselves in order to accommodate their AS/HFA clients and prevent them from dropping out of the therapy. The novel findings to arise from the current study were the therapists' difficulty reading their AS/HFA clients, their desire or need to experience empathy back from the clients, their experiencing of self-doubt, and their need to adapt when working with these clients. These findings are discussed in relation to existing literature and their potential implications for policy, practice, training and research are explored. A number of conclusions were drawn from the current findings, most notably that more evidence-based AS/HFA-specific training be provided for psychotherapists.

Chapter 1: Introduction

The aim of the current study was to explore psychotherapists' experiences of working with adult clients with a diagnosis of Asperger Syndrome/High Functioning Autism (AS/HFA), and to gain an in-depth understanding of these experiences. The three key objectives were:

1) Illuminate (from the therapists' perspectives) any particular challenges therapists experience when working with AS/HFA clients.
2) Explore what rewards (if any) therapists get from working with AS/HFA clients.
3) Illuminate how working with this client group might influence therapists personally and/or professionally.

1.1 Research Background and Rationale

Asperger Syndrome (AS) is an autistic spectrum condition which is sometimes referred to as High Functioning Autism (HFA). Unlike with classic autism, people with AS have average to above average intelligence with normal to advanced language development. AS/HFA is characterised by poor social skills, and restricted and repetitive patterns of behaviour. Other features of AS/HFA may include heightened sensitivity to certain sensory stimuli (such as loud noises or bright lights), difficulty understanding sarcasm and subtle meanings, and problems with everyday planning, organisation and multitasking (Attwood, 2006a). People with AS/HFA face many challenges in their daily lives and they are very susceptible to developing mental health issues, most notably depression and anxiety (Woods, Mahdavi, & Ryan, 2013).

With more public awareness of autism spectrum disorders in recent times, and increasing rates of diagnosis, more adults with AS/HFA are now seeking (or are being referred for) psychotherapy. However, these clients can be challenging to work with (Ramsay et al., 2005), and according to Leather and Leardi (2012), these challenges are even more problematic for therapists who are unfamiliar with the characteristics and features of AS/HFA.

Much of the literature pertaining to the topic of AS/HFA and psychotherapy has focused on psychotherapeutic models (most notably Cognitive Behavioural Therapy), as well as short-term outcomes. However, there are a few noteworthy publications which discuss the challenges this unique client group present for psychotherapists. This literature is based on the authors' own clinical experiences as psychologists or psychiatrists (e.g., Attwood, 2006a; Gaus, 2007, 2011, 2018; Ramsay et al., 2005), the reviews of existing literature (e.g., Leather & Leadi, 2012; Woods, Mahdavi & Ryan, 2013), and/or survey-based studies (e.g., Cooper, Loades & Russell, 2018).

To-date, there appears to be no in-depth qualitative studies which have explored the first-person experiences of psychotherapists who work with adult clients with AS/HFA (i.e., psychotherapists who are not psychologists or psychiatrists and whose role/work is exclusively that of a psychotherapist). Thus, the current study aimed to address this gap in the literature by gaining an insight into the lived experiences of therapists who work with this client group. It is hoped that the findings of the current study will contribute to the very limited literature on the topic of AS/HFA and psychotherapy, and will also help inform relevant policy, practice and training, and stimulate interest for further research in this area.

1.2 The Researcher's Work/Experience in the Area of Autism

The researcher is a Chartered Psychologist and psychotherapist. Autism is one of her main areas of interest and specialisation. She has many years' experience working with children and adults with autism (including AS/HFA), both conducting diagnostic assessments and providing psychotherapeutic supports and interventions. Throughout her professional career, the researcher has continued to work with people with AS/HFA and she has tried hard within her capacity as a professional to draw attention to the many challenges these individuals (and their parents) face on a daily basis. She collaborates regularly with other professionals who work with this client group, and over the years she has presented at many seminars/talks on the topic of AS/HFA.

In light of the growing demand for psychotherapeutic services for this client group, and given that most of the existing (albeit limited) literature appears to be based on the clinical experiences of either psychologists or psychiatrists, the researcher felt that the experiences of (non-psychologist or psychiatrist) psychotherapists who work with adult AS/HFA clients required further investigation.

When approaching the current study, the researcher considered how her own knowledge and understanding of ASD, and her extensive experience of working therapeutically with adults with AS/HFA, might be helpful or unhelpful. She believed that her knowledge and experience would greatly enhance her analysis and interpretation of the data, and it would also help facilitate the identification of any unique or novel findings and their potential importance. However, the researcher was also aware that her knowledge and experience could be unhelpful in terms of potential biases and preconceived expectations. With this in mind, she remained cognisant of the importance of reflexivity from the outset, ensuring that she engaged in continuing reflexive practice

throughout the research process in order to help manage any such biases or preconceived expectations.

1.3 Chosen Methodology

Interpretative Phenomenological Analysis (IPA) was considered to be the most compatible research approach (a good fit) for the current study, because (1) it allowed the researcher gather rich data about the phenomenon under investigation (i.e., psychotherapists' experiences of working with adult clients with AS/HFA), (2) it allowed her give voice to the participants' experiences and how they made sense of these experiences, and (3) it allowed her play an active role in the interpretation of the data.

The researcher had not conducted an IPA study before and her experience of qualitative research was quite limited (i.e., in comparison to her experience of quantitative research), so she felt somewhat apprehensive about undertaking an IPA study at doctorate level. However, she felt reassured by Smith, Flowers and Larkin (2009) who reminds the novice IPA researcher that this approach is a creative process and there is no right or wrong way of conducting an IPA study; what might work for one study may not be suitable for another. Furthermore, they note that IPA is flexible enough and sufficiently clear to enable the first-time IPA researcher to find their way through the process.

The researcher felt that by undertaking such a study she would help make qualitative research more visual is the area of autism, most notably it would help illuminate the lived experiences of psychotherapists who work with adult clients with AS/HFA. As a Chartered Psychologist she also hoped that the findings of a such study would help promote more qualitative research in the field of psychology, particularly relating to AS/HFA and psychotherapy.

1.4 Overview of the Thesis Chapters

This research thesis contains five chapters including the current chapter, “Chapter 1: Introduction”. The following is a brief outline of each of the four subsequent chapters.

Chapter 2: Literature Review

The literature review chapter provides a critical review and evaluation of relevant existing literature and offers a contextual background and rationale for the current study. The first part of the chapter discusses the history, diagnosis, characteristics and prevalence of AS/HFA. This is followed by a focus on the various everyday challenges and mental health issues that lead AS/HFA adults into psychotherapy. From here, the focus of the chapter turns to the therapeutic relationship, and the concept of empathy and intersubjectivity in the therapy room. The various issues and challenges that psychotherapists face when working with AS/HFA clients are also discussed, as are some of the strategies recommended to help alleviate these challenges. The chapter concludes with a brief overview of the role the parents/family (of the AS/HFA client) play in the therapeutic process.

Chapter 3: Methodology and Method

The methodology chapter begins by reminding the reader of the main aim and objectives of the current study, and why Interpretative Phenomenological Analysis (IPA) was considered to be the most suitable research approach for the study. This is followed by an overview of IPA, including its philosophical and theoretical underpinnings, its structural framework and design, and an outline of the four principles commonly used to assess the quality and rigour of the research. The chapter then discusses the utility and application of IPA in the current study, including ethical considerations, the recruitment

criteria and procedure, and the data collection process. This is followed by an account of the different stages of the data analysis, and the various procedures and processes utilised during the analysis. Aspects of the researcher's reflexivity are also discussed within this chapter.

Chapter 4: Findings

This chapter present the findings of the current study, focusing on the three superordinate themes that were identified following data analysis. These themes are, "Being in a One-Sided Relationship", "Feeling Frustrated and Inadequate" and "Needing to Adapt", Each of these three superordinate themes and their constituent subordinate themes are discussed in this chapter and supported with selected quotes from the participants.

Chapter 5: Discussion & Conclusions

This chapter explores and reviews how the current findings relate to, and diverge from, existing literature and research relevant to the topic under investigation. The current findings are critically evaluated through the lens of the extant literature, and those which are in some way unique or novel are illuminated. Various theoretical and contextual perspectives are explored with consideration given to how the current findings are positioned, and might be positioned, within these different perspectives.

From this critical evaluation, a number of conclusions are drawn and discussed. These relate to the importance of the findings and their potential implications for policy, practice and training. Directions for future research are also explored. In addition, the limitations of the current study are discussed, as is the process by which the quality and rigour of the study was assessed. The chapter concludes with the researcher's reflections on her

experience of conducting the study; what she learned and how the experience influenced her.

Chapter 2: Literature Review

Asperger Syndrome (AS), sometimes referred to as High Functioning Autism (HFA), is a neurodevelopmental condition characterised by social and communication impairments, and restricted and repetitive patterns of behaviour. In both the research literature and clinical practice, Asperger's Syndrome is distinguished from more severe, or "classic", autism by the presence of normal to above average IQ and the absence of a language delay (Baron-Cohen, 2008; Noterdaeme, Wriedt, & Höhne, 2010). A diagnosis of AS is rarely made before the age of six and often is not made until much later, sometimes well into adulthood (Baron-Cohen, 2008). Some individuals with AS/HFA learn to mask their difficulties very effectively, and as such, may never receive a diagnosis (Hull et al., 2017). People with AS/HFA are susceptible to mental health issues, the most notable being depression and anxiety (Woods, Mahdavi, & Ryan, 2013). With the greater awareness of autism in recent years (including AS/HFA) and the increasing rates of diagnosis, more adults with AS/HFA are presenting for psychotherapy (Gaus, 2018). However, the experiences of therapists who work with this client group is a topic which has gained little attention from researchers, and to-date there appears to be no in-depth qualitative research exploring this phenomenon.

This chapter provides a critical review and evaluation of existing literature related to AS/HFA and psychotherapy, offering a contextual framework and rationale for the current study. The chapter is divided into a number of sections. Topics discussed include the use of terminology in the AS/HFA literature, the history of the condition, its characteristics and features, as well as diagnosis and epidemiology. The various mental health issues that can affect individuals with AS/HFA, as well as the everyday challenges that they face, are also discussed. The focus of the chapter then turns to look at the topic

of psychotherapy and AS/HFA. Subsections here include the therapist-client relationship, and the issue(s) of empathy and intersubjectivity in the therapy room. The challenges therapists face when working with this client group and the recommendations made to help assist these therapists are also discussed. The chapter concludes focusing on the role family members (of the AS/HFA client) play in the psychotherapeutic process.

For the current literature review, academic articles were sourced via a number of electronic data bases (via DCU's online library). These include PsychINFO, PsycARTICLES, MEDLINE and PubMed. Other texts including hard copies of papers and books were accessed through libraries and bookshops. The researcher also attended several meetings and talks relevant to her topic of research to help keep up to date with current research and practice in the area(s) of AS/HFA and psychotherapy.

2.1 A Note about Terminology

There is ongoing debate about whether Asperger's Syndrome (AS) and High Functioning Autism (HFA) are the same or different conditions. The term Asperger Syndrome is used widely in the academic literature (e.g., Faridi & Khosrowabad, 2017; Nilsson et al., 2020) and in clinical practice, with some authors using the terms interchangeably (e.g., Baron-Cohen, 2000). Thus, for the purpose of this dissertation, the two condition(s) will be treated as one. Therefore, the acronym AS/HFA will be used extensively throughout this thesis. The acronym ASD will be used to refer to Autism Spectrum Disorder, while the term "neurotypical" will be used to refer to individuals who are not on the autism spectrum.

2.2 History of Autism and AS/HFA

Asperger Syndrome was first described in a paper by Austrian paediatrician Hans Asperger (1944/1991) in which he discussed a number of children who demonstrated similar patterns of unusual behaviour, notably: poor social ability, obsessiveness, reduced eye contact, and dyspraxic tendencies. He named the condition "Autistic Psychopathy". Through his observations, he noted that many of these children showed remarkable cognitive strengths, for example solving complex mathematical problems with ease and he suggested that the condition might be an extreme form of male intelligence (i.e., a logical /technical problem-solving style). Asperger also observed that the relatives of these children displayed some traits of Autistic Psychopathy themselves, leading him to speculate that the disorder may have a genetic component (Asperger 1944/1991). His paper on Autistic Psychopathy was first published in German in 1944 during the Third Reich era. It only came to the attention of the international medical community after Lorna Wing (an English psychiatrist) published an article in the early 1980s, outlining the condition Asperger had described and renaming it "Asperger's Syndrome" (Wing, 1981).

Formulated during a period when psychoanalysis was the predominant model within child psychology and psychiatry, early aetiological theories of autistic disorders generally focused on parent-child dynamics. Kanner (1949) and Bettelheim (1967) argued that autism was caused by the poor parenting style of emotionally aloof mothers. Bettelheim even went so far as to refer to the mothers as "refrigerator mothers". These theories are now considered thoroughly discredited (Attwood, 2006a). During the closing years of the twentieth century, the MMR vaccine was hypothesised to be associated with increasing rates of autism (Wakefield et al., 1998)[1]. This theory has also been refuted (e.g., Jefferson,

[1] The Wakefield et al. (1998) paper, published in the journal *Lancet*, has since been retracted.

Price, Demicheli & Biano, 2003; Madsen et al., 2002; Uchiyama, Kurosawa & Inaba, 2007).

The current understanding of AS/ASD's pathogenesis is that genetic mutations lead to atypical neurological development, which in turn leads to various autistic type behaviours (Buxbaum & Hof, 2013). According to a recent study by Bai et al. (2019), autistic disorders show a heritability rate of approximately 80%. Although environmental factors are likely to be involved in the pathogenesis of autism, it remains unclear exactly what these environmental factors are. However, high levels of sex hormones (particularly testosterone) in amniotic fluid appear to play an epigenetic role (Auyeung et al., 2009).

2.3 Diagnosis

The two most commonly used diagnostic criteria for autistic disorders are those of the World Health Organisation's *International Classification of Diseases* (ICD) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). "Asperger's Syndrome" had its own distinct diagnostic category in the previous edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994). It now comes under the umbrella term of "Autism Spectrum Disorder" in the most recent edition of the manual (DSM-5; American Psychiatric Association, 2013), which conflated all autistic disorders into the single category of Autism Spectrum Disorder (ASD). However, "Asperger's Syndrome" still remains a distinct entry in the *International Classification of Diseases, 10th edition* (ICD-10; World Health Organisation, 1992), although it is due to be subsumed into the diagnostic criteria for Autism in the forthcoming edition of the ICD (ICD-11), which is scheduled to come into effect in January 2022. In DSM-5, ASD is subdivided into three

levels of severity, with Level 1 most closely corresponding to what was previously called "Asperger's Syndrome" (Strunz, 2018).

Other diagnostic criteria for AS include those of Gillberg and Gillberg (1989) and Szatmari, Bremner and Nagy (1989). According to Attwood (2006a), Gillberg and Gillberg's criteria are the most similar to Hans Asperger's original description of the condition. Troublingly, there appears to be relatively little inter-rater agreement across and within the mentioned diagnostic criteria (Kopra, von Wendt, Nieminen-von Wendt, & Paavonen, 2008). For example, one of the criteria for AS in the previous edition of the DSM (DSM-IV) was "no cognitive or language delay" whereas this is not the case in the ICD-10. Such inconsistencies raise questions regarding the validity of the diagnostic construct of Asperger Syndrome and/or High Functioning Autism, and the potential for misdiagnosis.

For example, a recent American study by Maddox et al. (2017) examined the diagnostic accuracy of one of the most widely used assessment instruments for diagnosing autism spectrum disorder (ASD) in children and adults, the *Autism Diagnostic Observation Schedule, Second Edition* (ADOS-2). While the ADOS-2 accurately identified ASD in all adult participants (n = 75) with an existing diagnosis of the condition, it also had a high rate of false positives (for ASD) among the adult participants with psychosis. Maddox et al. believe that these findings should serve as an important reminder that social communication difficulties measured by the ADOS-2 (and possibility other ASD diagnostic instruments) are not necessarily specific to Autism Spectrum Disorders. This undoubtedly highlights the importance of the need for comprehensive diagnostic assessments conducted by suitably qualified and experienced clinicians.

Confusing the issue further is the fact that subclinical ASD traits are found in varying degrees in the general population (that is, the "Broader Autism Phenotype"), and there does not appear to be a natural biological divide between these subclinical and pathological autistic manifestations (Robinson et al., 2011). In other words, autism "proper" represents the quantitative extreme of a continuously distributed trait(s) found in the general population. Research studies have shown that subclinical traits of autism are commonly found in close relatives of those with the condition, but sometimes also in individuals with no (known) autistic relatives (Wheelwright, Auyeung, & Allison, 2010). Hence, to distinguish ASD from the subclinical Broader Autism Phenotype, a diagnosis should only be made when an individual's autistic symptomatology causes "clinically significant impairment in social, occupational, or other important areas of current functioning, and is evident across multiple contexts" (American Psychiatric Association, 2013, p.50).

Given the poor inter-rater agreement among clinicians when it comes to diagnosing autism (including AS/HFA), it may now be time to look at alternative approaches to diagnosis. Plomin (2018) has suggested that instead of viewing mental disorders (or conditions) as categorical entities, it may be more prudent to consider them in terms of dimensions that shade into normal psychological functioning. Thus, as applied to autism, clinical assessments could measure traits such as social functioning, communicative ability, repetitive behaviours, and motor skills as independent dimensions and identify problematic areas which require support and/or intervention. This would involve a step away from the current either/or approach to ASD, and may prove particularly helpful for individuals who experience difficulty in one or more areas of functioning associated with autism, but not others. However, given that the diagnosis of autism (including AS/HFA) is a social construct (Nadesan, 2005), gaining consensus for a new and acceptable

definition or diagnostic categorisation of the condition as a whole, and/or different dimensions on its spectrum (e.g., different subgroups) may be challenging. It is likely to take much collaboration and commitment from all relevant parties, including the various "expects" working in the area and importantly those who identify as having autism or having a particular type of autism, such as Asperger Syndrome and/or High Functioning Autism.

While the diagnosis of ASD (including AS/HFA) is currently made by either a psychologist or psychiatrist, the assessment process is typically multidisciplinary in nature, with input from other professionals such as Speech and Language Therapists and Occupational Therapists. Best practice guidelines for the assessment and diagnosis of autism spectrum disorders issued by the *Psychological Society of Ireland* (2010), recommend a thorough assessment involving the individual's records/history, an interview with parents/guardian, evaluation of cognitive ability and adaptive functioning, examination of social competence and restrictive/repetitive behaviours. These best practice guidelines also recommend that an assessment of the individual's mental health be conducted, as well as a speech and language assessment and information gathering about their family history. For individuals with AS/HFA, referrals to a speech and language therapist (regarding pragmatic language difficulties), an occupational therapist (regarding sensory issues and adaptive functioning), and a psychiatrist (for co-morbid mental health problems) may be made after diagnosis.

2.3.1. Debate about "Asperger's Syndrome" vs "High Functioning Autism"

Although AS is sometimes referred to as High Functioning Autism (HFA), it is important to note that there is continuing debate about whether or not Asperger Syndrome (AS) and High Functioning Autism (HFA) are in fact one the same. Certain theorists have

argued that AS should be considered distinct from "High Functioning Autism", based on normal versus delayed language skills (Noterdaeme, Wriedt, & Höhne, 2010), while others regard AS and high-functioning autism as synonymous (Calzada, Pistrang, & Mandy, 2012). According to the findings of a recent study by de Giambattista et al. (2019), there are good grounds for drawing an empirical distinction between AS and HFA. The authors argue that the conditions differ in terms of cognition, language ability, academic achievements (at school), as well as the nature of comorbidities. For example, findings showed that the HFA participants were more likely to have learning difficulties, while the AS participants had a significantly higher average Full-Scale IQ score.

Buxbaum and Baron-Cohen (2013) discuss the advantages and disadvantages of maintaining the term "Asperger's Syndrome" (as well as other autism subtypes). They note that an advantage of collapsing all ASDs into a single group is that it eliminates specific subgroups which have low inter-rater reliability, whereas the broad category of ASD has relatively good inter-rater reliability. Building on the work of McPartland, Reichow, and Volkmar (2012), Buxbaum and Baron-Cohen also discuss some potential disadvantages of removing the Asperger's term. Firstly, it is likely to complicate longitudinal and epidemiological research by making it difficult to compare "like with like". Secondly, they suggest that eliminating Asperger's Syndrome altogether could be regarded as too extreme when the disorder's validity could actually be improved by some definitional changes. For example, they note that the removal of the term Asperger could lead to some people with AS losing relevant supports and services because they no longer meet the criteria for autism.

Interestingly, Dr Cathy Lord and Dr Fred Volkmar who are both considered to be world leading experts in the area of autism, hold opposing perspectives regarding the conflation of all autistic disorders into the single category of Autism Spectrum Disorder

(ASD) in the DSM-5. Both have made contributions to the DSM classification system, with Volkmar being the primary author of the DSM-IV autism and pervasive developmental disorders section. Lord was equally active in the Neurodevelopmental Disorders Workgroup of the DSM-5. She argued in favour of collapsing all autistic disorders into one category, and the introduction of a severity scale in recognition of the diversity of those on the spectrum. In contrast, Volkmar expressed concern about collapsing all autistic disorders into a single DSM set of criteria, noting that it leaves open the possibility that many high functioning individuals may no longer be able to access clinical services. This is because these individuals can have superficially good social skills, which mask the fact that they struggle psychologically (Buxbaum & Baron-Cohen, 2013).

Undoubtedly this ongoing uncertainty and debate presents difficulties not only for researchers, but also for clinicians, including psychotherapists who must make informed judgements about the appropriateness of supports and/or interventions based on the client/patient's individual needs and abilities. Making such judgements can be particularly problematic in the absence of a comprehensive assessment, which includes cognitive testing and an examination of any comorbid conditions. However, it is important to note that Asperger Syndrome continues to be recognised as a disorder (in its own right) by many clinicians, and according to Gaus (2018), many clients presenting for psychotherapy continue to use the term because they experience it as part of their identity. However, it must be acknowledged that the diagnostic categorisation of autism (including AS/HFA) is a social construction (Nadesan, 2005), as indeed is the case with all psychiatric/psychological diagnoses as highlighted by social psychologist, Dr Kenneth J. Gergen (Gergen, Hoffman, & Anderson, 1996). Gergen points out that diagnostic labels are merely terms compiled by "the experts", and alarmingly that these diagnostic labels

have increasing become an intrinsic part of our language by which we define others and sometimes ourselves. Nevertheless, according to Chambers, Murray, Boden and Kelly (2020), receiving a diagnostic label can be welcomed by some individuals with autism, helping provide them with an explanation for their lifelong social difficulties, while for others it may help solidify their identity as someone with autism.

2.4 Characteristics and Features of AS/HFA

In addition to social/communication problems and restricted/repetitive patterns of behaviour, individuals with a diagnosis of AS/HFA often experience atypical sensory processing, pragmatic language difficulties, motor issues, and poor planning/organisational skills (Baron-Cohen, 2008). Three cognitive models have been formulated to describe aspects of the psychological functioning of people with autism spectrum disorders. They are "Impaired Theory of Mind" (also known as Mindblindness), "Weak Central Coherence", and "Executive Dysfunction" (Buxbaum & Hof, 2013). While each one of these deficits/impairments can present their own unique set of challenges for a person with autism, Attwood (2006a) argues that they should not be considered exclusively independently of each other.

2.4.1 Impaired Theory of Mind/Mindblindness

Baron-Cohen (1995) theorised that a core deficit of AS/ASD is the impaired ability to empathise with others (i.e., to put oneself in the other's shoes and see things from their perspective). A number of studies have shown that individuals with ASD have a deficit in determining other people's viewpoints in a variety of social situations (Baron-Cohen, Leslie, & Frith, 1985; Tine & Lucariello, 2012). This difficulty is referred to as Impaired Theory of Mind or Mindblindness. In order to be able to empathise with others, a person

requires the ability to read and interpret their social cues (verbal and nonverbal) and infer their mental states and/or intentions. Various studies have been conducted to examine these specific abilities in individuals with autism, including adults with AS/HFA. One of these studies was conducted in the UK by Baron-Cohen, Wheelwright, and Jolliffe (1997) when they were developing the "Reading the Mind in the Eyes" test. Two groups took part in this study, an AS/HFA group and the control group (neurotypical group) (N= 122). The participants were shown photographs of actors who were portraying different emotions and mental states. Some of the pictures showed the entire face area while some only revealed the area around the mouth and some only the area around the eyes. The participants were asked to select the mental state expressed/conveyed in each of the photographs. The findings of this study showed that the AS group had significantly more difficulty identifying the mental states than the control group, and this difference was most significant for the photographs showing only the eye area.

Other studies have also found that AS participants performed significantly poorer than controls at reading emotions from facial expressions (e.g., Clark, Winkielman & McIntosh, 2008; Lindner & Rosen, 2006). Kandel (2018) explains that neurotypical people look primarily at the eyes of the other because the gaze of the other provides important clues about their mental states (i.e., their desire, intention(s) and/or belief). People with autism tend to avoid the eyes and Kandel suggests that this likely due to a disturbance in neural connections that prevents them from inferring intentions from gaze.

Other studies have shown that people with AS/HFA have difficulty deciphering other peoples' mental states from body postures/body movement (e.g., Hadjikhani et al., 2009; Philip et al., 2010), and from tone of voice/vocal expressions (e.g., Stewart, McAdam, Ota, Peppé, & Cleland, 2013; Kleinman, Marciano, & Ault, 2001). For example, a study by Rutherford, Baron-Cohen and Wheelwright (2002) was conducted to determine if

AS/HFA individuals could infer the mental states of others from auditory information. The participants (N = 39) were asked to listen to the voices of actors expressing different emotions and identify what emotions/mental states were being expressed. As expected, the AS/HFA group also performed significantly poorer than the controls in this study.

While the cited research studies by Baron-Cohen and colleagues are important, it should be noted that they typically employ quantitative research methods and therefore often fail to capture the actual voices and individual experiences of those who have ASD. Thus, these studies can neglect to recognise the broad range of empathic abilities within this population. This is a point highlighted by some researchers including Fletcher-Watson and Happé (2019). They express concern about the lack of voices of those with autism in research. They propose that a key aim for the future should be to facilitate the access of university/college students on the autism spectrum into research training programmes, so that autistic-led research can become a prominent part of the knowledge landscape. Furthermore, Fletcher-Watson and Happé argue that the issue of heterogeneity of phenotypes within the autistic population remains a profound challenge. Hence, they suggest that the inclusion and exclusion criteria for participation in studies be revised to allow for more focus on transdiagnostic domains of functioning, rather than exclusively on diagnostic categories. Fletcher-Watson and Happé express hope that implementing such changes will lead to the delivery of research findings that matter to autistic people. A similar viewpoint has also been expressed by Pellicano, Dinsmore, and Charman (2014).

2.4.1.1 Double Empathy Problem

The reciprocal difficulties that AS/HFA and neurotypical people experience in trying to understand each other is sometime referred to as the “Double Empathy Problem”

(Milton, 2012). Thus, Milton reframes the problem from being a cognitive deficit in the AS/HFA individual, to being a relational problem occurring at the level of the dynamic interactions between an AS/HFA and neurotypical agent. Milton expresses concern that the champions of the ASD Impaired Theory of Mind hypothesis are scientists accustomed to using randomised controlled trials, but who tend to discount the first-person subjective experiences of those with the condition. Milton proposes that it is the human relationality and interaction that form a contested and constantly reconstructed social reality. This social "reality" is constructed via the agency of its "actors". Hence, Milton's perspective on this issue is in conflict with positivist methodologies in cognitive science which assume that an objective set of social norms and rules exist for people to follow. However, when neurotypical individuals attempt to understand the cognitive and affective states, and motives of those with AS/HFA, they often make wildly incorrect assumptions (Milton, 2012). As Milton points out, AS/HFA individuals can sometimes view such failing attempts to understand them as imposing, invasive, and threatening. This is especially true when assertions to the contrary are disregarded by the neurotypical person doing the empathising.

To help gain a greater understanding of the Double Empathy Problem, Dr Noah Sasson (a researcher at the School of Behavioural and Sciences, University of Texas), reported during an expert group discussion on Autism and Empathy that he has focused some of his current research on the bidirectional processes within the relationship between autistic and non-autistic people (Nicolaidis, Milton, Sasson, Sheppard, & Yergeau, 2019). He argues that there should be a move away from the traditional deficit model of autism, which takes as its norm the behaviours and cognitive processes of the neurotypical population. Furthermore, Sasson argues that the control group is almost

always taken as a standard in research, and if the autistic individual deviates from this standard it is usually inferred as an impairment, rather than a difference.

Crompton, Ropar, Evans-Williams, Flynn, and Fletcher-Watson (2020), noted that "the Double Empathy theory would suggest that communication difficulties arise from a mismatch in neurotype; and thus information transfer between autistic people may be more successful than information transfer between an autistic and an non-autistic person" (Crompton, Ropar, Evans-Williams, Flynn, and Fletcher-Watson. 2020, p.1). To test this hypothesis, they recruited autistic and non-autistic participants (N=72) and organised them into eight-person "human chains" consisting of AS/HFA, neurotypical or mixed participants. The first participant in each chain was read a story, who then told it to the second participant, who reiterated it to the next participant until the chain was complete. It was found that the participants with AS/HFA shared the information effectively with one another and demonstrated good rapport, while selective problems were observed during interactions between the autistic and non-autistic participants. However, a potential weakness of this study, is that all the participants were informed what group they were in (AS/HFA, neurotypical, or mixed) during each trial, which possibly may have influenced their behaviours (e.g., their level of ease or unease) and thus may have influenced the research outcome(s).

Interestingly, the findings of some other studies appear to call into question the "Double Empathy Problem" theory, as formulated by Milton (2012). For example, Edey et al. (2016) carried out an empirical investigation, the findings of which suggest that it is not just neurotypical individuals who have trouble decoding the mental states of those on the autism spectrum. In Edey et al. study, AS/HFA (n = 23) and neurotypical participants (n = 25) moved two triangles on a computer screen to generate animations depicting mental state interactions. Both neurotypical *and* AS/HFA participants

experienced similar difficulty deciphering the mental states or intentions of the animations generated by the AS/HFA target group. Edey et al. conclude from this that autistic people have difficulty reading the minds of other autistic people.

In another study by Georgescu et al. (2020), participants (n = 29 AS/HFA and n = 29 neurotypical) were organised into dyads (neurotypical, AS/HFA, and mixed) and were filmed as they engaged in conversational tasks. While individuals in the neurotypical dyads showed considerable interactional homogeneity (synchronicity of their nonverbal cues), those in the autistic dyads did not. Georgescu et al. concluded that it is probable "that atypicalities in ASD behaviour are idiosyncratic rather than shared" (p. 10). The mentioned research findings suggest that the patterns of behaviour and cognition associated with autistic disorders do not represent some type of "alternative" mode of communication that eludes the neurotypical population. Rather, as the Impaired Theory of Mind model proposes, these individuals experience a general deficit in accessing the mental states of other people (neurotypical or otherwise). Interestingly, the findings of research by Grossman, Mertens, and Zane (2020) suggest that individuals with AS/HFA tend to form negative first impressions of other people with the condition. The perceptions of an ASD target group made by AS/HFA participants were consistent with those of the neurotypical controls.

Heasman and Gillespie (2018) report that people with AS/HFA can act in ways that make it difficult for other people to read them. In their study, they examined social misunderstandings between AS/HFA individuals and their neurotypical family members. The study's findings suggest that family members tend to over-estimate the extent to which their AS/HFA relatives are egocentrically anchored in their own perspectives. A study by de Marchena and Eigsti (2010) found that in contrast with their typically developing peers, the hand gestures made by adults with AS were asynchronous with

their speech patterns, possibly leading observers to not fully grasp the communicative aspect of such gestures. Furthermore, AS individuals can often demonstrate atypical facial expressions, generally looking very serious (Hippler & Klicpera, 2004) and their speech (prosody) can be atypical in terms of pitch, rhythm, and vocal stress (Shriberg, Paul, McSweeney, & Klin, 2001). Given the unusual patterns of nonverbal/social behaviours displayed by many people with AS/HFA, it not surprising that research findings show that neurotypical people often find it difficult to read the facial expressions of AS/HFA individuals (Brewer et al., 2016) and understand their intentions and perspectives (Heasman & Gillespie, 2018).

As noted by Chown, Hughes, and Baker-Rogers (2019), while there is an incentive for those with AS/HFA to learn to make sense of neurotypical behaviours if they are to navigate through the social world, this does not work the other way around. In other words, there appears to be little incentive for neurotypical people to learn to read autistic individuals, which is something that therapists and other clinicians who work with this client group may need to consider. In fact, in the 2019 expert group discussion on Autism and Empathy, Dr Damian Milton (lecturer in Intellectual and Developmental Disabilities at the University of Kent, and project leader for the National Autistic Task Force, UK) made the point that autistic people must constantly put in much effort to read and connect with their therapists, but noted that this effort is not always reciprocated. However, Milton stated that he has come across some amazing practitioners in the field who do make enormous effort, but these are rare rather than the norm. Dr Milton reported that his background is in sociology and that he specifically became interested in autism in 2005 when his own son was diagnosed at the age of two. He also reported that he himself was formally diagnosed with Asperger's in 2009 (Nicolaidis, Milton, Sasson, Sheppard, & Yergeau, 2019).

2.4.2 Weak Central Coherence

People with autism tend to focus on small detail (minute information) so much that they often have difficulty seeing and/or perceiving the "bigger picture". Frith (1989) referred to this difficulty as "Weak Central Coherence (WCC)". The findings of a number of studies lend support to the WCC in ASD theory. For example, Happé (1996) found that ASD children tend not to be deceived by classic optical illusions, most likely due to the fact they focus excessively on the images' details, and consequently do not perceive the illusion. Similarly, Baron-Cohen (2008) found on a visual task called the "Navon Test" (in which the individual is presented with a large letter made up of numerous exemplars of a smaller incongruent letter) that the AS/ASD participants were more likely to initially see the smaller letter(s) than the big one, while the typically developing controls showed the opposite profile.

Research suggests that ASD piecemeal cognitive processing style can lead to notable difficulties in their everyday life; from difficulty perceiving faces (e.g., Watson, 2013) to problems with reading comprehension (Randi, Newman, & Grigorenko, 2010). Baron-Cohen (2008) suggests that weak connectivity between certain brain regions in AS/ASD individuals may be the underlying neurological explanation for WCC. However, it should be emphasised that the piecemeal processing of information demonstrated by those with AS/HFA can be advantageous for certain tasks. For example, findings show that people with AS tend to perform above average on psychometric block design tasks (e.g., Shah & Frith, 1993) and they often identify important details, inconsistencies, or errors that others may overlook (Happé & Vital, 2009).

While accepting that people with AS/HFA have a natural tendency to process information in a local fashion, Koldewyn, Jiang, Weigelt, and Kanwisher (2013) argue

that AS/HFA individuals can perceive the "bigger picture" when instructed or required to do so. Woods, Mahdavi and Ryan (2013) hold a similar view. They propose that therapists can help their AS/HFA clients encode and integrate contextual information by providing the information in an organised detailed and explicit manner.

2.4.3 Executive Dysfunction

"Executive Functioning" is the term used to describe the mental flexibility and complex cognitive processing that is needed to achieve a particular goal (Elliott, 2003). In particular, tasks that involve multitasking, strategic planning, organisation and effective time-management require this type of intricate mental ability. A deficit or dysfunction in this cognitive skill is known as "Executive Dysfunction". Studies have found that individuals with ASD and other disorders (including schizophrenia, Tourette syndrome, and ADHD) often show signs of executive dysfunction (Hill, 2004). For example, a study by Dichter et al. (2010) used "card sorting" tasks to examine the mental flexibility of AS/HFA individuals. Those with the condition performed significantly poorer on these tasks, in terms of accuracy and speed, than a group of neurotypical control participants. Shu, Lung, Tien and Chen (2001), propose that AS/HFA people's poor executive functioning has implications for their everyday judgement, as well as their ability to learn from their mistakes. For example, their findings have shown that individuals with AS/HFA will often continue using the same incorrect strategies, even when they appear to know that the strategies are not working.

It is worth noting that in a study by Johnston, Murray, Spain, Walker, and Russell (2019), while the majority of (adult) AS/HFA participants performed poorly on a task of executive function, 35.8% of the group showed no such impairment. Nevertheless, the findings of a factor analysis across all participants (AS/HFA and controls; n = 141)

suggested that performance on the neuropsychological test measures was associated with a single executive function factor (as opposed to a selective pattern of impairment). The two participant groups appeared to differ significantly on the said factor. Johnston et al. concluded that individuals with AS/HFA often experience clinically significant executive function problems which are disabling in their everyday lives.

2.4.4 Restricted Interests/Repetitive Behaviour and Obsessive Interests

Restricted interests and repetitive behaviours are hallmark symptoms of ASD including AS/HFA. As discussed by Leekam, Prior, and Uljarevic (2011), these repetitive behaviours constitute a major barrier to learning and social adaptation. They note that the said behaviours can take a number of forms: (a) preoccupation with restricted interests (b) non-functional routines or rituals (c) repetitive motor mannerisms (stereotypies) and (d) persistent preoccupation with parts of objects. Some changes in repetitive behaviours in people with autism have been noted across the lifespan. For example, a study by Murphy et al. (2005) found that atypical motor behaviours and responses to sensory stimulation reduced from childhood to adulthood, while resistance to change and routines did not. In a more recent study, Schulz and Stevenson (2019) found a significant correlation between sensory hypersensitivity and repetitive behaviours in autistic (as well as typically developing) children. It is important to note that sensory abnormalities fall within the criteria for repetitive behaviours in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5; American Psychiatric Association, 2013).

Dr Tony Attwood (2006a), who is considered by some to be one of the world's leading experts on AS/HFA, notes that people with the condition often develop special/obsessive interests in scientific topics. For example, he notes that some girls with AS/HFA may develop fixations with fictitious characters and/or stories. He cites cases of

girls and women with AS/HFA who have become obsessive about the works of J. K. Rowling, Charles Dickens or Roald Dahl, reading and re-reading their works many times. Attwood argues that fiction can offer people with the condition the chance to escape into an alternative world, and may, to some extent, help them understand the mental workings of other people. Note however that this view appears to be based on Attwood's own clinical experience, and does not seem to be substantiated by empirical research. Attwood (2006a) further proposes that special interests can help to facilitate entry into certain jobs or professions for people with AS/HFA. For example, a special interest in weather patterns may eventually lead to work as a meteorologist, or an interest in computer science may lead to a career in information technology (IT). However, the amount of focus and time dedicated to these special interests can result in the neglect of everyday tasks that require attention. According to Attwood, the AS/HFA individual's neglect of such tasks and their resistance to change can impact negatively not only on their own lives, but also on the lives of their family members.

While Attwood (2006a) puts forward many interesting points, it should be acknowledged that he often makes generalisations about individuals with AS/HFA, without giving due consideration to the variety of behavioural and cognitive profiles associated with the condition. In other words, he often fails to highlight that no two individuals with AS/HFA are the same; that they all have their own unique set of strengths and challenges, as is the case for all groups within the human population. Indeed, Bölte et al. (2019) note that categorical views of how autistic individuals present within therapy underestimates the wide diversity of functioning within the autism spectrum, even where IQ scores fall within the normal range.

2.4.5 Sensory, Motor and Pragmatic Language Issues

Reports of atypical sensory processing in AS/HFA were discussed as far back as Asperger's (1944/1991) original paper, and this issue is well attested to in autobiographical accounts of those on the spectrum (e.g., Robison, 2007; Sainsbury, 2000). Atypical sensitivity to certain stimuli, such as bright lights, loud noises, particular tastes, smells and/or textures is frequently reported by those with AS/HFA (Attwood, 2006a). Bogdashina (2003) and Harrison and Hare (2004) suggest that such sensory problems can take a number of different forms, including: hyper/hyposensitivity, sensory "tune outs", sensory distortions, sensory overloads, processing sensory stimuli in an unusual way, and difficulty in identifying the source channel of sensory information. According to their review of the relevant literature, Repetto, Jasmin, Fombonne, Gisel, and Couture (2017) report that between 45% and 95% of children with ASD experience sensory problems that interfere with their day to day functioning. The findings of their study suggest that sensory issues that are present at age 3 or 4 in ASD children will usually also be evident by school age. Interestingly, the findings of a prospective cohort study by Kojovic, Hadid, Franchini, and Schaer (2019) suggests that sensory processing abnormalities in ASD seem to interfere directly with "higher-order" domains such as social and adaptive functioning. In other words, they appear to be a contributing factor in the poor performance in many important domains of daily living.

Motor problems (both fine and gross) appear to occur relatively frequently in individuals with ASD, and again this issue was originally noted in Asperger's (1944/1991) paper. Motor difficulties/dyspraxia can manifest in a number of ways, including poor manual dexterity (Gunter, Ghaziuddin & Ellis, 2002), difficulties with balance, coordination, and hand grasp (Nass & Gutman, 1997), as well as slow speed in completing manual tasks, including handwriting exercises (Kushki, Chau, & Anagnostou, 2011). The findings of a number of controlled experimental studies suggest

that individuals with AS/HFA have problems with the mental preparation and planning of movements, even though the motor pathways themselves are often intact (Rinehart, Bradshaw, Brereton, & Tonge, 2001; Weimer, Schatz, Lincoln, Ballantyne, & Trauer, 2001).

The pragmatic and reciprocal aspects of language (for example, engaging in "small talk") can also pose a problem for people with AS/HFA. They have a tendency to take things literally, not understanding metaphors and sarcasm (Attwood, 2006a). It has been shown that people with AS have a poor understanding of idioms despite having relatively advanced intellectual/linguistic abilities (Kerbel & Grunwell, 1998). It has also been found that the speech of AS individuals can be overly pedantic and formal (Ghaziuddin et al., 2000), with a tendency to use very formal sentence structures, often with a focus on specific details. Woods, Mahdavi and Ryan (2013) suggest that therapists should be mindful of these unusual language patterns and to understand that their AS/HFA clients may not be aware how their pedantic and formal communication style might be perceived by others.

2.5 Comorbidities and Prevalence

Other psychological/psychiatric conditions often occur comorbidly with AS/HFA. These include Attention Deficit Hyperactivity Disorder (ADHD) (Goldstein & Schwebach, 2004), social anxiety (Russell & Sofronoff, 2005), Obsessive-Compulsive Disorder (OCD) (Baron-Cohen, 1990), and depression (Mazzone, Ruta & Reale, 2012; Shtayermman, 2007). Such coexisting disorders can present challenges not only for researchers (in terms of extraneous and/or confounding variables) but also for clinicians, including psychotherapists who must determine whether the symptoms of these conditions are phenotypical manifestations of the autism, or are indeed separate and

distinct (albeit comorbid) disorders when considering and evaluating appropriate interventions.

Given the poor consistency across the most commonly employed diagnostic criteria, the fact that AS no longer has its own entry in the DSM-5, and the increasing interchangeable use of the terms AS and HFA both in the literature and clinical practice, it is difficult to determine current prevalent rates of AS/HFA. Previous studies suggested that between 1.4 and 8.4 per 10,000 individuals may have AS (Baird et al., 2000; Chakrabarti & Fombonne, 2001; Powel et al., 2000; Taylor et al., 1999), with three times as many males as females diagnosed (Woods, Mahdavi & Ryan, 2013). With regard to the autistic spectrum as a whole, research points to increasing incidence in recent years. Once regarded as a rare condition, ASD is now considered relatively common. In America, the Centers for Disease Control and Prevention (2012) reported an incidence of ASD of one in 150 in 2007, one in 110 in 2009 and one in 88 in 2010. Data released in 2016 (for the 2012 period) suggests that 1 in 68 individuals may have ASD (Centers for Disease Control and Prevention, 2016). A study conducted by researchers at Dublin City University estimate that, at minimum, 1% of the population of Ireland have autism (Boilson, Staines, Ramirez, Posada, & Sweeney, 2016).

2.6 Gender Presentation Differences

As noted previously, ASD is a condition that seems to predominantly affect males. Nevertheless, the last few years have seen an increase in awareness of the behavioural presentation(s) of AS/HFA in females, as well as the set of challenges that girls and women with the disorder face. In fact, there are now a number of books devoted solely to the topic of females and AS/HFA (e.g., Attwood, 2006b; Steward, 2013). Milner, McIntosh, Colvert, and Happé (2019) conducted a qualitative study in the UK to

investigate the experiences of females with AS/HFA. Participants were 18 females with the condition (age range of 11 to 55 years) and four mothers of autistic daughters. They discussed their experiences about diagnosis, impact, and coping. Using a thematic analysis paradigm, the researchers concluded that females with AS/HFA actually experience many of the same challenges faced by males with the condition. These include struggling to initiate and maintain social relationships, difficulty in resolving conflicts within friendships, as well as sensory sensitivities. However, it was reported by some participants that girls with AS/HFA are particularly eager to "fit in" in social groups (whereas AS/HFA boys are more content to just be themselves), something that possibly makes them unhappier. Related to this, a number of the participants reported that females with AS/HFA are particularly likely to engage in camouflaging behaviours to mask their autistic traits. This in turn means that others often underestimate the extent of their social difficulties, and it can also make it harder for these individuals to obtain a formal diagnosis. The "female camouflage effect" in autism has been reported by other researchers (e.g., Rynkiewicz et al., 2016; Schuck, Flores, & Fung, 2019). According to Schuck et al., such camouflaging potentially contributes to the different gender rates of diagnosis.

Using Framework Analysis, Bargiela, Steward, and Mandy (2016) looked at the experiences of 14 women with AS/HFA (age range of 18 to 35 years) who had been diagnosed later in life (in late adolescence or adulthood). Many participants reported having their condition missed by various professionals throughout the years, and also spoke of conflicts between their autistic disorder and their traditional feminine identity. Many of the participants also reported the experience of sexual abuse, highlighting the potential vulnerabilities of females on the spectrum.

2.7 Mental Health Issues and Quality of Life in AS/HFA

Even as young children, individuals with AS/HFA can struggle with many aspects of social and practical functioning and these struggles tend to become more pronounced over the years (Picci & Scherf, 2015). The increase in social expectations and personal responsibility in adolescence and adulthood can present particular difficulty for people with AS/HFA given their various challenges (e.g., impaired theory of mind, weak central coherence and executive dysfunction). Their ongoing struggles and challenges can make them very susceptible to developing mental health issues, most notably depression and anxiety (Woods, Mahdavi, & Ryan, 2013). For example, Lugnegård, Hallerbäck and Gillberg (2011) examined emotional disturbances in a group of fifty-four adults with AS/HFA. It was found that 70% of the sample had experienced at least one episode of major depression, while 50% had suffered from recurring depressive episodes and/or anxiety.

A growing body of research suggests that AS/HFA individuals are at high risk for suicide. In a UK study, Cassidy et al. (2014) examined self-reported suicidal ideation, and suicide plans or attempts in a group of 374 AS/HFA adults. Sixty-six percent of respondents reported suicidal ideation, 35% reported plans or attempts at suicide, and 31% reported that they experienced depression. Cassidy et al. findings show that adults with AS/HFA are significantly more likely to experience suicidal ideation over their lifetimes than are individuals from the general population.

In another study, Cassidy, Bradley, Shaw, and Baron-Cohen (2018) found that a diagnosis of an autistic disorder, as well as self-reported autistic traits in the general population, are independent risk markers for suicidality. In particular, the research findings suggest that unmet support needs and camouflaging are risk factors for

suicidality unique to AS/HFA. Furthermore, self-injurious behaviours, employment troubles and mental health problems are risk factors shared with the general population, although these issues are significantly more prevalent in the autistic population. Interestingly, according to Gordon (2010), for suicidal young men to re-engage in the world and re-establish relationships it is necessary for them to learn to trust others (including peers, colleagues, and/or professionals). It is through the establishment of such trust that social support systems and professional help networks are created. While Gordon's work did not focus on any specific population of young men, no doubt these findings have relevance for young men (and indeed young women) with AS/HFA who experience suicidal ideations, and for the clinicians (including psychotherapists) who work with them.

While pharmacotherapy interventions can be helpful for treating and managing depression and anxiety in AS/HFA (as well as other coexisting disorders such as OCD and ADHD), there is currently no pharmacological treatment that directly targets the core deficits of ASD (Hollander, Hagerman & Fein, 2018). In the absence of such pharmacological treatments and the increasing prevalence of ASD, the demand for psychotherapeutic interventions for people with autism, including AS/HFA, is likely to increase.

Numerous studies have shown that both children and adults with AS/HFA have a poor quality of life compared to their neurotypical peers. In a longitudinal study carried out in Sweden by Cederlund, Hagberg, Billstedt, Gillberg and Gillberg (2008), the lives of a group of 70 males with AS/HFA were reviewed more than five years after initial diagnosis. All participants were found to be very dependent on their parents for support (including those who were now university students living away from home). In addition, it was found that 26% of the participants lived very restricted lives, having no friends or

regular employment. Similarly, Jobe and White (2007) conducted research on a group of American college students (N = 97) with autistic traits, and found that the students who had a particularly strong autistic phenotype reported markedly elevated levels of loneliness and few friendships.

Establishing and maintaining friendships and romantic relationships is often a serious challenge for individuals with AS/HFA (Attwood, 2006a). This can be due in part to a poor understanding of the nuances of social interactions; difficulty reading social/nonverbal cues (such as facial expressions, body posture, and tone of voice), as well as knowing how to respond appropriately in various situations. Comorbid psychiatric problems such as depression, anxiety, and ADHD may also interfere with social functioning (Ghaziuddin, 2005). In a single case study, Howard, Cohn, and Orsmond (2006) explored perceptions of friendship in a young man with AS/HFA. Data were collected via measures of quality of life and friendship, semi-structured interviews (with the participant and his mother), as well as photographs taken by the participant. Using a grounded theory approach, the researchers concluded that the young man seemed to enjoy having friends and was interested in having friendships, although his understanding of the characteristics of friendship was somewhat basic. It was noted that family members played a large role in helping the participant establish and maintain friendships. According to other research findings, AS/HFA individuals are significantly more likely to be the victims of bullying and criminality than are neurotypical individuals (Sofronoff, Dark, & Stone, 2011; Weiss & Fardella, 2018). This is largely due to their unusual behaviours and social naivety.

As reported in a review article by Chen, Leader, Sung and Leahy (2015), AS/HFA adults often face significant hurdles when it comes to obtaining and sustaining employment. Poor social skills, inflexible routines, poor attention to tasks, comorbid

psychiatric disorders, and limited educational level can all serve as obstacles to employment. However, they also note that there are now several specialist organisations in existence which help facilitate the transition of those with AS/HFA into the workforce. Kirchner and Dziobek (2014) suggest that the special interests of those with AS/HFA may be a valuable source to rely on when developing employment strategies for this population.

2.7.1 AS/HFA Dysfunction: Medical Model vs Neurodiversity Perspective

Having discussed some of the difficulties experienced by AS/HFA individuals in their daily lives, it is now worth considering two opposing views on the ultimate source of these challenges: the Medical Model and the Neurodiversity perspective (Jaarsma & Welin, 2012). According to the former, the behaviours and cognitive styles associated with ASD are inherently maladaptive and directly responsible for the poor adaptive skills of those with the condition. In contrast, the Neurodiversity viewpoint (sometimes referred to as the "Social Model") postulates that ASD, along with various other neurodevelopmental and psychological conditions, is first and foremost a natural variation within the broad tapestry of human neurological functioning. "Being neurodiverse or neurotypical (''normal'') are just different ways of existing as humans" (Jaarsma & Welin, 2012, p. 21). Hence, in accordance with this view, autistic behaviours are not intrinsically maladaptive per se; rather it is the presence of certain "systemic barriers" that impede the ASD individual in their day to day lives. In other words, society is structured by neurotypical people for neurotypical people, with few accommodations made for individuals on the spectrum (Armstrong, 2011). This view has led to the development of the "Neurodiversity Movement" which is associated with the struggle for the civil rights of all those with neurological or neurodevelopmental conditions (Jaarsma

& Welin, 2012). It aims to bring about a restructuring of society to make it more accommodating and inclusive of these individuals (Dillenburger, McKerr, Jordan, Devine, & Keenan, 2015).

2.8 Psychotherapy and AS/HFA

Anxiety and/or depression are the main reasons that bring AS/HFA individuals to psychotherapy (Lipinski, Blanke, Suenkel, & Dziobek, 2019; Woods, Mahdavi & Ryan, 2013), although they may also attend for other reasons. While the therapy may focus directly on their emotional issues, other issues such as social functioning, organisational/planning, and time management may also be addressed in the therapy room. However, clients with AS/HFA can be difficult to work with (Ramsay at al. 2005; Woods, Mahdavi & Ryan, 2013) and yet there has been limited research focusing on the psychotherapists who work with this client group. In one of the few studies conducted in this area (Chalk, 2012), it was found that the quality of supervision, therapists' previous knowledge and experience in the area, as well as the quality of the working alliance was positively correlated with therapist satisfaction with client outcome (the study used self-completed questionnaires to obtain the said information).

With regard to supervision, according to Spain and Happé (2019) both individual and group AS/HFA-focused supervision can be helpful for clinicians. They report that in particular the latter can be particularly resource-efficient, especially for therapists who work in generic psychological therapy services with a limited caseload of clients with AS/HFA. Similarly, the findings of a study by Cooper, Loades, and Russell (2018) highlights the role of AS/HFA-specific training and ongoing supervision in increasing therapists' confidence in making suitable adaptations to psychotherapeutic procedures when working with AS/HFA clients.

The literature suggests that Cognitive Behavioural Therapy (CBT) is the most suitable psychotherapeutic approach for people with AS/HFA (e.g., Gaus, 2018; Ramsay et al., 2005). For example, a review of several empirical studies attests to the effectiveness of this form of therapy (Spain, Sin, Chalder, Murphy, & Happé, 2015). Ramsay et al. (2005) argue that CBT has proven to be an effective intervention for treating low mood and anxiety in AS/HFA clients. They note that CBT can help modify the AS client's negative and rigid thinking patterns which can lead to, or contribute to their depression and anxiety. Gaus (2007, 2018) proposes that in addition to helping modify maladaptive thought processes, CBT can be used as a tool to help develop the AS client's social skills.

While other models of therapy may indeed be utilised with AS/HFA clients, there appears to be very little literature discussing the utility and/or efficacy of these models for this client group. Early works on autism by clinician-researchers like Kanner (1949) and Bettelheim (1967) typically considered the disorder from a psychoanalytic perspective. Since then, there have been very few authors who have considered autism from this viewpoint. One of these few is Anne Alvarez (1996) who outlined a psychoanalytic approach to working with children with ASD. This approach utilises the therapist's countertransference to repair deficits in the autistic child's social and communicative skills, and self-regulation, suggesting that these deficits are marked more by indifference than avoidance. Following in the psychoanalytic tradition, Alvarez (1996) hypothesises that certain child/caregiver interactions act as precursors to normal and abnormal social and cognitive development. Alvarez recommends that psychotherapists attune their responses so as to be appropriate to the developmental level of the child. She suggests that psychoanalytic treatments may be beneficial even for children with a severe autistic phenotype, providing supplementary supports to existing interventions (e.g., Speech and Language Therapy, Occupational Therapy).

Following on from this, Alvarez discussed her views (based on her own clinical experience) on the importance of personality factors in the pathogenesis of the condition (Alvarez & Lee, 2004; Alvarez, Reid & Hodges, 1999). Specifically, she acknowledges that each child with autism has their own unique personality, and ponders over how these personality factors may interact with the child's autistic traits to either exacerbate or reduce them. Bromfield (2000) also expressed some support for the utility of psychoanalysis for individuals with AS/HFA. While acknowledging that non-psychotherapeutic behavioural interventions are generally the most effective interventions (e.g., ABA[2], Pivotal Response Training) for severe cases of autism, he proposes that psychoanalysis can be beneficial for mildly affected individuals. He discusses a boy with AS/HFA who, following psychoanalytic intervention, demonstrated good judgement in making friends, and steered away from people who mistreated others (or him). However, Bromfield's article outlines a single case study, thus raising questions about the generalisability of his findings and conclusions.

Other psychoanalytically-inspired approaches for AS/HFA include analysing the unconscious thoughts and perceptions of individuals with this disorder using Rorschach inkblot tests (Holaday, Moak, and Shipley, 2001). The findings of this study point to atypical responses from the AS/HFA participants. Specifically, the AS/HFA participants were less likely than control participants to see "human content", "human movement", or "cooperative movement" in human or animal figures. However, it should be noted that psychoanalytical approaches such as these have gained little support from mainstream clinicians and researchers. For example, Searls (2017) notes that serious concerns have been raised about the validity and reliability of inkblot tests, and Kandel (2018) reminds

[2] Indeed, there is a considerable body of empirical research attesting to the efficacy of Applied Behavioural Analysis (ABA) as an intervention for children with classic autism (Foxx, 2008; McGarrell, Healy, Leader, O'Connor, & Kenny, 2009).

us that even though psychoanalysis may be scientific in its aims, its methods have rarely been scientific. Attwood (2006a) holds the view that psychoanalysis is an ineffective therapy for those with AS/HFA. This is because the therapy typically focuses on early formative experiences, which he regards as largely irrelevant in understanding psychological functioning in people with autistic disorders. In fact, this form of therapy according to Attwood is likely to lead to feelings of guilt in parents, and a sense of confusion in the AS/HFA individual.

Little appears to be have written about the use of humanistic therapy with AS/HFA clients. This therapeutic framework assumes that individuals have the innate capacity for self-understanding, and through extension can change their attitudes and behaviour (Rogers, 1980). This approach holds that if the therapist is able to create a caring atmosphere that provides and conveys the attributes of empathy, genuineness, and unconditional positive regard, it is likely that the client will be able to make positive changes (Rogers, 1967). Given the difficulties AS/HFA individuals experience empathising with others, humanistic psychotherapy may not be most suitable therapeutic model for these clients with Robinson and Elliott (2017) noting that there has been little research conducted in this area. Although, they do speculate that a group therapy adaptation of emotion-focused therapy might provide an effective intervention for people on the autism spectrum (i.e., adapted for the AS/HFA clients' deficits). However, they acknowledge that empirical research would be needed to support this claim.

2.8.1 The Therapeutic Relationship/Alliance

As noted by Wright (2011), the establishment of a positive therapeutic relationship is considered to be an intrinsic part of psychotherapy and other caring services. Many synonyms are used throughout the therapeutic literature to describe this relationship,

including “therapeutic alliance”, “working alliance”, “helping relationship”, and “therapeutic relationship”. Wright reports that establishing and maintaining a professional, respectful, and therapeutic relationship which promotes recovery is a huge challenge for the therapist. According to Antoniou and Blom (2006), with regard to therapy outcome, the therapeutic relationship itself is more important than the mode of the psychotherapy. This hypothesis is attested to in a recent metanalytic study of 295 independent studies that covered more than 30,000 patients (Flückiger, Del Re, Wampold, & Horvath, 2018). Similarly, the findings of an even more recent study by Gmeinwieser, Schneider, Bardo, Brockmeyer, and Hagmayer (2020) indicate that the interpersonal experiences of therapists and clients (including the therapeutic alliance) is a significant predictor of whether the client completes the course of therapy or drops out. Interestingly, severity of symptoms was not a useful predictor of drop-out.

According to Bordin (1979, 1994), a therapeutic alliance forms between therapist and client within a reciprocal understanding of the therapy. He identified three interdependent components of the therapeutic alliance; goals, tasks, and bond. For each of these components to function, it requires the client to engage in a mutually collaborative way with the therapist. Expanded further on the three mentioned components, Bordin states that it is necessary for the therapist and client to (a) agree on the goals of the therapy, (b) the client must agree that the tasks set out by the therapist are likely to address the issues that have brought them into therapy, (c) there should be a quality interpersonal bond between the therapist and client.

Clarkson (2003) proposes the “Five-Relationships” framework for psychotherapy integration. These are: (a) the working alliance, (b) the transference/counter-transference relationship, (c) the developmentally needed/reparative relationship, (d) the person to person relationship, (e) the transpersonal relationship. However, as noted by Wright

(2011), therapeutic services are often provided by multidisciplinary teams and in various settings, and so maintaining good therapeutic relations can be easier in theory than in practice.

Traditionally, the therapeutic relationship has been regarded as unilateral, the focus being on resolving the clients' issues (Morgan, 1996). Such professional relationships tend to be of relatively limited duration, with the duration itself being largely based on the achievement of stated goals. Contractual agreements are often used to guide the nature and boundaries of the therapeutic relationship, and Morgan used the term "engagement" to describe the steps the therapist takes to improve the contact with, and retention(s) of the clients within the therapeutic process. However, Ramsay et al. (2005) remind therapists that it can be difficult developing a therapeutic alliance with AS/HFA clients given their social deficits, including their poor nonverbal communication. While it may be difficult to develop a strong therapeutic alliance with AS/HFA clients, (Leather & Leardi, 2012), note that it is indeed possible, although it is likely to take longer.

A number of studies have attempted to examine the importance between nonverbal synchrony (movement coordination) between client and therapist in psychotherapy. For the most part, the findings of these studies indicate a significant positive correlation between the amount of coordinated movements and the quality of the therapist-client relationship (e.g., Ramseyer & Tschacher, 2008, 2011). However, a discordant finding was observed in a study by Paulick et al. (2018), something the authors attribute to differences in methodologies utilised across the studies. The issue of nonverbal synchrony in the therapy room is noteworthy because, as discussed earlier, Georgescu et al. (2020) found that AS/HFA individuals did not demonstrate interactional synchronicity when engaging with neurotypical people or other individuals with the condition.

Some innovative studies have investigated nonverbal aspects of therapeutic work, and specifically its impact on the therapeutic alliance that may be relevant to working with AS/HFA clients. Dowell and Berman (2013) examined the importance of eye-contact and trunk lean on perceptions of therapist empathy, the credibility of the treatment, as well as the therapist/client relationship. Using an experimental design, participants (N = 144 university students) viewed video footage of four different psychotherapists in four different combinations of eye gaze and trunk lean. Participants were required to rate therapists after viewing the videos in a randomised order. It was found that good eye-contact and a forward leaning trunk was associated with (perceived) enhanced therapist empathy and a positive therapeutic relationship. No effect for gender of therapist was observed. Dowell and Berman (2013) state that therapists could employ the mentioned behavioural cues in their practices to improve clinical performance and outcomes. They point out that as nonverbal behaviours are relevant to virtually all forms of psychotherapy, such findings are likely to have relevance across all therapeutic orientations. Note however that experimental research has shown that AS/HFA clients often demonstrate atypical eye-gaze patterns (spending more time fixating on the mouth than the eyes of another person) (Klin, Jones, Schultz, Volkmar, & Cohen, 2002; Pelphrey et al., 2002), and also have difficulty decoding many social cues, including body postures (Philip et al., 2010).

2.8.2 Empathy and Intersubjectivity in the Therapy Room

Empathy is considered to be a vital component of therapeutic relationships (Feller & Cottone, 2003), with much of the literature to date on the subject being largely underpinned by Rogers' (1980) definition of empathy. Rogers characterised empathy as "the therapist's sensitive ability and willingness to understand the client's thoughts,

feelings and struggles from the client's point of view. [It is] this ability to see completely through the client's eyes, to adopt his frame of reference…" (p.85). Rogers elaborates by saying that empathy in the therapy room involves the therapist being sensitive to moment to moment changes in their client's cognitive and affective states. This may even mean sensing meanings of which the client is him/herself not fully aware. Other definitions of empathy have been formulated over the decades including those of Mahrer (1997) who regards it as an act of "becoming" the experience of the client, and Watson (2001) who regards it as a hermeneutic interpretive process.

However, Dr Frank M Staemmler has a more dynamic view of empathy than that put forward by Rogers and other theorists (Staemmler, 2012) He argues (based on his own clinical experience and review of existing literature) that psychotherapists should not consider empathy as a one-sided affair but should instead understand it as an intersubjective process. This is a viewpoint that is likely to be shared by many psychotherapists, including those who work with clients with AS/HFA. Staemmler believes that it is the joint empathic relationship between client and psychotherapist that allows the two agents to begin to understand each other's worlds. The empathic relationship within the therapy room not only allows clients to give meaning to their explored experiences, but also to apply empathy and compassion to themselves and others in their everyday lives. Staemmler proposes that empathic alliance allows the client to feel less isolated from him/herself and the world, and thus to stay connected. For Staemmler, an important role of psychotherapy is to let the client feel a human connection with another person. He believes that the therapist and client not only have the ability to empathise, but they also have a desire to be understood by each other. However, Staemmler acknowledges that some clients find it difficult to put themselves in other people's shoes and he proposes that psychotherapists should remain mindful of the

spectrum of empathic ability among their clients. Although Staemmler does not mention any specific client group when making this point, it clearly has relevance for AS/HFA clients and the therapists who work with them.

To help explain the intersubjective nature of empathy between the therapist and the AS/HFA client, Gaus (2007, 2018) considers it in terms of cognitive and emotional empathic abilities. Cognitive empathy refers to the reading, interpreting and understanding of the other's emotions, mental states and intentions, while emotional empathy (also referred to affective empathy) refers to the sharing of the other's emotions/mental states and responding appropriately (Kerr-Gaffney, Harrison, & Tchanturi, 2019). Like other mental abilities, empathy operates at the neurological level. For example, the cognitive aspect involves activity in the prefrontal and temporal cortices (Frith & Singer, 2008), while emotional empathy has its neurological basis in the inferior frontal and parietal cortex (Shamay-Tsoory, 2011). This is part of a broader network known as the Mirror Neuron System, which is involved in emotion recognition (Shamay-Tsoory, Aharon-Peretz, & Perry, 2009). Gaus (2007, 2018) argues that individuals with AS/HFA have the capacity for empathy but their full experience of empathy is impeded by social processing deficits. The failure to read a verbal and/or nonverbal social cue prevents the AS/HFA client from experiencing the emotional response deemed appropriate for the particular situation. As Gaus points out, if a person finds it difficult to read social cues, he/she will have trouble inferring other people's mental states, and thus cannot engage in the high-order social process known as empathy.

Given that cognitive empathy is an adaptive function that can be taught (Tamayo, Rizkalla, & Henderson, 2016), several attempts have been made to enhance the social skills of AS/HFA individuals via systematic learning. For example, Golan and Baron-Cohen (2006) used computer software to teach adults with the condition how to decode

emotional facial expressions, while Fridenson-Hayo et al. (2017) used a specially designed computer game to teach AS/HFA children to read facial expressions and body postures, as well as integrate information from multiple sources. These interventions show some promise, although whether any newly acquired social decoding skills can be generalised to novel situations remains unclear.

Gaus (2018) advocates that therapists should seek to develop their AS/HFA clients' cognitive empathic ability in order to help improve their overall empathic experience, both in and outside the therapy room. She suggests that this process should begin by increasing the client's fund of social knowledge. This includes informing the client about social norms and social rules, explicit and implicit, and teaching them how to interpret various social cues, verbal and nonverbal. Gaus (2018) explains that these exercises require the AS/HFA individual to imagine the expectations of others which in turn will help develop their social inference ability. Ramsay et al (2005) makes similar suggestions regarding how therapists may help improve the social abilities of their AS/HFA clients, although Ramsay et al. recognise that some therapists may not wish to take on the role of teacher and social advisor. At this point, it is important to note that Ramsay et al. (2005) acknowledge that their recommended strategies are based on their own clinical experiences and/or review of existing literature, and they express hope that the effectiveness of the strategies will undergo empirical testing in future clinical studies.

2.8.3 The Challenges of Psychotherapeutic Work with AS/HFA Clients

Woods, Mahdavi, and Ryan (2013) note that clients with Asperger Syndrome present a unique set of challenges for the psychotherapist, a view echoed by a number of other authors. Given these challenges, Leather and Leardi (2012) propose that psychotherapists should ensure that they familiarise themselves with the characteristics and features of

Asperger Syndrome before they agree to work with this client group, and they should be aware that the emotional and cognitive structures of AS clients are quite different to neurotypical clients. Anderson and Morris (2006) also highlight these differences, and in light of these differences they argue that therapists should not be seeking an empathetic intersubjective relationship with their AS/HFA clients, but should instead be striving to establish a relationship that requires a limited level of emotional engagement (from both parties).

It has been noted by clinicians and researchers that establishing a workable therapeutic relationship with AS/HFA clients can be very challenging (Attwood, 2006a; Gaus, 2011, 2018; Leather & Leardi, 2012; Ramsay et al., 2005). Reasons put forward for this include their difficulties understanding and engaging in everyday social interactions, and through extension, a high degree of guardedness resulting from a history of social rejection. Experiencing high rates of bullying may also contribute to the cynicism and mistrust of those with AS/HFA (Cappadocia, Weiss, & Pepler, 2012; Sofronoff, Dark, & Stone, 2011). According to Attwood (2006a), some individuals with AS/HFA may develop a sense of arrogant superiority in response to their experiences of social rejection, another factor which arguably makes them difficult clients for therapists to work with. He suggests that an aim of psychotherapy should be to help alleviate these underlying insecurities and self-doubts, and to help the client see him or herself as someone who is "different" rather than "defective". Based on their own clinical experience, Leather and Leardi (2012) recommend that therapists should be aware of the AS/HFA client's various issues, and that it takes much longer to establish a therapeutic relationship with an AS/HFA client than it normally takes with a neurotypical client.

Ramsay et al. (2005) recommend that therapists should be mindful of their reactions to their AS/HFA clients. Although the client might suffer from a general difficulty

reading social situations, they are often very sensitive to any signs of criticism, and may even interpret such signs as a form of rejection. Ramsay et al. propose that the AS client is likely to appreciate a therapist who supports them and offers clear and meaningful guidance. Continuing in this vein, they encourage therapists to remain mindful of the AS/HFA client's social difficulties and to ensure that these difficulties do not interfere, at least too much, in the therapeutic relationship. To help avoid misunderstandings and their consequences, they recommend that therapists ensure that all information provided is unambiguous and that the clients are given opportunities to seek clarification, as necessary. Ramsay et al. also offer some advice to therapists about their own interpretations and misinterpretations. For example, they recommend that the therapist should be careful not to take offence if the AS/HFA client comes across as rude or hostile, because very often this is unintentional. Similar to Attwood and Gaus, Ramsay et al. (2005) tend to make generalisations about people with AS/HFA, often failing to acknowledge the heterogenous range of strengths and challenges to be found within this group. Hence, it is conceivable that their recommendations may prove more applicable to some clients than to others. Psychotherapists should remain cognisant of this when considering the use of such strategies so as to help prevent a "one size fits all" approach.

Ramsay et al. (2005) also note that therapists working with AS/HFA clients sometimes find themselves taking on the role of a "social advisor". When doing this, it should be ensured that any information provided is relevant to the individual and free of biases. For example, when advising about "social norms", the topics of attire and hygiene may be considered appropriate matters for discussion. The therapist may also offer the client guidance about how to broach sensitive subjects such as politics and religion, and in which situations these topics are best avoided (e.g., not to raise such subjects with people they have just met).

Attwood (2006a) suggests that therapists consider using perspective-taking exercises to help develop their AS/HFA clients' Theory of Mind (ToM) (that is, seeing /understanding something from another person's perspective) and modify their rigid thinking. For example, he proposes that the therapist may discuss a particular social situation with the client and ask how he/she might respond to it, and how another person (a fictitious person) might respond. The therapist may then introduce additional information about the other person in terms of their age, socioeconomic status, a traumatic life event, level of education and ask the same question again, how do you think this person might respond to this situation? Such exercises, according to Attwood will allow the client consider different variables and how these might influence a person's behaviour. The therapist can help the AS client gain a greater understanding of other peoples' social and emotional characteristics through such exercises. Attwood also reminds the therapist that AS clients have a tendency to see people as either "good" or "bad", and helping them understand that people can have both good and bad traits, should be a goal of the therapy.

According to Gaus (2007), AS/HFA clients can perceive any form of constructive criticism as a sign of rejection and to help avoid any such misunderstanding, she advises therapists to set out clear rules from the outset. For example, when to arrive, where to wait before a session begins. Given their social deficits and their difficulty with multitasking, strategic planning and time-management, she recommends that therapists should ensure that all information imparted to the AS/HFA client is explicit with no room for misinterpretation. However, she stresses that therapists should do this as gently as possible without appearing judgemental. She also proposes that therapists need to be careful how and when they broach the subject of any inappropriate behaviours (i.e., those that would be deemed socially and/or culturally unacceptable and/or inappropriate). She

recommends that such topics should only be raised after a strong therapist-client relationship has been established. While these recommendations made by Gaus may prove helpful for some clients with AS/HFA, it could be argued that they might be regarded as patronising by others. This highlights the value of research studies that explore and provide insights into the AS/HFA client's subjective experience of therapy, and also explores the experiences of the therapists who work them.

Another challenge for therapists is that many (possibly even most) AS/HFA clients pursue psychotherapy only at the encouragement of other people, as reported by Ramsay et.al. (2005) (based on their clinical experience). According to Attwood (2006a) and Gaus (2018), referrals for psychotherapy for these clients can come through various sources, including the diagnosing clinician, the family doctor (GP), a family member, and occasionally by self-referral. The relative scarcity of self-referrals may mean that these clients are entering therapy without any real motivation for change, which is likely to influence their level of engagement and therapy completion rates. This lack of self-referral also raises ethical questions about informed consent, and whether indeed these individuals are sometimes coerced into attending clinical services. These are issues that clearly need to be borne in mind by therapists who work with this client group.

Ramsay et al. speculate that non-directive therapies which do not have specific goals are likely to be ineffective, due to the AS/HFA clients' lack of motivation. They suggest that such approaches can lead to the client becoming frustrated and the therapist questioning his/her professional ability. In such situations, the therapist is advised to change approach and elicit workable treatment goals that are concrete and relevant to the client. Anderson and Morris (2006) also advocate for using a direct approach with AS/HFA clients, arguing that goal-directed and structure sessions are the most appropriate given their motivational and cognitive deficits.

It has also been found that AS/HFA clients have a tendency not to follow through on assigned tasks/homework exercises, and this presents another significant challenge for the therapist (Attwood, 2006a; Gaus, 2007, 2018; Ramsay et.al, 2005). To help explain the reason for this, Gaus emphasises that these individuals have difficulty with everyday planning/organisational skills and multitasking (executive dysfunction), and this coupled with poor time-management and procrastination often results in un-attempted or uncompleted assignments. She argues that having a family member involved in the therapeutic process can help the AS/HFA client stay "on track" between therapy sessions.

Ramsay et al. (2005) believe that group-therapy can also be beneficial for some adults with AS/HFA. They propose that group sessions can help AS/HFA clients realise that they are not alone in their struggles, and that even just meeting other like-minded people occasionally can be helpful. Group-therapy can provide an opportunity to "act out" social behaviours in a structured environment and simultaneously receive feedback from the therapist and other group members. On this point, Howlin (2004) emphasises that AS/HFA individuals can have trouble generalising and applying newly acquired knowledge to real-life situations. Therefore, it is important that the therapist encourages these clients to engage in "experiments" in which they can apply any newly acquired knowledge or strategies in practical ways. For example, they might be asked to initiate a brief conversation about the weather with a group member during a group-therapy session, and then initiate similar brief conversations outside the therapy room. Studies examining the efficacy of group-therapy for clients with AS/HFA appear to be limited, but the findings of those that have been conducted suggest some positive outcomes (e.g., Hesselmark, Plenty, & Bejerot, 2014).

Sensory processing difficulties are another feature of AS/HFA and can sometimes present a challenge for the therapist. A busy or noisy environment can result in sensory

"tune outs", distortions, and overloads for these individuals. Woods, Mahdavi and Ryan (2013) advise therapists to be very mindful of their AS/HFA clients' sensory difficulties and to make necessary adjustments where and when possible. This could include ensuring that the lights in the waiting and therapy rooms are not too bright, and that background noise is reduced as much as possible. Given that autism is a heterogenous condition, not all individuals with AS/HFA may experience sensory processing issues, or at least not to the same degree.

2.8.4 The Role of the Parents/Family in the Therapeutic Process

Gaus (2018) believes that having a family member, particularly a parent or parents attend the initial therapy session can be beneficial. It can help the therapist gain a third-party perspective on the client's developmental history and their current level of functionality, and the family member can help keep the client on track between sessions. Gaus notes that most family members are supportive and wish for their child/sibling to become more independent. This is particularly true when the parents are near or at retirement age. Of course, therapists must be mindful that when working with adult AS/HFA clients that they first obtain informed consent from their client before allowing involvement of the family members, as indeed is the case for all adult clients.

According to Attwood (2006a), based on his own clinical experience, it can be advantageous for family members (particularly parents) to receive psychotherapy themselves, as raising an AS/HFA child can be quite stressful. Indeed, according to Attwood, many parents report a feeling of being "burned out". Hence, in this context, the focus of the psychotherapy for the parents is often about developing effective coping skills and learning how to manage their child's emotional and behavioural issues. Gaus (2018) proposes that family-based therapy can also be very beneficial for both the

AS/HFA client and his/her parents because it can help them gain a greater understanding of each other's perspective(s).

2.9 Conclusion

Asperger's Syndrome (AS) is considered to be at the milder end of the autism spectrum and is sometimes referred to as High Functioning Autism (HFA). The term "Asperger Syndrome" had its own distinct entry in the previous edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and now comes under the umbrella term of Autism Spectrum Disorder in the most recent edition of the DSM (DSM-5). However, AS still remains as a distinct condition in the ICD-10. ASD is subdivided into three levels of severity in the DSM-5, with Level 1 most closely corresponding to what was previously called Asperger Syndrome. AS/HFA is characterised by social/communication difficulties, and restricted and repetitive patterns of behaviour. A number of models have been put forward to explain these aspects of psychological functioning, including Impaired Theory of Mind, Weak Central Coherence, and Executive Dysfunction. Research shows that neurotypical people and individuals with AS/HFA experience reciprocal difficulties reading each other's social/nonverbal cues. While undoubtedly such research has made a valuable contribution to our understanding of AS/HFA, and autism as a whole, such studies typically employ quantitative research methods and therefore often fail to capture the actual voices and individual experiences of those who have autism.

In recent years, some gender differences in the presentation of the condition have been noted in the literature. For example, females are more likely to engage in "social camouflaging" behaviours than are males. The increase in social expectations and personal responsibility in adolescence and beyond can present significant difficulties for

people with AS/HFA (both for males and females with the condition), making them very susceptible to developing mental health issues, most notably depression and anxiety. With a greater awareness of AS/HFA in recent years and an increase in rates of diagnosis, more people with the condition are now attending psychotherapy. Most of the literature to-date relating to AS/HFA and psychotherapy has primarily focused on psychotherapeutic models/orientations and short-term outcomes. However, there is some literature which highlights the unique set of challenges this client group can present for psychotherapists, and which also provides some recommendations to help assist the therapists and other clinicians who work with this adult population. These recommendations range from implementing CBT-based psychoeducational strategies to acting as social advisor to these clients. However, these recommendations are typically based on the authors' own clinical experiences and on generalisations about people with AS/HFA, often neglecting to acknowledge the heterogenous range of strengths and challenges of those with the condition. Hence, it is conceivable some recommendations may prove more applicable than others to any given client. Psychotherapists need to be cognisant of this issue to ensure that they do not offer or implement a "one size fits all" approach when working with clients with a diagnosis of AS/HFA.

Chapter 3: Methodology and Method

This chapter will begin by discussing the aim and objectives of the current research study and the rationale for choosing Interpretative Phenomenological Analysis (IPA). This will be followed by an overview of the philosophical and theoretical underpinnings of IPA, its structural framework and application, and the principles used to assess the quality and rigour of qualitative research, including IPA. The next part of the chapter will focus on ethical considerations, and the method and procedures employed in the current study.

3.1 Aim and Objectives

The aim of the current study was to explore psychotherapists' experiences of working with adult clients with a diagnosis of Asperger Syndrome/High Functioning Autism (AS/HFA), and to gain an in-depth understanding of these experiences. The three key objectives were:

1) Illuminate (from the therapists' perspectives) any particular challenges therapists experience when working with AS/HFA clients.
2) Explore what rewards (if any) therapists get from working with AS/HFA clients.
3) Illuminate how working with this client group might influence therapists personally and/or professionally.

3.2 Choosing a Methodology

The current study aimed to explore the experiences of psychotherapists. Given that subjective experiences do not easily lend themselves to quantification, a qualitative

research approach was deemed appropriate, and in particular, a phenomenological approach because it focuses on the individual's lived experiences. The researcher selected Interpretative Phenomenological Analysis (IPA) because she considered it to be the best fit for her study, for a number of reasons. Firstly, IPA allowed her to gather rich data on the phenomenon being studied (that is, psychotherapists' experiences of working with adult AS/HFA clients). Secondly, it gave voice to the participants' experiences and the way in which they made sense of these experiences. Thirdly, it allowed the researcher to play an active role in the interpretation of the data.

IPA has become an established qualitative research approach in psychology and other social sciences, and is recognised as being an effective tool for capturing people's lived experience and how they make sense of these experiences. Given its phenomenological, hermeneutic and idiographic underpinnings and its open and inductive approach, IPA can be especially valuable for exploring complex phenomena (such as the experience of working with clients with AS/HFA). Its use of semi-structured interviews and small sample sizes facilitates the collection of rich data and the in-depth interpretive analysis of this data (Smith Flowers & Larkin, 2009). It is through the joint reflections of both the participant and the researcher in IPA that the ultimate analytic account is reached and the research question is answered (Brocki & Wearden, 2006).

A search of the literature showed that Interpretative Phenomenological Analysis (IPA) has been used to explore the experiences of psychotherapists who work with other client groups including, those with Borderline Personality Disorder (Kirkham, 2013), with drug addictions (Andersson, 2014), as well as therapists own experiences of personal therapy (Dima & Bucuta, 2012; Oteiza, 2010). This highlights how valuable IPA can be for exploring a range of complex and emotive phenomena.

Before deciding on IPA, the researcher considered several other qualitative methodologies, including their purpose and end product and felt that they were not a good fit for her study. For example, Grounded Theory is more suitable for sociological research. It typically looks at convergences within relatively large samples to give support for broader conceptual explanations. In contrast, IPA is more suitable for providing detailed accounts of the experiences of participants within smaller samples. Discourse Analysis was also ruled out because it focuses on language seeing it as a mechanism of constructing social reality and is sceptical about whether another's thoughts/cognitions can really be accessed, While IPA assumes that sense and meaning can be made of the person's language and cognitions through a process of analysis. Narrative Analysis was also rejected because it focuses on the person's story as a whole and how they tell their story, and it is not concerned with themes within the story. In contrast, IPA is concerned with emerging themes within each individual case (or story) and across the different cases.

3.3 Interpretative Phenomenological Analysis

3.3.1 Philosophical and Theoretical Underpinnings

IPA is underpinned by three theoretical pillars *Phenomenology, Hermeneutics* and *Idiography.* Phenomenology is concerned with the way the world appears to individuals within their own subjective experience, and how they make meaning from these experiences. Hermeneutics in its broadest sense, is a methodology that deals with the interpretation of a text. There are different forms of it including empathetic hermeneutics and critical hermeneutics, but in general Pietkiewicz and Smith (2012) describe hermeneutics as an interpretative activity in which the researcher attempts to stand in the participant's shoes and see things from their point of view – it is an attempt to make a

person's experience comprehensible to another person. To help explain the important connection between these two pillars, Smith Flowers and Larkin, (2009) point out that 'without the phenomenology, there would be nothing to interpret, [and] without the hermeneutics the phenomenon would not be seen" (p.37).

3.3.1.1 Three Pillars: Phenomenology, Hermeneutics and Idiography

The philosopher Edmund Husserl (1859-1938), considered to be the founder of the school of phenomenology, proposed that experiences should be examined in the way that they occur, and in their own terms. He formulated the concepts of "lifeworld" and "natural attitude" (Husserl, 1913). Lifeworld refers to one's consciousness of the world; this includes the objects and experiences within consciousness, and it is always set against a horizon that gives context. Natural attitude relates to the way in which each of us is involved in the lifeworld. The nature of *being* in natural attitude is effortless. It is how one engages in a normal unreflective way in an already known world (Bevan, 2014). Husserl (1913) proposed that the phenomenological researcher who is concerned with capturing the essence of the participant's experience of the world (i.e., their lifeworld and natural attitude) needs to consciously shut out (bracket) or set aside their own prior experiences, assumptions and prejudices.

According to Smith, Flowers and Larkin (2009), Husserl's agenda for attentive and systematic examination of the lived experience while bracketing has helped shape many qualitative research approaches including IPA. They propose that Husserl's work has helped inform IPA's reflection process by offering the IPA researcher an appreciation of how a person attends to and reflects on their experience to access their understanding of a certain phenomenon. However, Smith et al. point out that IPA sees the interpretative process of the experience as an endeavour for both the individual (participant) and the

researcher, unlike Husserl who was only concerned with the individual's own interpretation (and making sense) of the experience.

The philosopher Martin Heidegger (1889-1976) questioned Husserl's position on researchers' bracketing and he put forward a case for hermeneutic phenomenology, arguing that phenomenology is an explicitly interpretative activity. He believed that separating the person from the world jeopardises the meaning that constitutes the lived experience and IPA follows on from this view, concluding that meaning emerges from oneself in relation to others and the world (Smith, Flowers & Larkin, 2009). According to Heidegger (1927/1962), the researcher (the analyst) cannot fully put aside their fore-conceptions because they will always look at new information (stimulus) in relation to their own prior experiences. However, he advocates that the researcher should give priority to the new object (or information) and not to his/her own preconceptions. It is through identifying and engaging in new information that the researcher will come to better know and understand what his/her preconceptions were (Smith, Flowers & Larkin, 2009).

Heidegger's work has been influential in IPA research by helping the IPA researcher understand how his/her own preconceptions might enhance or hinder the interpretation of the participants' lived experiences. Furthermore, according to Smith and Osborn (2015), Heidegger's work has managed to highlight the importance of the double hermeneutic process which is particularly relevant to IPA research. Double hermeneutics is a term used to describe the interpretative process by which the researcher is trying to make sense of the participant trying to make sense of their own lived experience. Of note also is the concept of the hermeneutic circle. This is the idea that in order to understand a text in its totality, one must understand the individual parts of the text. The whole text cannot be understood without understanding its individual components, nor can any

component be understood without reference to the other components (thus, understanding is circular in nature).

Merleau-Ponty, like his contemporary Heidegger, highlighted the situated and interpretative nature of one's knowledge about the world. However, whereas Heidegger put much emphasis on the *worldliness* of our existence, Merleau-Ponty considered the embodied nature of one's relationship to the world, and how this leads to the primacy of a person's own situated perspective on the world (Smith, Flowers, & Larkin, 2009).

For Merleau-Ponty, humans have a natural tendency to see ourselves as distinct from everything else in the world. In reality, we are subsumed within it. He argued that a problem with empirical science is that it does not factor into its framework adequately the mechanism of human judgement and perception. Advocating that science offers "second-order knowledge derived from a first order experiential base" (Smith Flowers & Larkin, 2009 p. 18). Merleau-Ponty looked at the embodied nature of a person's relationship to the world (i.e., *body-subjects*). He did not conceptualise the body as an object in the world, but rather as a means of communication with it (Merleau-Ponty, 1962). For example, if a person reaches their hand out to touch a chair, this act represents the meeting point of their self and the world. Their self is drawn to the world in that act of touching (Smith Flowers & Larkin, 2009).

Merleau-Ponty proposed that a person's perception of *other* (i.e., another person or an object) develops from one's own embodied perspective. Thus, one's relation to others starts from a position of difference. Another person's thoughts, cognitions, and emotions are not *lived through* by us, rather the outwards expressions of his/her inner experiences (via, expressions, vocalisations etc.) are observed. Although we can experience empathy for another person, it is never possible to entirely share their experience. This is because their experience belongs entirely to their own embodied position in the world.

Sartre (1956/1943) argued that, while we are self-conscious, this self-consciousness is meaning-making and action-orientated in its nature. It engages us with the world we live in. He suggested that "existence comes before essence" (Sartre, 1948, p.26), meaning that the self is not a pre-existing unity that needs to be discovered; rather it is a process of becoming. This process can be contrasted with *nothingness*, that is, things that are absent are as important as things that are present in defining who we are and how we perceive the world (Smith, Flowers, & Larkin, 2009). Sartre (1956/1943) gave an example of this concept of nothingness. He was due to meet a friend, Pierre, in a café. However, when he arrived Pierre was nowhere to be seen, and therefore instead of the café providing a context and surrounding for Pierre, it was instead characterised by his absence. Now the reason for the café's existence (for Sartre at that moment in time) was fixed by Pierre's being there, but rather his lack of being there. According to Sartre, our experience of the world is not all that exists; other people have their own perceptions, and indeed experiences can be (in part) shaped by the presence, or absence, of other and by their actions (Kaufer & Chemero, 2015).

Idiography is the third theoretical pillar of IPA and is concerned with the study of the individual and the uniqueness of each individual in terms of their subjective life experiences and life history. In order to accommodate this uniqueness, IPA researchers use small sample sizes, (sometimes a single case study) ensuring that each single case is analysed in-depth, each within its own unique context. This work is done first before the researcher explores possible links across the participants' accounts, and before any general statements are produced about the sample population (i.e., emergent themes, searching for connections across emergent themes) (Smith, Flowers & Larkin, 2009).

It must be noted that a number of criticisms of IPA have been put forward. For example, van Manen (2017) sees it as a psychological, theory orientated methodology,

rather than a psychological approach. He argues that IPA research papers fail to provide genuine phenomenological perspectives and insights, and thus should be reviewed and evaluated as psychological research. Therefore, by definition, it cannot offer phenomenological outcomes. However, Smith (2018) rebukes this, advocating that IPA can be both phenomenological and psychological. He also notes that IPA, like other approaches, can be insightful, surprising, and leaves the reader feeling they have learned something important and powerful.

Furthermore, as noted by Smith, Flowers and Larkin (2009), questions have been raised regarding the validity and reliability of IPA, as compared to the standards of quantitative research methodologies. In a similar vein, Pietkiewicz and Smith (2012) note that training in IPA (indeed qualitative methods in general) is still relatively new and underdeveloped. Hence, students are likely to approach qualitative research with a viewpoint developed from an initial training in quantitative methods. Although, Smith (2011) noted that as qualitative psychology (and related fields) mature, it can be expected that the general level of work in IPA to become stronger, richer and deeper. Ways of evaluating the validity and reliability of IPA research will be discussed later.

3.3.1.2 Intersubjectivity and Intentionality

Intersubjectivity refers to the overlapping perspectives which allow people to contemplate each other's conscious experiences via a shared framework of meaning (Smith, Flowers, & Larkin, 2009). Cornejo (2008) defines it as "the space when we are being-in-the-world-with-others. It requires the triadic convergence among a shared phenomenological experiencing between two persons on a common world" (p. 174). Thus, as Cornejo also points out, language comprehension is only possible between a speaker and hearer if common experiences between them exist. Intersubjectivity takes

into account the fact that personal experiences are, by their nature, idiosyncratic, but asserts that there nevertheless exist interpersonal interpretations which allow for human connectedness and mutual understanding. Smith and Eatough (2018) note that one of benefits of IPA is that it can be used to gain an understanding of intersubjective meaning from the other's perspective, which helps strengthen the power of the researcher's analysis.

Intentionality describes the relationship between the conscious process and the object of attention of that process (Smith, Flowers, & Larkin, 2009). This assumes that one's consciousness is always aware of something, such as a thought, a remembrance, a wish. This object of consciousness may have been inspired by the perception of a real-world object, or alternatively through an act of imagination. Hence, there exists an *intentional* relationship between an object and one's awareness of it. Note that in the context of IPA, the word intentionality has a specific meaning, distinct from its everyday connotation. If someone were to say that their memory has an intentional relation to a house, it means that their recollection is oriented towards the house. It does not mean that they are psychologically striving for the house to come into existence.

3.3.1.3 Reflexivity

Due to the nature of IPA, the researcher is both part of, and apart from, their research. Finlay (2002) describes reflexivity as an attitude, a deliberate mechanism to bring about a contemplative, conscious attentiveness of researchers with regard to their presence in their own research. It assists them in their dual role by informing self-awareness and analysis with the inclusion of the "other" (Goldspink & Engward, 2019). Thus, the reflexive approach essentially welcomes the other as an integral component of the research process. It is a continual process through which the researcher must engage with

and articulate their own place within the context of the research. Reflexivity also involves challenging and articulating any of the social or cultural influences which affect this context (Barrett, Kajamaa, & Johnston, 2020).

3.3.2 IPA: Structural Framework and Design

Like most qualitative methods, IPA does not involve generating a hypothesis prior to the research project commencing. Instead, it involves an open inductive approach to the collection and analysis of data (Pietkiewicz & Smith, 2012). For this reason, and given that IPA is concerned with the exploration of lived experience rather than the collection of quantitative data (as is the case in experimental research, for example), Willig (2001) argued that IPA allows more room for creativity and freedom than other qualitative approaches. IPA is particularly suited to examining individual's *experiences*, and how they give meaning to these lived experiences (Pietkiewicz & Smith, 2012). In fact, contemporary studies which utilized an IPA methodology have explored a range of experiences from the lived experience of pain (Smith & Osborn, 2015), the experience of living with anorexia nervosa (Fox & Diab, 2015), mothers' experiences of post-natal depression (Hall, 2006), and the day to day experiences of individuals diagnosed with Borderline Personality Disorder (Spodenkiewicz et al., 2013).

3.3.2.1 Sampling

While there is no rule regarding how many participants should be included in an IPA study, sample sizes are generally small. Pietkiewicz and Smith (2012) outline four considerations that researchers might want to take into account when deciding how many participants should take part in their research. (1) The depth of analysis of a single case study, (2) the richness of the individual cases, (3) how the researcher wants to

compare/contrast single cases, and (4) the pragmatic restrictions which the researcher is working under (this can include time constraints and limited access to participants, studying rare phenomena). Students completing doctoral research in clinical psychology, and who wish to utilise an IPA approach, are generally advised to recruit between six and eight participants (Turpin et al., 1997). According to Pietkiewicz and Smith (2012), IPA researchers should, as a rule of thumb, focus more on depth than breadth in a study.

The individuals who participate in IPA research normally represent a fairly homogenous group (as defined by important variables). Exactly how homogeneous the group is will depend on two factors (1) The degree of variation/similarity that can be contained in the analysis of the phenomenon under investigation (i.e., an interpretative concern), and (2) the ease with which potential participants can be recruited, which may depend on the level of rarity of the phenomenon in question (i.e., a pragmatic consideration) (Pietkiewicz & Smith, 2012).

3.3.2.2 Data Gathering

Within IPA, interviewing and diaries are generally considered the best ways of collecting data as they allow for a rich, first-person account of the participant's experience(s) (Smith, Flowers, & Larkin, 2009). Pietkiewicz and Smith (2012) advocate the use of semi-structured interviews, arguing that these allow the researcher and participant to converse in real time. They are also flexible enough that should novel or unexpected issues arise, the researcher will have the opportunity to investigate these issues further.

Pietkiewicz and Smith (2012) emphasise that researchers should have mastered their research skills by the time they attempt to carry out IPA research. This involves the ability to engage in "active listening" (listening attentively and trying to understand what is

being said, seeking clarification when things seems unclear), the ability to ask open-ended questions that are free from presumptions. They also suggest that researchers may need to work at gaining trust/building rapport with participants.

Researchers carrying out semi-structured interviews are also advised to prepare an interview plan in advance (Pietkiewicz & Smith, 2012; Smith, Flowers, & Larkin, 2009). This will help to ensure a natural flow in the dialogue and reduce awkward uncertainty in the researcher, wondering what to say or ask next. The researcher should have in mind certain key areas he/she wants to discuss. Questions asked in IPA research typically focus on psychological phenomenon such as memories, perceptions, cognitions. The researcher should be willing to use prompts when a participant finds a question too general, or when they continue to talk at length (researchers have to be realistic about time constraints). A skilled researcher will also allow moments of silence, as these often serve the purpose of allowing the participant to reflect on a question before responding (Pietkiewicz & Smith, 2012).

The length of an IPA interview is approximately one hour although it can take longer (Pietkiewicz & Smith, 2012). The order in which questions are asked may vary between interviews, dependent partly on participant responses. Interviews are usually audio-recorded and subsequently transcribed. As noted by Kvale (1994), a number of criticisms of qualitative interviews have been made such as, “they are not scientific, just common sense”, “they are too subjective”, “they are not reliable/objective, and they utilise leading questions”, and “the impressions drawn are subjective”. In his paper, Kvale addresses the some of these criticisms, and concludes that in fact “the qualitative interview based on conversation and interaction here appears as a privileged access to a linguistically constituted social world” (Kvale, 1994, p. 147). Similarly, Wren (2004) suggests that qualitative research can offer elaborations on empirical material which can further our

understanding of peoples' experiences by providing rich insights into the quality and textures of these experiences.

3.3.2.3 Analysis

Smith, Flowers and Larkin (2009) note that in IPA it is recommended that the researcher/investigator totally immerse him/herself in the data. When conducting IPA research, the investigator should aim to provide evidence that the participant is making sense of the phenomenon being examined, and also to document their own sense-making. Smith, Flowers, and Larkin outline a number of steps (or stages) in the process on analysing data, namely: - listen to the audio recording, read and re-read transcripts, initial noting and coding, identifying emergent themes, searching for connections across emergent themes. These stages of analysis will be discussed in more detail later in this chapter in relation to the current study.

3.4 Assessing Quality and Rigour in IPA

According to Yardley (2000) there are four principles which can be used to assess the quality of a qualitative study. The first is *sensitivity to context*. This means that the researcher shows sensitivity for the context in which the study is conducted. This may include the social/cultural setting or situation in which the study is conducted, material obtained from the participants, and pre-existing literature on the topic. Sensitivity to context is important in the data collection stage of IPA research, whereby the researcher should demonstrate close awareness during the interview process. He/she should try to experience empathy for participants. For example, recognising any difficulties or unease they may be experiencing while engaging with the researcher. Sensitivity to context also plays an important role in the analysis aspect of the research. Essentially making sense

of how the participant makes sense of his/her experience(s) requires disciplined attention to the personal accounts of the participant and what can be gleaned from it.

The second principle is *commitment and rigour*. This concerns the researcher's level of commitment, engagement and knowledge of the research topic and the methodology, and his/her level of competency and skills during the data collection and throughout the analysis process.

Yardley's (2000) third principle is *transparency and coherence*. Transparency relates to how well the stages of the research are described in the written account. Transparency can be enhanced by carefully describing how the participants were selected, how interviews were conducted, and how the analysis was carried out. Tables can be included to outline these and other features. Coherence relates to the extent to which the finished, written-up piece of research can be regarded by the reader(s) as the finished write-up. Thus, the researcher should read over their drafts of their articles carefully and try to put themselves in the shoes of the reader. According to Yardley, coherence can also relate to the degree of fit between research that has been done and the underlying theoretical underpinnings of the approach that is being implemented. In other words, it would be expected that the research which purports to be an IPA study would utilise IPA methodology and analysis, rather than those of another qualitative approach.

The final of Yardley's (2000) principles is *impact and importance*. She argues that irrespective of how well a piece of research is done, the ultimately test of its validity is whether it imparts something of interest or use to the reader. For example, an IPA study might produce interesting findings about the experiences of psychotherapists who work with clients with Asperger Syndrome/High Functioning Autism which in turn could/would influence clinical practice for this particular client group.

3.5 Method and Procedures for the Current Study

3.5.1 Current Study: Ethical Approval and Related Considerations

The current study received ethical approval from Dublin City University (DCU) Research Ethics Committee (see Appendix A). The researcher conducted the current research adhering to DCU's and the *British Psychological Society's* codes of ethics and guidelines for conducting research with human participants (British Psychological Society, 2010). These ethical guidelines guided the researcher through all stages of the research; that is, from inception through to dissemination.

She gave due consideration to the research from the participants' standpoint, with the aim of avoiding potential risk to the participants' psychological well-being, their personal values, their professional status/position and their privacy and dignity. She also gave due consideration to other stakeholders with the aim of reducing any potential risk to them (e.g., the adult AS/HFA clients and their family members whom the participants discussed, the participants' employers and/or colleagues and the professional bodies and organisations through which recruitment of participants occurred).

The study used a small sample size of nine participants and the researcher was aware that this posed a level of risk to the participants' anonymity. The researcher made every effort to safeguard the anonymity of the participants and all other stakeholders. She removed/deleted any information from the transcripts that could identify an individual, organisation or a location, although she informed the participants that she could not always guarantee that she would be able to catch all potentially identifying data. The researcher also ensured that she adhered to DCU's guidelines and protocols regarding the storage, security and disposal of the research data and other research materials, including the consent forms.

The participants were informed about the limits of confidentiality within the law and the current data protection legislation. They were informed that should they provide information that was deemed to be unethical and/or posed a risk of harm to an individual or individuals, the researcher would have a legal obligation to share this information with relevant parties/organizations and in such event, she would do this by following legal and ethical procedures and guidelines (e.g., she would consult with her research supervisors and other relevant parties such as her own professional body, to ensure that all appropriate legal and ethical protocols/guidelines were followed).

The researcher also talked to the participants about potential benefits of partaking in the study. For example, participating would provide them with the opportunity to reflect on their own experience of working with AS/HFA clients which could help aid their personal and professional development as a therapist. Also, it was hoped that the findings of the study would contribute to existing literature in the area which could help inform practice, policy and training for therapists who work with client group, which in turn could help benefit the participant(s).

3.5.2 Current Study: Sampling and Recruitment

Inclusion Criteria

The participants recruited had to be accredited psychotherapists working in Ireland. They had to have experience of working with adult clients with a diagnosis of Asperger Syndrome (AS)/ High Functioning Autism (HFA). The participants were not excluded based on their age, gender or their geographical location in Ireland.

Exclusion Criteria

Potential participants were excluded if their client(s) did not have a formal diagnosis of AS or HFA (made either by a psychiatrist or psychologist). This was to help ensure the validity of the phenomenon under investigation (i.e., the clients the therapists were discussing actually had AS/HFA). Note that the researcher did not have access to the clients' diagnostic reports so she was reliant on the participants to provide accurate information about their clients' diagnoses. Potential participants were also excluded if they had not seen AS/HFA client(s) for more than one year. This restricted timeframe was used to help ensure that the participants' recollections of their experiences were relatively fresh.

Recruitment

Recruitment of participants commenced soon after ethical approval had been obtained from Dublin City University's Research Ethics' Committee. The researcher recruited participants by emailing the Recruitment Poster (see Appendix B) directly to accredited members of the *Irish Association for Counselling and Psychotherapy* (IACP) and the Irish Council for Psychotherapy (ICP). The IACP and the ICP (and some of its branch members) provide a list of their accredited members, with contact details, on their respective websites.

The Recruitment Poster gave a brief overview of the proposed study and invited accredited psychotherapists who work/have worked (within the last year) with adult clients with a diagnosis of AS or HFA to contact the researcher directly with a view to participating in the study. To help recruit additional participants, the researcher asked the psychotherapists who had already agreed to participate in the study whether they knew any other therapists who might be interested in participating (snowball sampling). The therapists who responded to the invitation were emailed the Information Sheet (see

Appendix C). The Information Sheet outlined the rationale for the study, the practical requirements of the interview, as well as a description of the measures that were taken to protect participants' confidentiality and anonymity while also informing them of the limits of confidentiality and anonymity. They were informed that they had the right to withdraw from the study up to the time of the data analysis, if they so wished. The participants were also advised that they would be provided with a summary of the research findings (by email or by post) when the research was completed, if they requested it.

The researcher's contact details (telephone number[3] and her DCU email address), and her research supervisors' email addresses were provided on the Information Sheet. All potential participants were informed that they could contact the researcher directly should they require any further information about the research study. The therapists who agreed to partake were asked to sign and date the Informed Consent Form (See Appendix D) when they met with the researcher prior to the research interview.

The researcher recruited nine participants for the current study, all of whom were fully accredited psychotherapists and worked in Ireland at the time of the study. This participant group (i.e., accredited psychotherapists) is not considered to be a vulnerable group within psychological research. Information about the nine participants is provided in Table 3.1

[3] The researcher obtained a new mobile telephone number that was used exclusively for this study.

Table 3.1
Participant Demographics

Participant Number	Participant's Name (Pseudonym)	Gender	Years workings as a Psychotherapist	Therapeutic Orientation	Years of experience working with AS/HFA clients	Level of specific training or study in the area of AS/HFA
1	Ann	Female	18 years	Humanistic	14 years	None
2	Barbara	Female	10 years	Humanistic	approx. 10 years	None
3	Caroline	Female	Between 20-25 years	Person-Centered & CBT	15 years	None
4	Deirdre	Female	14 years	Humanistic	14 years	Attended Talks & Seminars
5	Edward	Male	Over 20 years	Integrative & CBT	approx. 16 years	None
6	Freda	Female	More than 20 years	Integrative /Eclectic	approx. 15 years	Attended Workshops and Talks
7	Geraldine	Female	Approx. 20 years	Integrative & CBT	approx. 15 years	Attended Talks
8	Henry	Male	Over 30 years	Psychoanalysis & Gestalt	approx. 30 years	Attended Talks
9	Irene	Female	18 years	Integrative /Eclectic	13 years	Attended Talks

3.5.3 Current Study: Conducting Interviews and Data Gathering

Data for the current study was gathered using semi-structured interviews. Each of the nine participants were interviewed individually with each interview taking approximately 60 minutes to complete. All interviews were audio-recorded and were duly transcribed. These face-to-face interviews were conducted in the participant's office or the researcher's office (whichever was the most convenient and most comfortable for the participant). Each participant was asked to read the Information Sheet carefully once again before they signed the Informed Consent Form. Before commencing the interview, the researcher reminded the participant again about the limits of confidentiality and anonymity, and their right to withdraw from the study up to the time of the data analysis.

The interview questions were (1) open enough to allow participants to be expansive about their individual experiences, and (2) were flexible enough to allow novel or unexpected issues that arose during the interview to be investigated further if needed (a sample of interview questions can be found in Appendix E). While all participants were asked the same primary research questions, there were some minor divergence in the interviews. These divergences facilitated the fluid nature of the interview allowing the researcher follow the participants' stories. It also facilitated the resequencing of questions when necessary, and allowed for the rephrasing of a question or prompting when relevant.

At the end of each interview the researcher followed DCU's Debriefing Research Schedule. This involved: (1) Thanking the participant for partaking in the study, (2) Asking the participant if they had any questions about the interview (that they had just engaged in), or if they had any further questions about the research project itself, (3) Advising the participant to talk to his/her supervisor if they felt that discussing their experience of working AS/HFA clients had caused them any undue discomfort or unease, (4) Reminding them once again that they had the right to withdraw from the study up to the time of the data analysis, and (5) Reminding them that they would be provided with a summary of the research findings (by email or by post) when the research was completed, if they requested it (Appendix F provides an outline of the debriefing protocol).

Making reflective notes

The researcher made brief notes after each of the interviews, writing down her thoughts and reflections of anything she felt was of potential significance. For example, an experience or an aspect of an experience that the participant might have dwelled on during the interview, or how strongly the participant may have conveyed a particular

experience - verbally (he/her use of language/phrasing) and/or nonverbally (his/her facial expressions/gestures/tone of voice). She found these notes to be very useful records to refer to and reflect on during the analysis process.

Transcription of Interviews and Removal of Sensitive Information

Each of the nine interviews were transcribed by the researcher. She transcribed each interview into a MS Word Document and labelled each transcript with the participant's respective code and pseudonym. Each Transcript/Word Document was then page and line numbered for the purpose of locating and referencing specific pieces or extracts of the data as/when necessary. She ensured that all sensitive information was omitted and/or removed from the transcripts.

3.5.4 Current Study: Analysis of the Data

Case by Case Analysis

The researcher analysed one case at a time, following Pietkiewicz and Smith's (2012) IPA guidelines for data analysis.

Immersion in the Data

She began by immersing herself in the data. This involved listening to the audio recording of the interview repeatedly and reading and rereading the transcript line by line, section by section, which provided her with new insights each time. As she read through the transcript and listened to the audio recording, she reflected and made some brief notes about the content of the interview, the participant's use of language/communication and the atmosphere during the interview. The researcher also reflected upon how her own

behaviours or characteristics may have affected the responses of the participants. (e.g., her effort to make the participants feel relaxed and comfortable, her age, her gender, her professional status).

Noting and Identification of Themes

This stage of the analysis involved a process of coding and thematic development. She began by copying the transcript into a table which had two wide margins, one to the right and one to the left. As she read through the transcript line by line, she made notes (comments) in the right-hand margin, starting with descriptive comments and moving to more interpretative comments (i.e., linguistic and conceptual) as the analysis developed and advanced. This comprehensive exploratory noting and commenting led to a substantial body of information from which emerging themes were identified and labelled. These emerging themes were written in the left-hand margin of the table. They were identified based on the frequency they appeared within the transcript and/or how strongly they captured the participant's experience (or an aspect of the participant's experience) pertaining to the phenomenon under investigation. Appendix G provides a sample of a transcript extract with coding/analysis.

The researcher then looked for connections between the emergent themes and grouped (clustered) them together according to conceptual similarities and then attached a descriptive label to each cluster. She then reviewed and reconsidered the identified themes a number of times to ensure that they were consistent with the actual text within the transcript.

The researcher followed the same procedure (noting/coding and identification of themes) for all nine transcripts. She made every effort during this process to honour the uniqueness of each participant's account by bracketing out the data (any possible

influences) from the previous transcript or transcripts. When she had completed analysing all nine transcripts/cases, she then moved to the next stage of the analysis.

Cross Case Analysis

The next stage of the analysis involved gathering the coded clusters of themes from each of the nine interviews and looking for patterns across these themes. At this level of analysis, the researcher was able to gain a meaningful understanding and interpretation of how the various themes related to each other. Priority was given to the themes considered to be the most important or salient to the participants and how strongly these themes addressed the aim and objectives of the research study. After a very long and systemic process of analysis, the researcher identified three superordinate (major) themes, of which were nestled a number of subordinate themes. All these themes encompassed an experience or aspects of an experience that was shared by the participants (i.e., by some or all of the participants) regarding their work with adult clients with AS/HFA.

Writing the Findings

The main themes and concepts to emerge from the data were then amalgamated and written up as a narrative account, which included selected quotes from the participants. This narrative of the findings is presented in the Findings Chapter of this thesis.

3.6 Researcher's Reflexivity

In IPA, the researcher's reflexivity is an integral part of the analysis and interpretative process serving to help strengthen the rigour of the research (Goldspink & Engward, 2019). It not only helps to heighten the researcher's awareness and sensitivity

to the different perspectives in the research, but also allows the researcher consider how their own personal assumptions and biases might influence the direction and outcome of the research (Morrow, 2005). Being very mindful of the integral importance of reflexivity, the researcher made every effort during the current study to engage in continuing reflexive practice throughout the various stages of the research process, including when gathering and analysing the data. The researcher remained conscious of the power imbalance between herself and the participants, and how this might cause the participants to feel some unease. To help lessen this imbalance, she engaged in some small-talk with the participants before commencing the interviews, which she felt helped to create a more collaborative connection between her and the participants.

During the interviews the researcher remained aware of her own behaviours (verbal and nonverbal) and how these behaviours might affect the participants' responses. For example, she remained cognisant of how she phrased and paced the interview questions, and whether she might unintentionally express any overt signs of affirmation or disapproval in response to the participants' accounts of working with AS/HFA clients. When analysing the data, the researcher reflected on her own preconceived assumptions and possible biases to help ensure that they did not impact on the participants' accounts of their lived experiences.

3.7 Conclusion

This chapter outlined the aim and objectives of the current study. It provided a succinct overview of the chosen research approach, namely, Interpretative Phenological Analysis (IPA). The philosophical and theoretical underpinnings of IPA were also discussed. This included its three underpinning three "pillars" **(**Phenomenology, Hermeneutics and Idiography) as well as the concepts of intersubjectivity, intentionality,

and reflexivity. An outline of IPA's structural framework and design was also provided. This included subsections on sampling, data gathering, and analysis. The principles used to assess the quality and rigour of qualitative research, including IPA were also discussed, as were the method and procedures employed in the current study. These included, ethical approval and related considerations, sampling and recruitment, data gathering and analysis of the data.

Chapter 4: Findings

The nine interviews provided a body of rich data, analysis of which identified three superordinate themes, namely "Being in a One-Sided Relationship", "Feeling Frustrated and Inadequate", and "Needing to Adapt". These three themes capture salient aspects of the participants' experiences of working with adult clients with Asperger Syndrome/High Functioning Autism (AS/HFA).

The first theme captures the participants' experience of feeling they were in a one-side or non-reciprocal relationship. This stemmed from their sense of disconnectedness with their AS/HFA clients and the feeling that they were working in the dark, struggling to read what these clients were thinking and feeling. Within many of the participants' narratives, there was a strong desire or need to experience empathy from the AS/HFA clients and a sense of disappointment when this desire or need was not fulfilled. The second theme reflects the participants' feeling of frustration and inadequacy. This frustration was evoked by the AS/HFA clients' rigidness, repetitiveness and/or poor motivation, as well as the participants' struggle to meet expectations. Self-doubt and the questioning of their clinical competency also arose as an issue within this theme. The third theme pertains to the participants adapting themselves and their approach to accommodate their AS/HFA clients, and in the process often suppressing part of themselves. Some participants felt that adapting for these clients had helped them become more patient and tolerant, and had taught them to see the world through different eyes.

In this chapter, these three superordinate themes and their constituent subordinate themes will be discussed and supported with some selected quotes from the participants. Although the selected extracts do not cover all aspects of the participants' experiences,

the researcher feels they capture the core of these experiences. The themes are presented in Table 4.1 below.

Table 4.1
Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Being in a One-Sided Relationship	• Feeling disconnected • Working in the dark
Feeling Frustrated and Inadequate	• Frustrated by AS/HFA clients' rigidity • Struggling to meet expectations • Questioning myself
Needing to Adapt	• Suppressing part of myself • Growing more patient and tolerant • Seeing the world through different eyes

4.1 Superordinate Theme 1: Being in a One-Sided Relationship

One of the major themes to emerge from the interviews was the participants' feeling of being in a one-sided or non-reciprocal relationship, and this experience was shared by most of the participants. It was evident from the participants' accounts that they struggled to build a strong emotional connection or bond with their AS/HFA clients, and despite making great efforts they felt the clients were emotionally detached, remaining outside of their reach. Within the participants' narratives, there was a strong sense of reflection about how their relationship with AS/HFA clients differed from other clients, and it was through this reflection that they seemed to construct some meaningful perspective by which they could measure and make sense of their experiences. For example, in the

following extract Barbara reflects on her relationship with an AS/HFA client in the context of other therapeutic relationships: *"It felt like it was pretty one-sided. In a relationship there's two people in the relationship, but in this relationship, it was really only about what was going on in the room for him" (Barbara; 85-86).*

4.1.1 Subordinate Theme: Feeling disconnected

Feeling disconnected from their AS/HFA clients was an experience shared by all nine participants and this experience seemed to be particularly testing for those coming from humanistic/person-centred backgrounds. For example, Ann's lack of emotional connection with her AS/HFA clients clearly did not sit well with her, and was undoubtedly in conflict with her preconceived expectations of what the client-therapist connection (or alliance) should be like. In an attempt to confront this conflict, she reflected on her relationship with other clients which appeared to give her some meaningful perspective from which she could make sense of the experience. She seemed to find some comfort in knowing that she could connect emotionally with other clients, but just not with these clients. *"The connection was very different compared to my typical clients, it just didn't flow very well, I suppose it was in conflict with how I would normally work." (45-47).* However, for Ann there seemed to be a lingering desire to experience empathy back from her AS/HFA clients and a sense of unresolved disappointment when this was not, or could not be achieved (at least not to the level of her own preconceived expectations).

Barbara also experienced a disconnectedness from her AS/HFA clients, but unlike Ann, she seemed more resigned to a non-reciprocal relationship. She had tried hard to build a strong connection with her AS/HFA clients but *"didn't get very much back*". For Barbara, there was a sense of coming to terms with her own limitations as a therapist and

accepting that a relationship without an emotional connection was probably the best she could achieve with these clients.

> *"As I said earlier I invest an awful in these clients, but to be really honest, and this might sound .. em, a bit harsh but I really don't expect anything back, because they don't have a loyalty like most of my other clients. They'd never ask "how are you?, or "did you have a nice weekend?", so it's hard to know …… (pause) mmm if they don't know that I care, or that they don't care if I care, and that can be a real challenge sometimes. But it has never really been an issue, well maybe a little bit at the start because as I said earlier, I don't expect anything back." (179-184)*

The experience of working with AS/HFA clients also proved to be challenging for Caroline and she described it as being *"personally unrewarding"*, attributing a lack of alliance and connection as being the reason for this. To illustrate her sense of disconnectedness and what was missing in the relationship, she provided an example of how her other clients might engage with her when arriving in the therapy room, asking her "*how are you today?"* This lack of social discourse with her AS/HFA clients seemed to evoke a sense of loss in Caroline, a loss of intersubjectivity and reciprocity typically experienced with other clients. "*And there's no real alliance with them so there's no personal reward even in terms of a connection that you might have with another client" (413-414).* Similar to Ann, Caroline also seemed to a have a desire to experience empathy from her AS/HFA clients, and seemed to feel unfilled when this was denied to her.

For Deirdre, it was the AS/HFA clients' formal demeanour and lack of humour that presented the barrier; a barrier that she seemed to be unable to overcome. Their level of formality in the therapy room seemed to create a sense of heightened awareness and unease in her, and in response to this she tried becoming more formal herself. In an attempt to maintain some sort of relationship with these clients, albeit a more formal one,

she seemed to feel that it was necessary to replace the lighter part of herself with a more prescriptive self, a self that keep her emotions under check:

> *"And his whole manner was very formal, very dry, there was no humour so there was no emotional connection with him" (227-228). "with my other clients it can be easier to have an emotional connection, but with Asperger's the connection is through logic and facts and sometimes they'll only look at you properly when they're interested, and I find that disconcerting myself because it's always more formal. And it's very disconcerting really, ..mm..(pause) because I have to remind myself that I can't go into emotions because they're likely to close up" (242-247)*

Edward also experienced difficulty connecting emotionally with his AS/HFA clients, and to gain some meaningful understanding of his difficulty, he looked to his relationship with other clients: *"they're not active players in the therapy so there wouldn't be that same type of relationship I'd have with my other clients" (192-194)*. He seemed to accept that the only type of relationship possible with these clients was an intellectually-based relationship. Coming to terms with this may have helped free him from any self-doubt that he would have experienced otherwise *"there's no real emotional level, mm…. I'd say it's very intellectual, that's really the basis of the relationship" (296-297)*, unlike some of the participants who expressed feelings of inadequacy.

It is interesting that Edward should describe his AS/HFA clients as non-active players in the relationship, suggesting that he saw himself as an active player, and they as more passive bystanders. It is possible that Edward may be expressing a sense of appointment here; feeling disappointed that he was unable to establish the reciprocal relationship that he had hoped for.

Trying to connect emotionally with her AS/HFA clients also presented a challenge for Freda, making her look for some meaningful explanation as to why this should be the

case. To help illustrate this, she shared her experience of working with a young woman with AS/HFA with whom she struggled to connect:

> *"The animals seemed to come before human relationships for her so it was very challenging trying to establish a warm relationship with her. I don't think she had any real empathy for humans, not even her parents. She told me, that she couldn't feel the same about humans the way she felt about her animals" (103-108).*

Knowing that this client had a history of poor relationships with other people seemed to reassure Freda that she was not alone in her struggle. She also seemed to find some exoneration in the belief that this client could not, or did not want to change. "*My feeling was that she doesn't want to, or she couldn't make any changes and that's something I had to accept for both her sake and mine" (126-128).*

Like Barbara and Edward, Geraldine also seemed to have learned that a non-emotional relationship was the only type of relationship achievable with her AS/HFA clients. She felt that it was her role as a therapist to develop a workable relationship with these clients (albeit without an emotional connection) in order to accommodate their needs, and meet their expectations of her.

> *"from my experience, they're not seeking an emotional bond with me, they see me as the professional with the necessary knowledge and training needed to help them, and strangely enough that's how I see myself when I'm working with them, so my stance would be much more clinical than it would normally be" (139-142).*

Geraldine seemed to be expressing a sense of disappointment here; disappointed that her AS/HFA clients were not seeking an emotional bond with her, and that her desire for such a relationship would need to be suppressed.

Henry described his AS/HFA clients as *"closed books*" and as being very challenging to work with, and he expressed this in a very matter of fact way during the interview. His lack of connection with these *"closed"* clients did not seem to evoke the same emotional response as experienced by some of the other participants, especially those with a humanistic background. Possibly because as a psychoanalyst, he remained both within and outside the therapeutic relationship, immersing himself in the occurring transference/countertransference, and yet maintaining an outside presence as an interpretative agent. Henry's lack of emotional connection became more apparent when he described the therapist as "*someone who is essentially a stranger"* to these clients. Unlike the other participants, Henry's AS/HFA clients lay on a couch in the therapy room, with their gaze directed away from him. This suggests that his relationship with these clients whom he described as *"closed books*" was formed without the nonverbal interplay that would typically occur in therapy. This lack of nonverbal interplay coupled with his dual role in the relationship, may explain why his lack of connection with these clients did not appear to evoke the same emotional response as experienced by some of the other participants.

Irene also spoke about feeling emotionally disconnected from her AS/HFA clients. Like many of the other participants, she too tried to construct some meaningful perspective about her relationship with these clients by comparing them to other clients. Once again highlighting the participants' need to try make sense of these non-emotional relationships.

> *"I wouldn't feel as emotionally connected to the Asperger's or High Functioning ones as I would with most of my other clients. As I said, there isn't a natural flow…mmm (pause) or spontaneity that you would experience with most people. There's a sort of disconnect with them" (234-237)*

4.1.2 Subordinate Theme: Working in the dark

Eight of the participants conveyed the difficulty they experienced reading their AS/HFA clients making them feel uncertain what these clients were thinking and/or feeling, like they felt they were working in the dark with them

Ann's struggle to read her AS/HFA clients' nonverbal cues created much uncertainty, making her unsure what direction to take the therapy, not knowing where to go next.

> *"How I would work naturally would be reading somebody's facial expressions that would lead me to go to certain spots, or issues. So, I would know where to go based on the body language and just the expression. I didn't have those cues with these clients, so again it made it difficult, I didn't know if I was going down the right road with these clients" (115-119)*

The challenge for Barbara was the AS/HFA clients' lack of eye contact. This lack of engagement made it difficult for her to know, or infer what these clients were thinking which clearly impacted on how she connected and related to them: *"these clients would look at the top of my head when I'd be talking and that was difficult, not the looking at my head but just trying to read what they were thinking" (52-54).*

Caroline also experienced difficulty reading her AS/HFA clients: "*they don't provide cues like other clients because it's hard to read them"*. Highlighting how cognisant she was of these atypical cues/behaviours in the therapy room, and the challenge these behaviours presented for her. As with most of the other participants, Caroline also seemed to be working in the dark with these clients, not knowing what they were thinking or feeling.

Similarly, Edward also struggled to decipher these clients' nonverbal cues. In the following extract, he provides a strong account of what this experience was really like for him, illustrating his sense of uncertainty and what this felt like.

> *"their poor eye contact is another problem so it can be hard to know if they're really engaging very well because they don't tend to look at my face and make normal levels of eye contact. But then at other times clients with Asperger's will stare in a blank sort of way which can be hard to read, it's hard to know what they're thinking or are they taking on board what I'm saying or not, taking it on board, agreeing or disagreeing" (261-266)*

For Freda the struggle went beyond the AS/HFA clients' eye contact (or lack of eye contact), and she conveyed how aware she was of these atypical behaviours and how difficult she found them.

> *"most of them have problems making eye contact and then on top of that, their facial expressions and their hand gestures are usually very insipid, very bland so it can be very difficult to know what they're thinking or feeling" (216-218)*

Geraldine also expressed how difficult it was to decode the AS/HFA clients' nonverbal behaviours, and when doing so, emphasised that she was not attributing any blame to these clients. Suggesting that she understood the clients' challenges and that she empathised with them.

> "*You wouldn't describe their eye contact as being normal. And it's the same with their facial expressions and their gestures, they wouldn't be normal and I absolutely know that none of that is their fault but it just makes my work harder" (168-171).*

In the following account Irene expresses how challenging it was to read her AS/HFA clients, with the exception of their anxiety which appeared obvious to her. In the face of this challenge she had learned to become more reliant on her intuition. To try make sense of this difficulty and find a logical explanation for it, she considered it from both her own and the clients' perspective(s).

> *"they're very had to read, except for their anxiety that's usually very obvious, but other than that it can be hard to decipher what's actually going on in their heads, so you end up relying more on your intuition because they don't give much away really" (24-27). "There's a sort of disconnect with them, and I think that's because they have difficulty reading other people and other people have difficulty reading them so that immediately creates a barrier, and that presents a real challenge when you're trying to build a relationship with them" (237-240)*

4.2 Superordinate Theme 2: Feeling Frustrated and Inadequate

Working with AS/HFA clients evoked feelings of frustration and self-doubt in many of the participants, and this was another theme to emerge from the data. The AS/HFA clients' rigidity, repetitiveness and/or lack of motivation were considered as being the main reasons for this frustration, and for some participants the frustration elicited feelings of inadequacy. Although for Ann, it seemed to be the struggle to build an emotional connection or relationship with these clients that evoked the most frustration,

> *"I struggled because my focus would normally be around building the relationship, and most of the time I didn't feel that I was getting anywhere with the relationship, mm* (pause)*, and so it was quite difficult for me and I suppose unusual in how I would normally work" (31-33)*

4.2.1 Subordinate Theme: Frustrated by AS/HFA clients' rigidity

Six of the participants conveyed their experience of the AS/HFA clients' rigidity and/or repetitiveness and how these autistic features impeded progress in the therapy.

In the following extract, Barbara provides a very vivid account of her AS/HFA client's repetitiveness and the lack of movement in the therapy:

> *"another client with Asperger's high functioning that I saw for about eight sessions, I think about eight sessions and there was no movement in it. It was always the same story and it was always told in the same way and that was a little bit challenging because there was no real movement" (189-190).*

It is interesting that Barbara should describe the experience as only *"a little bit"* challenging*"* and yet she mentions the lack of movement twice. She seemed to be unsure how she really felt about the experience, and in an attempt to clarify this and possibly try make sense of it, she provided the following explanation:

> *"when I say challenging it wasn't necessarily challenging in the real sense, it's just trying to help reframe his thinking rigid thinking but that didn't really happen so that was challenging" (193-195).*

Caroline also found the repetitiveness and the lack of movement in the therapy to be challenging, and she attributed the AS/HFA client's black and white thinking as being the reason for this: *"It went on and on and there was no movement in the therapy because he just couldn't, he couldn't move outside the black and white thinking" (288-290).* Here she seems to be conveying a strong sense of relentlessness, as if she felt stuck and was going nowhere.

Deirdre, Freda and Geraldine also felt frustrated by the AS/HFA clients' rigidness and the lack of movement in the therapy, and like Caroline, they too used the term "black

and white" to illustrate how inflexible the clients' thinking was. In the following extract Freda captures what this experience was really like for her, and the effort she made to try modify the clients' rigid thinking.

> *"Because they really do think very differently to other people, they see and think in black and white and so it can be exhausting just trying to persuade them to even consider an opinion or a viewpoint from another person's perspective" (254-256)*

Geraldine also expressed how difficult it was to modify or change the AS/HFA clients' rigid (black and white) thinking, explaining *"that can be the biggest obstacle in therapy" (38).* This difficulty seemed to be a particular challenge for Geraldine because she revisited this issue several times during the interview, possibly to help illustrate how inflexible their thinking was, and how difficult and relentlessness she really found the work:

> *"Well as I said already it's really their rigid thinking that has been the main challenge for me, because they see everything as either black or white with no shades in between" (202- 204). "And that kind of thinking is a real challenge for any therapist because you're constantly trying to change it, mm (pause) or at least modify it, and sometimes you will be able to modify or reframe it in relation to a given situation, but from my experience you won't be able to change it in any long term sense because they'll revert back to their default position" (225-229).*

For Irene it was the AS/HFA clients' repetitive behaviour that seemed to cause the most frustration. Their repetitiveness made the work feel relentless, making her feel that she was going around in circles. Her sense of frustration is expressed very clearly in the following extract:

> *"Because every time he comes back, we talk about the same problem but in a different context or situation and then I go through the same things with him (166-167), "So it's a bit like Groundhog Day" (171)*

The AS/HFA clients' lack of motivation to engage in the therapy, or to work with the therapist was another source of frustration for some of the participants, and for Edward it seemed to present particular difficulty. Trying to motivate these clients was clearly a struggle for him, and the clients' unrealistic expectations of him just seemed to add further to his frustration.

> *"I'd say probably their lack of motivation is probably the greatest challenge for me. For me it's often about trying to entice them along, that's probably the most challenging part for me (48-50); "I think they expect the therapist to do all the work. And that can be very frustrating for me" (98-99).*

Edward used the word *"probably"* here three times, suggesting that he was not quite sure if their lack of motivation was indeed the most challenging for him. Maybe he considered some of their other difficulties to be just as challenging, or at least, almost as challenging.

Freda felt frustrated not only by the clients' lack of motivation, but also because she was unable to motivate them. Despite trying very hard, her efforts seemed quite futile.

> *"it's like the donkey with the carrot, I feel much of time that I'm trying to cajole them along. And motivational interviewing doesn't really work with them either, not in any real sense (164-165); "I would have gone around in circles for weeks and sometimes months trying to motivate them, trying to encourage them along" (272-273)*

Henry also felt frustrated by the AS/HFA clients' lack of motivation or commitment but unlike some of the other participants, he looked outside of the clients in an attempt to try make sense of this:

> *"I've had some clients with Asperger's who dropped out of therapy, and I found that frustrating, because many of these were on the verge of substantial progress but they decided not to come back. And that's often due to pressure from their parents. I remember I had one mother ringing, insisting that I discuss her son's therapy, and I explained that I wasn't at liberty to do this. She proceeded to tell me that the work I was doing with her son was causing him much distress (147-152).*

Another source of frustration for Henry seemed to be how people with AS/HFA are represented (or misrepresented) in the media. For him there seemed to be a questioning if these people really had Asperger's, and a suggestion that such misrepresentation was putting additional pressure on his clients, by creating unrealistic expectations they would never meet, or indeed they would ever wish to meet:

> "*the people presented by the media as having Asperger's seem to thrive on attention and adoration. And these people are nothing like the clients that come into me with Asperger's. The people I see with Asperger's are content to remain in the background and live a very quiet and simple life" (207-210).*

4.2.2 Subordinate Theme: Struggling to meet expectations

Some of the participants struggled to meet their own expectations, and the expectations of others which often led to strong feelings of frustration. For Ann, trying to meet her AS/HFA clients' expectations and her own expectations clearly presented a challenge for her. At one point during the interview, she described her AS/HFA clients

as being "*much more intelligent than most people",* and expressed the view that *"they would come to therapy expecting the intellectual piece from the therapist".* To help illustrate this, she gave an example of one of her AS/HFA clients who asked her questions about the neurobiology of psychotherapy, which she was unable to answer and made her feel *"very unskilled in the room"*. She not only felt that "*it was my* [her] *role to provide this information"* but that is what the client expected of her. These expectations seemed to weigh heavily on Ann's shoulders, and in an attempt to meet these expectations, she did "*some reading between sessions to bring myself* [herself] *up to speed (336-339).*

For Deirdre, there was conflict between trying to meet her own expectations as a therapist, and the expectations of others. She explained that she had an AS/HFA client whose wife wanted him to change, essentially to become somebody else. And that the client struggled to be this other person. The dilemma for Deirdre was deciding should she be true to herself and her client by accepting him for who he was, or should she be trying to change him in order to meet his wife's expectations.

> *"And in the end I had to consider if there was truth in what he was saying, was his wife trying to turn him into somebody else and was this fair to him. For me, these were the questions, and in the end I realised that I needed to accept him the way he was, because otherwise the same issue in his marriage would have become the same issue in the therapy (93-97). I suspect that's probably the biggest conflict for the therapists who work with them because they have to feel accepted in the therapy room otherwise why would they come to see any therapist. Realistically why would they bother coming." (101-103).*

Many of the participants explained that their AS/HFA clients were referred to them by other professionals, mostly GPs, which seemed to place another set of expectations on their shoulders. For example, Barbara talked about one of her AS/HFA clients who was

referred to her by the GP while he was waiting to see a psychiatrist. The GP's expectation was that she should keep this client in therapy, "*holding him while he was waiting to see the psychiatrist"*. Trying to meet this expectation was clearly demanding for Barbara and she conveyed this by explaining "*And to be honest I felt relieved when he went to the psychiatrist".*

Some of the participants also talked about the AS/HFA clients' parents during the interviews and the positive role these parents played in the therapeutic process. For example, arranging the appointments for the adult son/daughter, providing important background information and helping to keep their son/daughter motivated between sessions. However, the parents' involvement proved to be a far less favourable experience for some other participants, who felt frustrated by the parents' unrealistic expectations and their denial of their child's autism.

For example, Freda recalled her experience of meeting with the parents of one of her adult AS/HFA clients who had recently dropped out of university.

> "*They came with him for the first session, because it was actually their GP who made the referral to me. And I found them very difficult, I'd say both of them were somewhere on the spectrum themselves and their whole focus was about criticising the college, the lectures and the disability officer" (139-142)*

Freda felt that these parents' hostility was due to their denial and their underestimation of how challenging college life can be for a person with AS/HFA. When recalling this experience, Freda's frustration appeared to be twofold; on the one hand frustrated by the parents' unrealistic expectations of professionals, and on the other hand frustrated by how their denial and rigidness was impacting on their son (her AS/HFA client) *"and you can imagine how that affected the boy and his anxiety" (143)*. For Freda,

there seems to be a sense of resentment of the parents, as if they were a barrier between her and her client, which seemed to be adding further to her frustration.

The parents' unrealistic expectations also evoked feelings of frustration in Geraldine:

> *"I think like many parents of adult children with mental health issues, I think they believe that the professionals have some magic wand that will fix everything" (188-189); "And sometimes I can feel quite aggrieved by this, and the professionals who can't meet this expectations are then open to all sorts of criticism" (195-197).*

Geraldine's use of the metaphor "magic wand" is quite powerful here, helping to convey how unrealistic she felt the parents' expectations were of her and other professionals, and how aggrieved she felt about this. Geraldine's focus on the parents suggests that she felt the need to apportion blame or responsibility elsewhere in order to understand or explain why her work with these clients was so difficult. It is interesting that Geraldine, like Freda should feel frustrated by the parents' expectations given that they both had also expressed feeling frustrated with the AS/HFA clients. Maybe these participants had more in common with the parents than they realised, with all feeling frustrated by the lack of progress they had expected or hoped for.

Irene expressed similar sentiments about the parents' unrealistic expectations and denial, and while doing so, briefly touch upon the limitations of her own work as a therapist:

> *"I'm just patching their problems up and sending them on their way, because I think with any neurodevelopmental disorder that's all any therapist can do really, you're never going to transform them into neurotypical people although sometimes I think that's what their parents believe is going to happen, which of course is totally unrealistic" (70-73); "I think the most frustrating part for me is*

that many people with Asperger's or autism don't get the supports they need until it's too late and that's partly due to their parents, not always but sometimes it can be due to the parents being in denial" (93-96).

Irene's frustration is very evident here, and it appears to be threefold. Firstly, she seemed to be frustrated with herself, because the best she can do for these clients, is just patch up their problems and send them on their way, suggesting she is not meeting her own expectations as a therapist. Secondly, she is frustrated by the parents' unrealistic expectations, i.e., expecting her to be able to transform their AS/HFA son or daughter into a neurotypical individual, and thirdly, frustrated by the parents' denial which prevents their AS/HFA son or daughter from receiving the supports they need until it is too late.

The frustration Irene felt with herself (not being able to do more for these clients) may have clouded her insight or understanding of the parents' perspective. For she seemed unaware, or possibility had not considered that it can take a long time for parents to make sense of, and come to terms with their child's diagnosis of autism, whether the diagnosis is made in early childhood, the teenage years or in adulthood.

4.2.3 Subordinate Theme: Questioning Myself

For some participants, the challenges of working with AS/HFA clients led to feelings of self-doubt and a sense of feeling inadequate as a therapist. These feelings of self-doubt arose from their own reflection and evaluation of how effectively they felt they had helped these clients, and whether they had met their own and others' expectations. For some of these participants there was a sense of coming to terms with what they felt they should be able to do, and what they realistically could do for these clients.

Working with AS/HFA clients clearly presented a challenge for Ann, often making her question herself and her ability. The struggle to build a strong relationship with them was one of the main reasons for Ann's self-doubt.

> *"I questioned…[pause] well, if I'd be able to build a relationship with this client, and what type of relationship I could build…[pause], whether I was the right fit for that client" (58-59).*

Ann also felt challenged by how knowledgeable and intelligent these clients were, making her question her own knowledge and intellectual ability:

> They "*would want me to explain somethings in detail often making me realise that I didn't know as much about this as I thought I did. So this was a challenge for me."(326-327). "They seemed to know everything about everything which made me feel very unskilled and lack ..mm [long pause] well maybe I'd say not as intelligent as them (346-347).*

Barbara also experienced strong feelings of self-doubt when working with AS/HFA clients. To help illustrate this, she provided some examples of how this doubt manifested in the form of questions that she might ask herself: "*how am I helping here? ... what am I doing?... what could I be doing differently?" (203-204).* She explained that her self-doubt was also present when she was communicating with other professionals, including the GPs who made the referrals to her, and she seem to believe that more specialised training would help alleviate this problem:

> *"I'd really like to have more training to back up what I do because I might then be able to use the correct language and correct terms"(416-417)."Sometimes I find it difficult to actually talk about Asperger's and high functioning autism to other professionals because I don't always have the correct language and*

terminology and that can make me feel very uncomfortable sometimes, or sometimes understanding the language in referral letters." (420-422)

Being unable to establish a connection with her AS/HFA clients despite her relentless trying, evoked a strong sense of self-doubt in Deirdre. Her use of words in the following extract helps illustrates how strong this self-doubt became for her:

"they can make you feel totally inadequate and make you question your ability as a therapist. I think it all comes down to the lack of connection with them, you're always trying to connect but it never really happens" (482-484).

Deirdre's sense of self-doubt seems to be stemming from her inability to develop a mutual empathic relationship with these clients. Despite her great effects she seemed to be unable to achieve the mutuality and reciprocity she so greatly desired.

The experience of working with AS/HFA clients had also led to strong feelings of self-doubt in Geraldine and Irene, although Irene seemed to have learned to manage these feelings over the course of time. *"Well you could certainly start doubting yourself, and questioning your ability as a therapist if you let yourself go there. But I've learned not to do that anymore" (142-143).*

4.3 Superordinate Theme 3: Needing to Adapt

Six of the participants felt they needed to adapt in order to accommodate their AS/HFA clients and maintain some sort of connection or relationship with them, and this was expressed very clearly by Freda: *"The more I've come to understand them, the more I've realised that I need to adapt for them because they're not going to adapt for me or*

the therapy and I've accepted that" (208-209). In the process of adapting, some of the participants felt it was necessary to lose or suppress part of themselves.

4.3.1 Subordinate Theme: Suppressing part of myself

Ann felt concerned that her AS/HFA clients would drop out of the therapy if she did not adapt for them. *If I had worked the way I would ordinarily work, it wouldn't have been satisfactory for me or for these clients. I believe they would have left."*

This concern seemed to be so strong at times that she felt it was necessary to suppress a part of herself in order to maintain a relationship with them.

> *"I think if I had not adopted a different stance then these clients would just disconnect completely. I don't think they would have shown up" (225-226); "I think you have to adapt your style in order to be able to maintain a relationship with somebody who thinks from that perspective. I would often use humour in my work but if I'd used it with these clients they would never come back, they would have thought I was an idiot probably" (299-302)*

Geraldine also went to great lengths to change and adapt for her AS/HFA clients. She not only adapted her approach, but she also tried changing herself so she could become more compatible with her AS/HFA clients. As if she felt it was necessary to become somebody else in order to work with them:

> *"I usually take on a different type of persona when I'm working with Asperger clients, I think I leave most of my Rogerian training outside the door when I'm working with them. I suppose what I'm saying is that I adjust my persona to meet their persona" (143-145).*

It is interesting that Geraldine said that when is she working with these clients, she "*usually take on a different type of persona".* This suggests that under normal circumstances (i.e., when working with other clients), she wears a specific mask or persona that portrays the genuine/ authentic psychotherapist (The Rogerian trained therapist). It is possible that she felt that her AS/HFA clients did not, or could not, interpret her authenticity, or maybe she felt that these clients did not value or approve of who she was (her authentic self).

Barbara, Caroline and Deirdre also felt the need to suppress part of themselves when working with these clients. For Barbara, this involved suppressing how she would normally think:

> "*when you're working with these particular clients you have to think differently and you don't do the emotional piece really, it becomes all about being practical and sticking to the point" (348-349).*

Whereas, for Caroline she felt she needed to be careful about what she said *"every word I use is quite laboured",* and also to be *"much more pedantic, much more clear-cut.* She found that when *"attempting to meet them* [AS/HFA clients] *at their social emotional level you do pass part of your own natural self and that's my experience" (133-134).*

Similarly, Deirdre also felt she needed to keep her *"emotions under check"* and be careful about was she said: *"you have to be very careful as well that you don't offend or say something that they might take offence to".* Deirdre found that she also needed to make other adaptions and changes:

"*some of them can be very sensitive to the light and for some it would be certain noises and some it can be smell" (401-402); "I couldn't even wear perfume on the day I was seeing him"; "So, I'm very careful about any kind of scent in the room when I'm working with them. And for some others it's the light and I'm very careful about the lighting too" (405-408).*

4.3.2 Subordinate Theme: Growing more patient and tolerant

Some of the participants felt that working with AS/HFA clients had some positive benefits. Like Caroline who explained that she had become more patient *"They've taught me patience, a lot of patience (424)*. While some of the others participants felt that they had become more tolerant.

As noted earlier, Edward found AS/HFA clients challenging to work with, and some of them tested him more than others, especially the ones who lacked motivation and were uncooperative. However, Edward felt that the experience of working with these clients had helped him to become a more patient therapist, and he had learned to become more accepting and tolerant of them.

"I think one thing is that as a therapist I've become more patient than I would otherwise" (271-272); "the Asperger clients who are likely to test you most are the ones who don't or won't cooperate, and won't follow through on any of the homework. And I've definitely become more tolerant and accepting of that now" (451-452).

Freda also felt that working with AS/HFA clients had helped her become a more patient therapist. In order to work effectively with these clients, she felt that she needed to be very patient. She learned that these clients require a slow step by step approach that is mapped out and comprehensible for them, and that taking shortcuts was not an option.

"I definitely think that you learn to become more patient when you're working with Asperger clients because you have to, the work requires patience if that makes sense. In other words, you can't hurry these clients along, it's one step at a time and you need to follow a structured pathway that's all mapped out and that makes sense to them, there's no taking shortcuts with Asperger clients." (261-265)

Geraldine also felt that working with these clients had influenced her in a positive way, helping her to become more patient and tolerant.

"I suppose if I weren't working with Asperger clients I mightn't be as patient as I am, so I suppose working with them has influenced me in that way" (277-279); "I think that's another way the work has influenced me, I definitely think I've become much more understanding and I suppose tolerant of people who have poor social skills" (285-287).

4.3.3 Subordinate Theme 3: Seeing the world through different eyes

Three of the participants expressed that they gained a greater understanding of their AS/HFA clients' world by working with them. Even though only three participants expressed this, it is important because it helps to illustrate how the process of working with these clients can influence and deepen some therapists' insights and empathic understanding. For example, Ann felt that the experience of working with AS/HFA clients had given her a greater insight into how these clients think and perceive the world. She learned that their thinking is much more logical than emotional and is ruled more by *"their heads than their hearts"* and that they see or perceive the world very differently to her (and probably most other people/ the neurotypical population).

> *"I learned it was really about what's going on in their heads and not in their hearts. The work with them taught me that they see the world through different eyes, very different to mine." (371-373).*

Barbara also felt she had developed a greater insight into the AS/HFA clients' world, feeling that this was one of the most influential and enlightening aspects of her work with these clients. She had learned that their perception of the world is very different to hers and most other people's (the neurotypical population).

> *"I suppose one of the biggest things that happened for me along the journey is to realise that they function everyday but they see the world differently" (356-357).*

For Freda, the experience was similar, she also felt that the process of working with these clients had developed her understanding:

> *"I'd say that it has given me more understanding of their difficulties, a much better insight to their lives. And I do think that I have become much more empathic towards them than I did say when I first started working them*" (249-251).

While some participants clearly felt that there had been some positive outcomes or influences from working with this client group (i.e., had become more patient, tolerant and/or developed greater insight), many participants expressed the need for more training for therapists who work with AS/HFA clients. This need for further training seemed to be driven by their frustration and their sense of inadequacy and appeared to be their way of finding a meaningful solution for this problem. For example, Ann stated "*I think there should be some specific training in the area Asperger's or Autism for all therapists because then you'd know what to expect" (128-129),* a sentiment also expressed by Freda:

"I feel there's definitely a need for more training courses for therapists and other professionals who work with Asperger clients, because their needs are definitely different" (21-22).

However, Barbara made the point that "*it's very difficult to actually get training" (27-28),* a view which was echoed by Deirdre:

"realistically there's nothing out there to help therapists who work with these clients. When thinking about it now, I'd say the talks and seminars I've attended were all theory based …mmm (pause) there was nothing really about the practical aspects of the work." (31-35).

Irene also alluded to this point, believing that *"Even one workshop a year would be good"* She felt that such workshops could help her keep up to date with current research and practices in AS/HFA, and would also allow her meet other therapists who work in the area.

4.4 Conclusion

This chapter presented and discussed the major themes to emerge from the current research. The first of these themes was "Being in a One-Sided Relationship", captures the participants' experiences of feeling that they were in a non-reciprocal relationship with their AS/HFA clients. It was evident from the participants' accounts that despite their great efforts, they struggled to build a mutual empathic relationship with these clients and experienced a strong sense of disappointment when their desire or need for such a relationship was not fulfilled. In an attempt to make sense of this struggle and disappointment, there was much reflection on the clients' atypical behaviours and social and communication difficulties and how these behaviours and difficulties impacted on

the relationship. These included the AS/HFA clients' atypical eye contact and gestures, their formal demeanour and lack of humour. The participants felt that their difficulty to read and make sense of these atypical behaviours were the main contributing factors for feeling disconnected.

The second theme "Feeling Frustrated and Inadequate" reflects the participants' experiences of feeling frustrated and the sense that they were going nowhere with these clients. These feelings were evoked by the AS/HFA clients' rigidness/inflexibility and the participants' struggle to meet their own and others' expectations. The participants' self-doubt and the questioning of their clinical competency also arose as an issue within this theme. The clients' "black and white" thinking style proved to be a cause of exasperation for a number of the participants and one of the participants described it as probably the "biggest obstacle" in therapy. The AS/HFA clients' lack of motivation was another source of frustration, as was the unrealistic expectations of some clients and their parents. These various challenges led some participants to question whether they were effective therapists, asking themselves if they were a good fit for these clients and if they could do anything differently.

The third theme "Needing to Adapt" captures the participants' attempt to adapt their approach and/or themselves in order to accommodate the AS/HFA clients' needs and prevent them from dropping out of the therapy. Some participants felt that it was necessary to suppress part of themselves to stop the clients disconnecting completely. This involved refraining from using humour, keeping their emotions under check and taking on a different persona. Although for some of the participants, the experience of working with AS/HFA clients and adapting for them had provided some positive rewards and influences. Some participants felt they had become more patient and tolerant, and

others felt that they gained a greater understanding and insight into the AS/HFA clients' world.

Chapter 5: Discussion & Conclusions

The aim of the current IPA study was to gain an in-depth understanding of psychotherapists' experiences of working with adult clients with a diagnosis of AS/HFA. Nine accredited psychotherapists (working in Ireland) participated in the current study, all of whom had many years' experience working therapeutically with adult clients with AS/HFA. As outlined in the previous chapter, analysis of the data derived from the nine interviews identified three major themes: (1) Being in a One-Sided Relationship, (2) Feeling Frustrated and Inadequate, and (3) Needing to Adapt.

This chapter will discuss how the findings of the study builds upon, or diverges from, existing literature and research relevant to the research topic. The importance of the current research findings, and the potential implications these findings have for policy, practice, and training will also be discussed within this chapter. The limitations of the study will be discussed and some directions for potential future research will be explored. This will be followed by an overview of the principles and process by which the quality and rigour of the current study was assessed. The chapter will conclude with the researcher's reflections of her experience of conducting it; what she learned and how the experience influenced her.

The literature discussed in this chapter consists of some literature discussed previously in this thesis and additionally sourced literature.

5.1 A Challenging Relationship

The experience of working with AS/HFA clients presented various challenges for the participants in the current study, and establishing a strong relationship/alliance with these

clients appeared to be the greatest challenge for them. Despite making great efforts they felt that these clients were emotionally detached from the relationship, and remained outside of their reach, making them feel they were in a one-side relationship. This is perhaps not so surprising, as difficulty with social interactions and forming relationships is a defining feature of AS/HFA. According to Leather and Leardi (2012), "When working with individuals diagnosed with AS it is important for a clinician to understand that a therapeutic alliance will take longer to establish and will become established differently" (Leather & Leardi, 2012, p.1018). They explain that in comparison to neurotypical clients, AS/HFA clients can have difficulty communicating (socially and reciprocally). In addition, these clients can be guarded and reserved, and they often provide facts sometimes with no obvious signs of feelings or emotions attached. This can cause problems in establishing an alliance that relies heavily on an emotional bond, and it often takes increased time to gain the trust and fully understand the needs and wants of these clients. Other authors have also noted the one-sided nature of the relationship between psychotherapists and their AS/HFA clients (e.g., Anderson & Morris, 2006; Gaus, 2007; Woods, Mahdavi, & Ryan, 2013). The cognitive model that seems to go furthest towards explaining the poor therapist-client relationship in psychotherapy is Baron-Cohen's (1995) "Impaired Theory of Mind" hypothesis of ASD. It will be recalled from the literature review that, according to this model, individuals with Autism Spectrum Disorders (including AS/HFA) have difficulty putting themselves in other people's shoes and seeing things from their point of view, which undoubtedly can impact on the intersubjectivity of any relationship, including the therapeutic relationship. However, given the heterogeneous nature of autism, therapists need to aware that no two individuals with AS/HFA are the same and that their ability to comprehend and appreciate

other peoples' intentions and perspectives can vary greatly. This indeed has been the clinical experience of the researcher.

5.1.1 Difficulty Connecting

The feeling of being disconnected from the AS/HFA clients was experienced by all nine participants. In an attempt to make sense of this experience, the participants reflected on how their relationship with these clients differed from that with other clients, which helped to illuminate what was missing in the relationship. The participants found that in contrast to their other clients, the AS/HFA clients did not ask usual questions such as "how are you?", a question they felt would typically facilitate positive social interactions. Some described the clients' formal demeanour and lack of sense of humour as being an emotional barrier that was difficult to overcome. They found that such formality made them uneasy at times, and in response to this unease they became more formal themselves. For some participants, the relationship with their AS/HFA clients tended to be more intellectual than emotional, with some of them believing that this was the only type of relationship achievable with these clients.

For most participants there seemed to be a strong desire or need to have the same type of mutual empathic relationship with their AS/HFA clients, that they experienced with other clients. This is an important and noteworthy finding of the current study, for as Staemmler reminds us, "the more two people are able to relate empathically to each other, the more probable it is that the relationship between them will be successful and endure" (Staemmler, 2012, p. 2). Furthermore, empathy is deemed to be a vital component of the therapeutic relationship (Feller & Cottone, 2003), and a good therapeutic alliance considered to be important for successful therapy processes and outcomes (Wright, 2011). In essence, according to Antoniou and Blom (2006) a positive client-therapist

relationship trumps mode of psychotherapy. However, according to various authors, establishing a strong therapeutic alliance with AS/HFA clients can be difficult (e.g., Attwood. 2006a; Gaus, 2018; Ramsay et al., 2005; Woods, Mahdavi, and Ryan, 2013), with the problem being largely attributed to the clients' poor social/empathic abilities.

Interestingly, the participants who seemed to struggle most with the lack emotional connection with their AS/HFA clients were those coming from a humanistic/person-centred background. This is perhaps not too surprising considering the importance placed upon the therapist-client bond within the humanistic models. However, Heasman and Gillespie (2019), reminds us that the intersubjective relationship put forward by the humanistic theorists are primarily based on neurotypical interactions. Note again that the said participants seemed to have their own preconceived expectations of what the bond between a therapist and client should be like. Heasman and Gillespie stress that autistic divergences from neurotypical norms of behaviour often results in a gap in *mutual* understanding, making empathy, social perception, and perspective-taking difficult for both parties. Hence, they argue that there is a danger of clinicians interpreting autistic behaviour solely on neurotypical terms.

The feeling of being disconnected from their AS/HFA clients did not evoke the same feelings or response for all the participants in the current study. For example, some participants accepted that an intellectually based relationship was the only type of relationship possible with these clients. Whereas, for another participant it was more about finding some comfort and possibly some exoneration in the knowing that her AS/HFA clients had a history of poor relationships with others. Given that the participants all brought something different into the therapy room, in terms of their level of professional training, therapeutic orientation, and their expectations and desires it is therefore not surprising that they expressed different response to their disconnectedness

with their AS/HFA. For as Heidegger (1927/1962) reminds us, it is the individual's own lived experience and his/her own preconceptions that enhances or hinders the interpretation of the experience.

One of the participants who was a psychoanalyst also experienced a disconnect from his AS/HFA clients, describing them as "closed books" and expressed the sentiment that the "therapist is "essentially a stranger" to them. Although interestingly, this participant did not appear as concerned about the lack of emotional connection as did some of the other participants. This may be because, as a psychoanalyst he viewed the emotional connection between the therapist and client differently than those coming from other therapeutic backgrounds. Psychoanalysts tend to place much emphasis on transference and countertransference in therapist/client relations (Marmarosh, 2012). Of course, it must be borne in mind that as an interpretative agent the analyst must be both within and outside the therapeutic relationship. Within the relationship, they immerse themselves in the occurring transference/countertransference, and yet maintain themselves outside of it for the purposes of their interpretative functions (Kernberg, 1997). Regarding the mentioned participant, his AS/HFA clients lay on a couch with their gaze directed away from him during the therapy sessions, and as such neither him nor the clients could observe each other's nonverbal cues. Given the important role that nonverbal cues play in the formation of social bonds (Bull, 2002), it could be argued that this arrangement (non-face-to-face therapy) is not particularly conducive in the development of emotional connections in the therapy room. Although, for this participant the experience of working with AS/HFA clients in this way may have been more effective and less cognitively demanding considering the "Double Empathy Problem" as put forward by Milton (2012). This posits that not only do individuals with AS/HFA have difficulty reading the

social/nonverbal cues of other people, but that neurotypical people have trouble reading individuals with AS/HFA.

The salience of nonverbal cues in interpersonal relations and their role in the development of emotional bonds is attested to in numerous studies. For example, in a phenomenological study by Register and Henley (1992), participants actually *defined* their experiences of emotional intimacy in terms associated with nonverbal behaviours. For example, the touching of the hand or meeting of the eyes. Furthermore, movement coordination (or interactional synchrony) whereby two individuals move in close harmony with one another, is often taken as an indicator of rapport (Condon & Ogston, 1966; Hasson & Frith, 2016). Given the important role that nonverbal cues play in the formation of social bonds (Bull, 2002), the findings of such research clearly have relevance for our understanding of the formation of. and the interplay in all relationship, including the therapeutic relationship. For example, in studies by Charny (1966) and Trout and Rosenfeld (1980), video footage was recorded of psychotherapists and their clients during therapy sessions. In both studies, congruent body postures between therapist and client were identified as being associated with greater rapport than were incongruent postures. According to Nietzsche (1903), when we are trying to understand another person, and produce in ourselves their feelings, we do not do this by the cause of the feelings, but instead by how they are expressed by the other person and how we imitate these in ourselves; through the eyes, gait, attitude and voice, reaching a resemblance to the play of these muscles and nerves.

5.1.2 Difficulty Reading the AS/HFA Clients

As noted in the literature review, there is a considerable body of evidence showing that AS/HFA individuals have difficult decoding social/nonverbal cues. For example,

research has shown that those with the condition are often impaired at decoding mental states from facial expressions (Clark, Winkielman, & McIntosh, 2008; Lindner & Rosen, 2006), whole body expressions (Hadjikhani et al., 2009; Philip et al., 2010), and prosody/tone of voice (Kleinman, Marciano, & Ault, 2001; Stewart, McAdam, Ota, Peppé, & Cleland, 2013). This poor ability to read social cues is typically put forward as accounting for much of the social difficulties that AS/HFA individuals experience.

However, what is interesting is that the majority of participants in the current study experienced difficulty reading and interpreting their AS/HFA clients' atypical social/nonverbal behaviours. This difficulty lead to much uncertainty in the participants; not knowing what these clients were thinking and/or feeling, and whether they were actually fully engaged in the therapy. This is both an interesting and novel finding, and to the author's best knowledge, it is the first time this phenomenon has been attested to in relation to psychotherapists. However, a number of studies have found that, in general terms, neurotypical people have difficulty reading the social cues of those with AS/HFA. As discussed previously, the "Double Empathy Problem" posits that not only do individuals with AS/HFA have difficulty reading the social/nonverbal cues of other people, but that neurotypical people also often experience difficultly reading them.

A study by Heasman and Gillespie (2018) examined social misunderstandings between AS/HFA individuals and their neurotypical family members. The study's findings suggest that family members tend to over-estimate the extent to which their AS/HFA relatives are egocentrically anchored in their own perspectives. Similarly, in research by Edey et al. (2016), it was hypothesised that AS/HFA individuals' body movements are quantifiably different from those of neurotypical individuals and that, through extension, neurotypicals will have difficulty deciphering these movements. In their experiment, AS/HFA and typically developing adults manually directed two triangle

shapes to create animations depicting mental states. The findings of this study indicated that neurotypical participants were better able to "decode" the mental states portrayed in the animations created by other neurotypical individuals than those made by the AS/HFA individuals. In contrast, the AS/HFA individuals demonstrated no significant difference in their decoding ability between the two groups (in other words, there was no "same group" advantage).

In a study by Brewer et al. (2016), both AS/HFA and neurotypical participants were video recorded making posed expressions representing six basic affective states. The participants then viewed the video clips of each other and then attempted to decode the expressed emotions. It was found that neurotypical participants performed poorly at decoding the expressions made by the AS/HFA individuals. Interestingly, the AS/HFA individuals also experienced difficulty reading the expressions made by other AS/HFA participants. Brewer et al. concluded that people with AS/HFA have a "genuine deficit in the representation of typical emotional expressions" (Brewer et al., 2016, p. 262). In the current study, some participants found that the AS/HFA client's facial expressions did not appear normal during the therapy sessions, which supports Brewer et al. finding that neurotypical people can have difficulty decoding the facial expressions of those with AS/HFA.

It is also worth noting that a study by de Marchena and Eigsti (2010) found that the hand gestures made by adults with AS/HFA were unusually asynchronous with their speech patterns (relative to a neurotypical control group). Although the researchers did not specifically examine the ability of neurotypical individuals to interpret the AS/HFA participants' gestures, this finding would suggest that the atypical gestures of AS/HFA individuals may be hard to read and interpret, as was the experience of some participants in the current study.

Participants in the current study highlighted the difficulty they had reading their AS/HFA clients' atypical eye contact. They found that their AS/HFA clients made no, or very limited eye contact, or on occasion just stared in a blank way, all of which created a sense of uncertainty in them. One participant described an AS/HFA client looking at the top of her head when she was talking to him. Eye-gaze in AS/HFA has been the focus of a number of experimental enquiries, with most studies finding that these individuals show atypical scanning patterns when observing faces. Specifically, they spend more time fixating on the mouth and less time looking at the eyes than neurotypical individuals (e.g., Klin, Jones, Schultz, Volkmar, & Cohen, 2002; Pelphrey et al., 2002). While there are a number of reports in the academic literature of blank stares and bland facial expressions associated with AS/HFA (e.g., Trevisan, Roberts, & Birmingham, 2017), this participant's observation of her client staring at the top of her head during therapy sessions is less well attested to in the literature. It is possible that this behaviour was idiosyncratic to this particular AS/HFA individual.

Either way, as discussed by Petzold (1995), in all forms of psychotherapy eye-contact is fundamentally important. He notes that human eyes can "speak" and covey to the other person the basic recognition, "this is you!". This is because one person is reflected in the gaze of the other and vice-versa. Thus, experiencing the self, being certain of one's identity, and feelings of self-esteem occur via being looked at in a way that is caring but which also recognises one's identity and value. Interestingly, Rushton et al. (2020) found that when given the choice between telephone therapy or face-to-face therapy, many clients invariably choose the latter. Many of the participants in this study believed that the therapists and the clients' communication and understanding was diminished during telephone therapy by the absence of nonverbal communication and other visual information present in the therapy room. However, Rushton et al. did not state whether

or not any of these participants were on the autism spectrum. It is possible that a similar study conducted exclusively with AS/HFA clients may yield different findings.

Almost all of the participants in the current study experienced difficulty reading their AS/HFA clients, so it was notable that one of the participants should mention that the only easy thing to read about them was their anxiety. Indeed, there is a wealth of research findings showing that anxiety disorders frequently occur comorbidly with AS/HFA (Mazzone, Ruta, & Reale, 2012; Russell & Sofronoff, 2005). However, there appears to have been no research to establish whether anxiety is easily observable in people with AS/HFA, as was the experience of this one participant. From the researcher's own clinical experience, anxiety would be as observable in a client with AS/HFA as it would be in any other client.

There is a considerable body of evidence attesting to AS/HFA people's difficulty reading (decoding/deciphering) social cues (e.g.., Kleinman, Marciano, & Ault, 2001; Lindner & Rosen, 2006; Philip et al., 2010), and several participants in the current study alluded to this in their accounts, including one who expressed that "*they have difficulty reading other people and other people have difficulty reading them".* However, none of the participants provided any concrete examples of how this was evident in the therapy room (i.e., their experience of the AS/HFA clients' having difficulty reading them). Possibly, the participants viewed their own difficulty reading their AS/HFA clients as being the more important and relevant issue during the interviews, given that the focus of current study was on the participants' experiences, and not their clients' experiences.

All participants in the current study had many years of experience working with AS/HFA clients (ranging from 10 years to 30 years), and it is unclear if they felt that their ability to read their AS/HFA clients had improved over the course of these years.

Although for one participant, it seems unlikely given that she expressed that she had come to rely on her intuition to try to understand them. Suggesting that her intuition served as a navigational tool, taking her from a place of uncertainly to a place of some meaningful understanding or insight. Intuition of course is driven primarily by factors outside of conscious awareness and the phenomenon of intuition in psychotherapy has been discussed by a number of authors, although not specifically in relation to therapists who work with AS/HFA clients. However, it is worth noting that according to Marks-Tarlow (2014), "Every psychotherapist relies on clinical intuition, whether in the form of flashes, hunches, gut feelings, body experiences or behavioural impulses to fill the gap between theory and practice." (p. 392).

This view has also been expressed by Welling (2005), who argues that psychotherapists who consider their decision making to be based exclusively on their conscious reasoning alone, are likely to be mistaken. Expanding further, Welling proposes that it is intuition that helps the therapist deal with new and complex information when faced with a range of other factors, including the presenting problem and its features, the client's characteristics, the therapist's own attributes and the ongoing therapy process. According to Welling, the therapist's intuition, which often involves sudden hunches and insights and the choosing of a trajectory without consciously knowing why, can be of great importance for the therapy and its outcome. However, Welling notes that despite its importance in psychotherapy, the topic of intuition has gained little attention from researchers, likely because the phenomenon itself can be hard to define and classify in the context of scientific research. This may indeed explain why there appears to be nothing in the literature pertaining to the intuitive experiences of psychotherapists who work with AS/HFA clients.

5.2 The Frustrated Therapist

Feeling frustrated was an experience shared by most of the participants in the current study. This feeling seemed to be evoked by a number of issues, including the AS/HFA clients' inflexibility and lack of motivation, their (the participants') struggle to meet others' expectations, and their own unfulfilled expectations and desires. According to Freud, frustration is the condition (or mental state) that emerges in the individual from being denied, or denying him/herself an innate desire or demand (Laplanche & Pontaslis, 1973), and this seems to fit well with the participants' experiences. It is evident that these participants had the desire, or indeed the need to experience empathy back their AS/HFA clients but felt that this desire or need had not been fulfilled, at least not to the depth or level they had hoped or expected.

The frustration of therapists who work with AS/HFA client is a topic which has gained little interest from researchers, although some studies suggest that not having sufficient training can be a cause of frustration in therapists who work with clients with autism. For example, an American study by Brookman-Frazee, Drahota, Stadnick, and Palinkas (2011) examined the perspectives of therapists who worked with children with autism spectrum disorders. Findings showed a correlation between limited specific training and high levels of frustration. Similarly, a recent study conducted by Cooper, Loades and Russell (2018) surveyed 50 therapists and found that their confidence levels were positively correlated with the amount of relevant training they received in ASD, rather than their years of professional practice. Cooper et al., concluded that these findings highlight a need for training and ongoing supervision to increase therapists' confidence and ability to work with this population. Again, it is worth noting that none of the participants in the current study had received any in-depth specific training in the area of

AS/HFA (other than attending some talks or workshops), which may have been a contributing factor in their frustration.

5.2.1 Challenged by the AS/HFA Clients' Inflexibility and Poor Motivation

Rigid and repetitive patterns of behaviour are a defining feature of AS/HFA. Most participants in the current study found their AS/HFA clients' rigidity and/or repetitiveness to be challenging and a cause of frustration. Several participants spoke of the clients' rigid, "black and white" cognitive style, and their difficulty considering things from another's perspective. Some of the participants found that it was very hard to change or modify their clients' rigid thinking style, with one participant finding that their rigid thinking was the biggest obstacle in the psychotherapy. Their experiences of the AS/HFA clients' rigid thinking are congruent with the findings of the Cooper, Loades, and Russell (2018) study. Many of the respondents in this study reported that they found the autistic clients' rigid thinking to be a barrier in their therapeutic work. However, Cooper, Loades, and Russell did not state where these clients were on the autism spectrum, whether they had received a diagnosis of AS, HFA, moderate or severe autism.

In the current study, in addition to the AS/HFA clients' rigidness, several participants found that the clients' general repetitiveness was another source of frustration. For example, one participant expressed that her client repeated the same story over and over in the same manner at all of his eight sessions. She found this frustrating and conveyed this by describing her work as being like "Groundhog Day", explaining that her AS/HFA client talked about the same problem at every session. Another participant also spoke of finding her clients repetitiveness (and the associated lack of movement in the therapy) challenging, with another describing the client's repetitiveness as "exhausting". While these kinds of repetitive behaviours in clinical settings are attested to in the literature

(e.g., Attwood, 2006a; Gaus, 2007, 2018), less has been written about these behaviours evoking frustration in psychotherapists. According to Murphy et al. (2005), while motor problems and responses to sensory stimuli reduce from childhood into adulthood in individuals with ASD, resistance to change and routines do not. Therefore, it is not surprising that some of the participants in the current study found that their adult AS/HFA clients' rigidness and repetitiveness was an ongoing challenge.

As sensory issues commonly occur in individuals with AS/HFA (Bogdashina, 2003; Harrison & Hare, 2004), it is worth making mention of them at this point (especially given that they are categorised under restricted/repetitive behaviours in the DSM-5 criteria for ASD). According to Woods, Mahdavi and Ryan (2013), psychotherapists' consultation rooms can often be too bright and/or too loud for individuals with AS/HFA. For this reason, they recommend that therapists should ask their AS/HFA clients if the therapy room is comfortable for them, and if necessary, appropriate adjustments should be made. Woods, Mahdavi and Ryan note that asking such questions will be greeted by the AS/HFA client as an empathic gesture, showing that the therapist is aware of their difficulties. One participant in the current study expressed her awareness of some of the AS/HFA clients' sensory issues, highlighting that she had made some adjustments to accommodate these issues. For example, she had used soft lighting and stopped using scented candles and perfume, although she did not express if, or how the clients had responded to these adaptions or changes.

According to Kojovic, Hadid, Franchini, and Schaer (2019) sensory problems in those with ASD appear to interfere directly with "higher-order" domains such as social and adaptive functioning. Similarly, motor skills issues can interfere with written tasks (Kushki, Chau, & Anagnostou, 2011). In the current study, some of the participants found that their AS/HFA clients did not complete agreed homework exercises/ tasks and they

attributed this to the clients' poor motivation. It is possible that the AS/HFA clients' sensory and/or motor issues may have also been a contributory factor for their uncompleted homework, although the participants made no reference to this during the interviews. However, one participant did discuss assigning an experimental homework task to one of her AS/HFA clients that involved the client going shopping on his own in a busy/noisy environment.

As mentioned previously, the poor motivation of AS/HFA clients in psychotherapy has been well documented in the literature (e.g., Attwood 2006a; Gaus, 2018). With regard to the current study, two participants described this as an issue that caused them much frustration, with one participant describing it was the biggest challenge for him. Both participants emphasised that they attempted to motivate the clients, and one used the expression "entice them along". He felt that his AS/HFA clients expected him to do all the work in therapy, something that seemed to add further to his frustration. The efforts made to motivate these clients were deemed unsuccessful by these participants. One participant tried utilising Motivational Interviewing but without any meaningful benefit. She described the situation as being like *"the donkey with the carrot, I feel much of the time that I'm trying to cajole them along"*.

In Cooper, Loades, and Russell's (2018) survey, poor completion rate of homework exercises was reported by the respondents as being a source of frustration, which on the surface would appear to be due, at least in part, to low motivation. However, Cooper at al. point out that failure to complete tasks (seemingly due to poor motivation) may actually be related to the executive dysfunction issues commonly found in people with autism. They note that executive functioning includes skills in mental flexibility, planning and inhibition, and the complex cognitive processes needed when engaging in psychotherapy. Given autistic people's executive functioning difficulties, Cooper et al.

argue they are likely to require different pacing to reap the full benefits of the therapy, and that they may need additional structure/reminders to help them complete homework exercises. Gaus (2018) holds a similar view and makes some recommendations to help the therapist overcome some of these problems when working with clients with AS/HFA. For example, breaking the homework up into small units, and using visual cues as reminders to complete tasks.

Given that the participants in the current study had not undertaken any course of study in AS/HFA, or had not received any specialised training in the area, it is possible that some of them were not familiar with the Executive Dysfunction model (Hill, 2004) nor the strategies recommended by various authors to help alleviate the difficulties associated with this problem. For the participants who felt particularly frustrated by the clients' lack of motivation to complete the assigned homework, this may have been case. Although it should be pointed out that AS/HFA clients' lack of motivation should not be regarded as being completely underpinned by executive dysfunction issues. As noted by Ramsay et al. (2005), most AS/HFA patients (clients) only pursue psychotherapy at the recommendations of others. Some of participants in the current study reported that the parents of a number of the AS/HFA clients were involved in the therapeutic process. For example, making the appointments for their adult son/daughter, or helping to keep them motivated between sessions, suggesting that high "external locus of control" could been a factor in the clients' lack of motivation. This theory seemed to be supported by one participant's experience (or perception) that his AS/HFA clients expected him to do all the work in the therapy.

Another source of frustration reported by the respondents in Cooper, Loades, and Russell's (2018) study was that autistic clients' have difficulty with generalising skills learned in therapy to broader contexts. This issue has also been discussed by several other

authors (e.g., Howlin, 2004; Ramsay et al., 2005). However, this was not something that was specifically highlighted by the participants in the current study, although they did express feeling frustrated by the lack of progress in the therapy. The clients' difficulty applying their skills to different contexts or situations may have also been a factor contributing to this lack of progress. For example, an AS/HFA client may be able to use effective time management strategies to complete his/her college work, but may have had difficulty applying the same strategies when attempting to complete his/her assigned therapy homework.

5.2.2 Trying to Meet Expectations

Some of the participants in the current study seemed to struggle to meet their own expectations, and the expectations of others, (e.g., the referring clinician, the AS/HFA client or the AS/HFA client's parents), and for some of these participants this struggle evoked feelings of frustration. For these participants there was a strong sense of feeling that they should be able meet expectations, as if this was a requirement of being a therapist.

Requests or referrals for psychotherapeutic supports for adults with AS/HFA can come through various sources, including the AS/HFA adult's physician (GP or psychiatrist), the diagnostician (the psychologist or psychiatrist who made the diagnosis), another psychotherapist or other professional (e.g., occupational therapist), a family member and occasionally the client him/herself (Gaus, 2018). Most, if not all referrals for psychotherapy come with a caveat of expectations of the therapist, and probably no more so then those coming from other professionals, whether the client has AS/HFA or not. For example, a study by Rudisill (1989) found that when referring patients for psychotherapy, family physicians (GPs) considered the therapist's ability, experience,

interaction skills, their appreciation of the whole person, and their availability. In cases where the patients' problems were severe, the physicians typically sought therapists who offered specialised treatments. Although not explicitly stated in Rudisill's article, it is possible that these referring physicians would have also expected the therapist to encourage the patients, particularly the less motivated ones, to complete their course of therapy thus reducing the risk of them leaving prematurely (dropping out).

In the current study, most participants reported that their AS/HFA clients had come through referrals from GPs, which seemed to have created an additional set of expectations and pressures for these participants. By accepting such referrals, they not only had to try to meet their own and their AS/HFA clients' expectations, but also those of the referring clinician and occasionally those of the clients' parents. For example, one participant reported that she had accepted a referral from a GP, and she felt obliged to keep this AS/HFA client in therapy, "*holding him while he was waiting to see the psychiatrist".* For this participant, the experience of meeting this expectation was clearly demanding, and she felt a great relief when this expectation had been met, and had been lifted from her shoulders "*And to be honest I felt relieved when he went to the psychiatrist".*

In an attempt to prevent their AS/HFA clients from dropping out of the therapy, some participants clearly felt they themselves needed to adapt. For example, for one participant this almost felt like a requirement: "*If I had worked the way I would ordinarily work, it wouldn't have been satisfactory for me or for these clients. I believe they would have left."* Edwards and Bess (1998) discuss such adaption by therapists and advise against adaption that requires significant compromise. They argue that to be an effective therapist, the therapist must acknowledge what they know (in terms of their level of knowledge and training) and who they are (their personality traits, personal belief

systems and how they relate to the client), and it is through this acknowledgment that they will come to accept that they cannot be all things to all clients. These authors remind therapists that it is not possible to help all clients, and that they should be mindful that they can only give what they have to give, and what they have to give is an integration of themselves and their professional knowledge and training. However, Rønnestad and Skovholt's (2003) research suggests that practitioners generally come to accept their own limitations (develop a confident humility) over the course of time with accumulating experience.

Some participants expressed how intelligent they found their AS/HFA clients, and one participant found them to be "*much more intelligent than most people"* and she explained that *"they would come to therapy expecting the intellectual piece from the therapist"*. To help illustrate this, she gave an example of one of her AS/HFA clients who asked her specific questions about the neurobiology of psychotherapy, which she said made her feel unskilled. In an attempt to answer these questions, she tried to improve her knowledge on the said topic by doing some reading between sessions.

This participant's experience of her AS/HFA clients being much more intelligent than most people is very plausible, particularly with regard to her clients with a diagnosis of Asperger Syndrome. People with AS have average to above average intelligence (Baron-Cohen, 2008; Noterdaeme, Wriedt, & Höhne, 2010), and research shows that they typically have advanced ability in the areas of vocabulary, crystalized knowledge (Attwood, 2005; 2006a) and fluid reasoning (Hayashi, Motoichiro, Kazue, & Haruo, 2008). A significant number of them often achieve scores in the gifted range on certain IQ subtests, and some have full-scale IQs in the Gifted or Very Gifted Range(s) (Lovecky, 2004). People diagnosed with HFA typically have significantly lower full-scale IQ, verbal IQ and nonverbal IQ scores than people with AS (Chiang et al., 2013), which lends

support to the argument (as discussed earlier, in the literature review chapter) that AS and HFA are two distinct conditions (see also Volkmar & Klin, 2000).

Attwood (2006a) notes, based on his own clinical experience that people with AS place great personal value on their own intellectual ability and they admire other people with high intellect. He argues that by developing an intellectual connection with their AS clients, therapists can boost the client's motivation to engage in the therapy and enhance their involvement in the client-therapist relationship. Hence, in the current study the participant's efforts to try to meet her AS/HFA clients' intellectual expectations of her could arguably be seen as an attempt to gain their admiration or respect, and through extension forge a greater connection with them. Again, it is worth noting (as discussed earlier) that some of the other participants in the current study stated that the only type of relationship possible with these clients was an intellectually based relationship. Of course, the value of this type of relationship should never be underestimated given that an important role of psychotherapy is to allow the client feel a human connection with another person (Staemmler, 2012), whether this might be at an emotional or intellectual level. The researcher has found from her own clinical experience, that many clients with AS/HFA enjoy having intellectual conversations with the therapist, so identifying a shared topic, or topics of interest from the outset can to be the basis for a strong therapeutic alliance.

Little, if anything, appears to have been written about such intellectual relationships with AS/HFA clients in therapy. However, Attwood (2006a) notes that during his psychotherapeutic work with AS/HFA children, he often appeals to their intellectual vanity, commending them for their high intelligence. He found that this serves as a better motivator to complete tasks than telling them that something they have done or said has made somebody happy or proud.

Holmes (2016) explored the doctor-patient relationship in the context of attachment theory (Ainsworth, 1969; Bowlby, 1979), proposing that when people are ill, or feeling stressed they will often seek out an older, wiser and stronger figure to find comfort and security. Within this framework, he considers the concept of "mutual investment company" which is the gradual acquisition of knowledge and shared experience that the doctor and patient both negotiate. Through this shared investment, important knowledge can be gained and ultimately lead to early preventative or modifying interventions. In the current study, many of the participants found that their AS/HFA clients sought an intellectually-based relationship (as opposed to an emotionally-base one). It is possible that by facilitating such a relationship, these participants fulfilled the clients' need or requirement for the "wise" figure that could help alleviate their difficulties. For as mentioned earlier, one participant recalled her experience of an AS/HFA client asking her specific questions about the neurobiology of psychotherapy. Imparting and discussing such knowledge in the consultation room may have helped to increase the participant's self-efficacy and brought a sense of comfort and security to the client; knowing that he was in the capable hands of a therapist with the knowledge needed to help resolve his difficulties.

The participants' experience of trying to fulfil the AS/HFA clients need for an intellectually based relationship possibly represented an attempt to validate the clients' experiences. As noted by Stark (1999), the therapist who speaks to where the client is, does so to validate their (the client's) experience. Assuming that the psychotherapist is accurate in their empathy, he/she can offer the client the opportunity to feel understood. The therapist may also direct the client's attention elsewhere in an attempt to help them expand their knowledge. Through this process, the therapist essentially offers the client the opportunity to understand. However, in the current study participants struggled to

read their AS/HFA clients, which caused them a sense of uncertainty in knowing how, or where, they should direct these clients.

A number of participants in the current study discussed the positive role some AS/HFA clients' parents played in the therapeutic process. For example, arranging the appointments for their adult child, providing important background information, and helping to keep their son/daughter motivated between sessions. For these participants, the parents input seemed to be viewed as a shared endeavour and also an acknowledgement and validation of the huge amount of work necessary to support these individuals. It is not unusual for family members of clients with AS/HFA to be involved in their clinical services (Gaus, 2018; Stoddard, 1999). As discussed by Gaus, having a family member come to the initial therapy session can be beneficial as it can help the therapist gain a third-party perspective of the client's developmental history and their current level of functionality. She also notes that most family members are supportive and wish for their child/sibling to become more independent. This is particularly true when the parents are near or at retirement age. Gaus argues that a supportive family member can help the AS/HFA client stay "on track" between sessions.

However, some participants felt less happy about of the involvement of AS/HFA clients' parents, feeling that some of them have unrealistic expectations of the professionals who work with their adult children. One participant in particular expressed this view very clearly *"I think they believe that the professionals have some magic wand that will fix everything"* Another participant expressed the view that with any neurodevelopmental disorder all the therapist can do is patch up the client's problems and send them on their way. She highlighted that it is not possible to transform these individuals into neurotypical people, but she believed that is what many of their parents expect and she felt frustration by this.

Indeed, unrealistic expectations regarding interventions for individuals with ASD has been reported in the academic literature. According to Simpson et al. (2005), the promotion of various unproven "miracle" interventions for ASDs have fostered unrealistic, unhealthy, and implausible expectations about treatment outcomes amongst the public. Gaus (2018) recommends that the clinician should take time to define the target problems and expected goals with the AS/HFA client (and parents, if applicable) at the initial consultation in order to avoid any misunderstandings. Constantino, Ametrano and Greenberg (2012) hold a similar view. They propose that therapists working with all client groups should try to identify the clients' expectations before the therapy commences, and should systematically assess and track their treatment expectations over the course of the therapy. They suggest that therapists can do this effectively by using specifically designed questionnaires/measures. The participants in the current study did not indicate whether they had followed any of these procedures, although one participant expressed that she tries to set clear boundaries from the outset with her AS/HFA clients.

Another reason why the parents' expectations of therapy outcomes may have been so high (or indeed unrealistic) might be due, at least in part, to how AS/HFA individuals are presented or portrayed in the media. For example, guests on chat shows who have a diagnosis of AS/HFA are often very accomplished people with good adaptive functioning and appear quite comfortable in front of the camera. While of course it is important that the media highlight how accomplished people with AS/HFA can be, it must also be asked if such individuals are truly representative of the many adults with AS/HFA who typically have poor adaptive functioning and experience social anxiety/avoidance. This was a sentiment expressed very strongly by one of the participants "*the people presented by the media as having Asperger's seem to thrive on attention and adoration. And these people*

are nothing like the clients that come into me with Asperger's. Of course, it could be argued the people with AS/HFA who seek or are referred for psychotherapy are likely to have more anxiety and adaptive functioning problems than AS/HFA individuals who do not seek or attend therapy. However, various studies have shown that people with AS/HFA have significantly higher levels of social anxiety and social avoidance than neurotypical people (e.g., Bejerot, Eriksson & Mortberg, 2014), and that these issues in children with AS/HFA increase as they get older (Kuusikko et al., 2008). Such findings would seem to support the sentiment expressed by the participant, that the media portrayal of people with AS/HFA is not an accurate depiction of most adults with AS/HFA.

Further sentiment about the parents' unrealistic expectations was expressed, with one of the participants suggesting that these unrealistic expectations stemmed from the parents' non-acceptance or denial of their child's autism, and that this denial often leads to delays in them seeking appropriate supports for the child. *"I think the most frustrating part for me is that many people with Asperger's or autism don't get the supports they need until it's too late and that's partly due to their parents, not always but sometimes it can be due to the parents being in denial"*

This participant's perception of the parents being in denial may indeed have been an accurate one, given that studies have found denial is a common emotion experienced by many parents of children with autism. McCabe (2008) found that shock, denial, anger, regret and sadness are frequently reported by parents during and after their child's diagnosis of ASD. Similar findings were obtained by Oprea and Stan (2012). In a recent study using a Grounded Theory approach, Gentles, Nicholas, Jack, McKibbon, and Szatmari (2020) found that denial is a common experience among the parents of children with autism (although in their paper they refer to the phenomenon as "readiness for

involvement"). Gentles et al. emphasise that there is a need for professionals to be sensitive to the parents' non-acceptance of their child's diagnosis and their delayed readiness to be engaged and involved in their child's intervention programmes and supports.

Another participant described her experience of meeting with the parents of one her AS/HFA clients who had recently dropped out of college. She found these parents difficult (rigid) and she suspected that they might be on the spectrum themselves. These parents were critical of their son's college lecturers; she found this frustrating and suggested that they had underestimated how challenging college life would be for their son. Many people with AS/HFA find the experience of college life challenging, so the participant's assumption that the parents had underestimated how difficult university would be for their son seems to be congruent with existing research findings. For example, Gurbuz, Hanley and Riby (2019) compared the college experiences of AS/HFA students (n = 26) and neurotypical controls (n = 158). Compared to the controls, the AS/HFA participants reported significantly more challenges with the social aspects of college. These challenges included social functioning, social support opportunities, and low levels of ASD awareness from others. They did however report a particular strength in the area of academic skills. The AS/HFA students had significantly more thoughts of withdrawal from university than did the neurotypical students. Gurbuz et al. concluded that their findings highlight the need for supports at Third Level education for autistic students. Similar findings were obtained in a review study by Gelbar, Smith, and Reichow (2014). Although it is important to note that in recent years, universities have become more aware and supportive of the mental health needs of their students, including those with AS/HFA (Barden & Caleb, 2019).

With regard to the participant's suspicion that the client's parents may have also been on the autism spectrum, this is a plausible theory and supports the research which shows that ASD has a large genetic component. A number of studies have shown that first-degree relatives of individuals with autism often show traits of the disorder themselves (e.g., De la Marche et al., 2012; Rubenstein & Chawla, 2018).

5.2.3 The Self-Doubting Therapist

Many participants in the current study found that working with AS/HFA adult clients had led to feelings of self-doubt and a sense of feeling inadequate as a therapist. This is perhaps not too surprising, as according to Theriault, Gazzola, and Richardson (2009), feelings of self-doubt about one's clinical effectiveness are common among mental health professionals, regardless of their level of experience. For many of the participants there was a strong sense of uncertainty when working with their AS/HFA clients, which seemed to be the underpinning factor in their self-doubt. This sense of uncertainty was illuminated at various times during their interviews. For some participants it seemed to be a prevailing experience, often trying to make sense of their challenges and reflecting on their competency, asking themselves such questions as "*how am I helping here? ... what am I doing?... what could I be doing differently?"*

Voller (2011) explores the concept of the therapist's uncertainty, and proposes that it needs to be understood not as a single attitude, but rather as a dynamic process of movement between the being "with" uncertainty, and being "in" uncertainty. She argues that a full understanding of these differences has been lost in the current evidenced-based culture and that there is a lack of acknowledgement of the pioneering work, such as that of Freud (e.g., construction of the unconscious) and Rogers' (e.g., development of core conditions) from which we can evaluate and understand the complex nature of

uncertainty. She suggests that both modes of uncertainty are necessary in the therapist, although not equal. She describes the therapist's being "with" uncertainty as the therapist's grappling with a given inhibiting situation, and being "in" uncertainty as the therapist's self being in the inhibiting situation. Voller suggests that it is the latter that opens the therapist to numerous possibilities, such as touching into, or reflecting on his/her own vulnerability or existential anxiety, vicariously experiencing the clients' world or creating the space for imaginative exploration. The participants in the current study appeared to have experienced both modes of uncertainty, often grappling with the inhibiting situation(s) or challenges of working with their AS/HFA clients, while also being in the situation and reflecting on their own vulnerabilities.

Given that none of the participants had undergone any in-depth training in the area of AS/HFA, it is possible that this may have been a contributing factor in their self-doubt and their questioning of their clinical competency. However, it important to note that some participants did not express any sense of doubt about their competence or refer to their lack of specialised training, although some of these individuals did mention that they had supervisors who were very knowledgeable in the area of AS/HFA. This indicates the importance of ongoing supervision in developing practitioner confidence.

Some of the participants in the current study used a person-centred approach with their AS/HFA clients which may have also contributed to their frustration and self -doubt. According to Ramsay et al. (2005), this approach tends to be unsuitable for AS/HFA clients because of its emphasis on the client-therapist relationship (emotional connection and reciprocity) and because it is typically non-directive. Using this approach with AS/HFA clients is likely to result in the clients becoming frustrated, and the therapist feeling ineffective.

Many participants in the current study seem to expect or hope that they would be able to establish an emotional bond with their AS/HFA clients. For one participant, it was precisely the failure to establish such a connection which made her feel completely inadequate and led her to question her ability as a therapist. She expressed that as a therapist she is always trying to connect with these clients, but it never really happens. However, in practice the participants found that the social interactions with their AS/HFA clients tended to be very much one-sided. As Ramsay et al. (2005) points out, "it is the expectation of reciprocity of communication that creates problems for individuals with AS" (p. 490). In this regard, perhaps the participants in the current study were expecting too much of themselves and their AS/HFA clients, especially given the Double-Empathy Problem (Milton, 2012), as discussed previously.

Another participant expressed having experienced self-doubt, although interestingly she seems to have come to terms with it over time: "*But I've learned not to do that anymore*". In so far as self-doubt can pave the way for change and personal growth, maybe this participant's suppression of her self-doubt was not particularly beneficial. On the other hand, it is possible that her self-doubt may have grown out of a period of self-reflection. For as Theriault, Gazzola, and Richardson (2009) remind us, introspection is "an effective means toward a revered end: self-awareness" (p. 105). Perhaps the participants who experienced ongoing self-doubt when working with AS/HFA clients may have benefited from working with a supervisor who had expertise in the area, or possibly engaging in some personal therapy.

McMahon (2018) found that psychologists can feel inadequately equipped for the complex nature of their psychotherapy practice, and that they can feel critical of their training, believing that if only they had more instruction the work would be much easier. Similar findings were obtained in a cross-sectional and longitudinal qualitative study of

100 psychotherapists and counsellors (Rønnestad & Skovholt, 2003). Such findings no doubt have relevance for all therapists, including those who work with AS/HFA clients.

While self-doubt has been found to be ubiquitous among psychotherapists given the complex nature of their work, there is evidence to suggest that issues such as lack of knowledge, level of experience, and training are associated with feelings of self-doubt in psychotherapists across all areas of practice (Theriault & Gazzola, 2010). Some well-known academics/clinicians, many of whom have extensive experience working with AS/HFA individuals, recommend various techniques and strategies to help support therapists who work with this population (e.g., Attwood, 2006a; Gaus, 2018; Ramsay et al., 2005). For example, Ramsay et al. recommend that therapists use experiential exercises with their AS/HFA clients. They propose that using role-play during sessions or setting up behavioural experiments to practise between sessions can help clients learn and apply specific social skills. Several of the participants in the current study alluded to having used some strategies to help develop their AS/HFA clients' social skills and adaptive functioning. However, only one participant provided a concrete example of implementing such a strategy. This involved using exposure experiments by which the client was assigned various practical, everyday tasks to help develop his adaptive functioning. This participant was one of the few who did not express any feelings of self-doubt or a sense of inadequacy as a therapist, so it is possible that her use of such experiential strategies with her AS/HFA clients (as suggested by Ramsay et al, 2005) had helped to improve her clinical competency and self-efficacy with this client group.

5.3 The Adapting Therapist

Some participants felt that they needed to adapt themselves and/or their approach for their AS/HFA clients, so as to try establish and/or maintain some form of relationship or

connection with them. The various challenges they experienced when working with these clients had led to uncertainty and self-doubt, and often much frustration. It is possible that these participants felt that adapting would free them from, or at least alleviate their frustration, and would help them gain new ways of being that might lead to more healthy therapeutic relationships. According to Jaffe (1997), in clinical relationships there is an underlying assumption by both the therapist and client that each will be sufficiently welcomed and valued to make a meaningful bond possible. However, when this bond fails to occur the therapist will question their competency, and this self-questioning will often result in certain feelings and/or behaviours that will indicate a compensated or failing self-system. Jaffe argues that such compensatory reaction and behaviour is the therapist's attempt to preserve their self-esteem, although he notes that such compensation can diminish the therapist's resilience and interrupt their development. As mentioned earlier in this chapter, Edwards and Bess (1998) caution psychotherapists against excessive compromise to accommodate their clients. They propose that a good therapist will accept who they are (with regard to their personal views, personality traits) and the scope of their knowledge (in terms of the information they have accumulated through their training and experience).

Adding further to this, O'Farrell (2006) advocates that the therapist's genuineness is an essential component of the trust between the client and therapist, so the therapist must bring self-sincerity and honesty to the relationship that is without any sense of artificialness. She advocates that trust will develop and grow when the client realises that the therapist is "what they seem", and they "mean what they say" (p.39). While this may indeed be the case for most clients, some of the participants in the current study felt strongly that they needed to adapt for their AS/HFA clients and in the process change or adapt themselves. This would suggest that the participants felt that either the AS/HFA

clients did not, or could not, interpret their authenticity, or that the clients did not value or approve of who they were (their authentic self). However, Woods, Mahdavi and Ryan (2013) remind therapists that AS/HFA clients tend to be confused by insincerity, so empathy and genuineness are important characteristics to have when working with this client group. However, Woods, Mahdavi and Ryan accept that therapists often need to adapt and tailor the therapy to meet the specific needs of these clients. Interestingly, these authors appear to be presenting a paradox for the therapists who work with AS/HFA clients. On one hand they are advocating that therapists need to be genuine, essentially be themselves when working with these clients, and on the other hand they are recommending that the therapists adapt for their AS/HFA clients. Possibly, they mean that therapists should be open to adapting or changing their approach for the clients while remaining genuine without any sense of artificialness. The researcher has found from her own clinical experience, that clients with AS/HFA appreciate genuineness in their therapist, and that the more genuine and comfortable the therapist feels, the more comfortable the they will feel.

In the process of adapting for their AS/HFA clients, some participants attempted to suppress part of themselves. For example, one participant felt she needed to refrain from using humour when she was working with these clients. *"I would often use humour….but if I'd used it with these clients they would never come back, they would have thought I was an idiot probably".* This participant's perception of people with AS/HFA not having a sense of humour is understandable given that Gaus (2018) reports that people with AS/HFA report that they can struggle to understand what other people are laughing about. However, Gaus notes that when these individuals "get it", they can use humour very effectively and cleverly. According to Lyons and Fitzgerald (2004), most individuals with AS/HFA do actually appreciate humour, although usually a less conventional form of

humour, ranging from slapstick to highly sophisticated jokes based on nonsense and the use of puns. It is therefore understandable why the mentioned participant should believe that her humour (presumably conventional humour) would not be received well by her AS/HFA clients.

Interestingly, a recent American study by Hussong and Micucci (2020) investigated psychotherapists' experiences of using humour with their clients. Ten psychotherapists from a range of therapy backgrounds participated in the study, and all had at least five years' clinical experience. They were asked to discuss their experiences of the benefits and risks of using humour in the therapy room, and were also asked questions about the contraindications of using humour (i.e., when they felt concerned or cautious about using it, or when they felt it was not appropriate). All ten participants expressed the view that humour had the potential to strengthen the therapeutic alliance and the rapport between therapist and client. Although the participants cautioned about using humour with certain clients, including those on the autism spectrum, expressing the view that such clients are susceptible to misreading abstract communication and that such misunderstanding can damage the therapist-client relationship. These findings are consistent with the findings of the current study in terms of the participants' concern about the use of humour with their AS/HFA clients. Some participants in the current study indicated that they would normally use humour in their therapeutic work, suggesting that they too felt that humour has the potential to enhance the therapist-client bond with neurotypical clients.

Some of the participants in the current study also talked about their experience of suppressing or regulating their emotions when working with their AS/HFA clients, and for one in particular this was done out of concern that she might overwhelm them. For another it required her becoming more "*practical and sticking to the point",* and for another it demanded the suppression of part of her *"own natural self*". At this point, it is

worth noting that research shows that suppressing one's emotions requires a considerable amount of mental effort (Dunn, Billotti, Murphy, & Dalgleish, 2009). It leaves open the possibility that divided attention may lead to the therapist missing important information that a client may impart, although this was not an issue that was alluded to, or highlighted by any the participants in the current study.

A number of participants felt that they needed to take on a different persona for their AS/HFA clients, which seemed to add yet another challenge for them. O'Farrell (2006), reminds us that it takes a huge amount of cognitive effort for a therapist to maintain a persona from one session to another, almost akin to playing an acting role. According to Goffman's theory of social interaction (Goffman, 1959, 1967), when we need or want other people to form a particular impression of us, we orchestrate a carefully designed presentation of self that fits with our desired goals or needs. Goffman equates this to the actor who is playing a particular role when on the stage, and who is not actively engaging in the role when off stage. For the participants in the current study, there was a sense that they needed to play a particular role, a different type of role when working with their AS/HFA clients.

The participants' adoption of personas might also be considered through the framework of Jungian theory. For Jung, the persona is "a kind of mask, designed on the one hand to make a definite impression upon others, and on the other to conceal the true nature of the individual" (Jung, 1966, p. 192). Its development is essential for a person to adapt to living effectively in the world. Ideally, the persona should be malleable, as having a pervasive, inflexible persona (e.g., the expected role/face of the doctor or teacher) can lead to a shallow, conformist personality, which is itself *all* persona. Such an individual has difficulty distinguishing between themselves and society's expectations of them, and they will often be excessively concerned with what others think of them.

Of course, therapists typically wear a mask/persona when in the therapy room (i.e., that of a psychotherapist). Thus, in the current study when the participants discussed adjusting or adapting their persona, it seems that they were adjusting what they felt was the acceptable face of the therapist. This suggests they believed that the generic persona of "the therapist" normally utilised by them, was not an appropriate or suitable persona when working with AS/HFA clients.

Some participants felt that they needed to adapt their approach for AS/HFA clients, and one participant illumined this point very clearly saying that she leaves her *"Rogerian training outside the door".* As discussed in the literature review, there has been little research examining the use of person-centred psychotherapy with AS/HFA clients (Robinson & Elliott, 2017). However, considering its focus on building an emotional rapport with clients, this mode of therapy would not seem to be particularly suitable for this client group given their difficulty processing and expressing their emotions, as noted by various researchers and clinicians (e.g., Fitzgerald & Bellgrove, 2006; Kinnaird, Stewart, & Tchanturia, 2019). Therefore, it was probably through simple trial and error or possibly through her insight or intuition that the participant found that the Rogerian approach was not beneficial for those with AS/HFA.

5.3.1 Rewards and Influences

Some participants in the current study felt that their experience of working with AS/HFA clients had brought some positive outcomes, and one of these, as mentioned previously, was learning to become more patient and tolerant. According to Attwood (2006a), tolerant people are more likely to be able to form relatively long-lasting relationships with AS/HFA individuals than are people with low tolerance thresholds. Therefore, the participants' experiences of becoming more tolerant and patient sits well

in the context of the current social arena which aims to make society more accepting of various forms of neurodiversity (Armstrong, 2011). According to the "neurodiversity" perspective, many of the more unusual variations that exist in human cognition and brain functioning should be conceptualised as differences rather than "disorders". Hence, from this perspective, conditions such as ASD and ADHD are not intrinsically psychopathological, but rather there are "systemic barriers" imposed by society that impede the daily functioning of people with psychological conditions.

In this spirit, one of the participants discussed the conflict she experienced when having to decide whether or not to accept one of her AS/HFA clients for who he was, or try to change him so he could meet his wife's expectations (to become more sociable). The participant concluded that, as a therapist she needed to accept the client the way he was, a conclusion not very surprising given her humanistic background. The humanistic model places great emphasis on unconditional positive regard (i.e., accepting the client for who he/she is, and valuing their worth as a unique human being). It also values and respects the individual's phenomenological world and life experience, and works to meet each individual in their lifeworld. This sentiment is illustrated by Prouty (2001), who points out that even in catatonic clients (including people with schizophrenia and general learning disabilities, as well as withdrawn and isolated geriatric patients), humanistic psychotherapy holds a foundational belief that implicit selfhood can be observed in their episodes of lucidity.

While of course the world would benefit from becoming more accepting and tolerant of the various cognitive and neurological differences that exist, this may be easier to achieve in theory than in practice given the "Double Empathy Problem" (as discussed earlier). Clearly it is important that therapists try to strike the right balance between tolerating/accepting the clients' atypical behaviours and/or thinking styles and trying to

help them modify these behaviours and forms of thinking. For example, one of the participants initially expressed that the AS/HFA clients he found most testing were the ones who *"don't or won't cooperate*", and who do not complete homework exercises, while later on he expressed that he had become more tolerant and accepting of this behaviour. While such tolerance may indeed be a very admirable quality of any therapist, it is unclear if any of this participant's AS/HFA clients had actually benefited from his tolerance/acceptance. For a person to function adequately in many aspects of daily life (college, employment, friendships/romantic relationships) they need certain social and adaptive life skill, and the motivation and willingness to follow through on commitments. Therefore, therapists who work with AS/HFA clients often have to consider how tolerant and accepting they should be of the AS/HFA clients' atypical thinking/behaviours, given that such thinking/behaviours have the potential to hinder these individuals' daily lives and mental wellbeing long-term. For example, Gaus (2018) advocates that therapists should seek to develop their AS/HFA clients' cognitive empathic ability in order to help improve their overall empathic experience, both in and outside the therapy room. Ramsay et al (2005) makes similar recommendations about how therapists may help improve the social abilities of their AS/HFA clients, and suggest that they might consider acting as social advisor as part of their work.

However, taking on such a role or actively seeking to change or modify the AS/HFA clients' behaviour, may be more difficult for some therapists than for others, especially those who adhere to a pure Rogerian person-centred (or humanistic) approach, as opposed, for example to cognitive behavioural therapists. For as Schmitt (1980) reminds us, person-centred therapists strive for unconditional regard and they inherently have difficulty assuming differential treatment for the person and the behaviour. For these therapists, according to Schmitt, the paradox is that they believe if they are unaccepting

of the behaviour then they must be unaccepting of the person. However, he argues that this is not necessarily the case and that by separating the two, therapists are more likely to foster a stronger therapeutic relationship and better client progress. In such situations, when the therapist conveys unacceptance of a particular behaviour or behaviours, the client will be more likely to perceive the therapist as open and honest. Whereas, trying to cover or hide such unacceptance will evidently be communicated subtly to the client (through subtle verbal and nonverbal cues/signals), which will ultimately have a negative impact on the relationship and outcomes. With regard to the humanistic-trained participants in the current study, this may have been the dilemma they experienced, given that none of them expressed using or discussing any modifying strategies with their AS/HFA clients. In contrast, one participant, who was trained in CBT, reported using exposure experiments to help improve/modify her AS/HFA clients' thinking/behaviours.

5.3.2 Becoming more Empathic

Three of the participants in the current study found that working with AS/HFA clients had helped them gain a greater understanding and insight into the clients' world, and therefore helping them see the world through the AS/HFA client's eyes. One mentioned that the AS/HFA clients' way of thinking is much more logical than emotional, and it is all about what was going on in "their heads and not their hearts". Another felt that gaining a greater insight into these clients' world(s) was one of the most enlightening and influential aspects of their work. The fact that so few participants made mention of this experience is perhaps not too surprising, given that eight of the participants had experienced difficulty reading their AS/HFA clients. Being able to decipher the mental states of another person is, to a certain extent dependent on being able to decode the person's social/nonverbal cues. Similarly, the participants who felt that they had learned

to see the world through the eyes of their AS/HFA clients, simultaneously reported that they had come to realise that AS/HFA individuals think and perceive the world very differently to most neurotypical individuals.

As noted by Attwood (2006a), one component of any psychotherapeutic process is for the therapist to learn about the client's inner thoughts. It is this empathetic process which allows them to see things from the AS/HFA individuals point of view. Two of the said participants were trained in the humanistic psychotherapeutic tradition, while the other had a background in integrative therapy. Given the large focus on the therapist's empathy in person-centred therapy (Rogers, 1980), it is not surprising that these participants (particularly the humanistic therapists) had tried developing an empathetic stance. Perhaps the participants who had not expressed the feeling of gaining an insight into their AS/HFA clients world, may have already obtained enough knowledge about AS/HFA from their experience, supervision and/or their limited specific training (attending some talks/seminars) to appreciate that they could only speculate what the world might look like through the eyes of an adult with AS/HFA. It is possible that they had considered their AS/HFA clients' world from Merleau-Ponty's (1962) premise. That is, that their perception of the "other's" world could only develop from their "own embodied perspective", and that "while we can observe and experience empathy for another, ultimately we can never share entirely the other's experience, because their experience belongs to their own embodied position in the world."

This chapter has thus far discussed and explored how the current findings relate to, and diverge from, existing literature and research relevant to the phenomenon under investigation. Various theoretical and contextual perspectives were explored with consideration given to how the current findings are positioned, and might be positioned, within these different perspectives. From this critical evaluation, some conclusions were

drawn, and what was some way unique or novel about the findings was illuminated. The remainder of this chapter will discuss the importance of the current research findings, as well as the potential implications these finding might have for policy, practice and training. Directions for some potential future research will also be explored. The strengths and limitations of the current study will also be discussed, as will the process by which the quality and rigour of the study was assessed. The chapter will conclude with the researcher's reflections on her experience of the research journey; what she learned and how the experience influenced her.

5.4 Importance of Research Findings

There is little literature on the phenomenon of psychotherapists' experiences of working with adult clients with a diagnosis of AS/HFA, and the available literature on this phenomenon appears to be centred around the clinical experiences of either psychologists or psychiatrists, or on survey-based studies of psychotherapists. The findings of the current IPA study go some way towards contributing to this much under-researched phenomenon, most specifically in relation to qualitative research exploring the experiences of psychotherapists who work with adult AS/HFA clients (i.e., psychotherapists who are not psychologists or psychiatrists, and whose role/work is exclusively that of a psychotherapist). For the most part, the participants' feelings of being in a one-sided relationship and feeling frustrated are consistent with literature from other clinicians/therapists who work with adults with AS/HFA. This itself is noteworthy as it adds support to the anecdotal evidence or survey findings that these are experiences commonly encountered by clinicians who work with this client group.

In contrast, the participants' feeling that they needed to adapt adds new insight to the limited literature relating to this experience. In the current study, some of the participants

tried adapting their approach and/or suppressing part of themselves in order to accommodate their AS/HFA clients. In the process of adapting, some felt that they had become more patient and tolerant, while a number believed they had gained a greater insight into the AS/HFA clients' lives, learning to see the world through their eyes. These findings thus represent a novel insight into the experiences of psychotherapists who work with this client group. While there is literature pertaining to therapists adapting for their clients, these studies do not relate specifically to psychotherapists working with individuals with AS/HFA.

One of the unique findings of the current study relates to the participants' desire or need to experience empathy back from their AS/HFA clients (i.e., to have a mutual empathic therapeutic relationship), and their sense of disappointment when this desire/need was not fulfilled (at least not to the level or depth they had hoped for, or expected). This is a novel finding because there appears to be no research examining or exploring this issue, specifically in relation to the therapist–AS/HFA client relationship. Although, Staemmler (2012) does discuss this issue in terms of the generic therapist-client relationship, arguing (based on his own clinical experience and review of existing literature) that both the therapist and client have a desire to be understood by each other.

Another unique/novel finding to emerge from the research, were the participants' difficulties in reading their AS/HFA clients. There is some empirical support for the theory that neurotypical individuals have difficulty reading/decoding the social behaviours of those on the autism spectrum (Edey et al., 2016), although this hypothesis does not appear to have been tested or explored in relation to psychotherapists. This finding obviously has important implications for the formation and maintenance of therapeutic alliances, and particularly when considered in relation to the Double Empathy Problem (Milton, 2012).

Similarly, many participants in the current study experienced feelings of self-doubt when working with their AS/HFA clients, and this was another novel finding to emerge from the current study. Self-doubt is reported in the literature as being a common experience among mental health professionals, and yet there appears to be little research examining or exploring this issue, specifically in relation to psychotherapists who work with adults AS/HFA clients.

5.5 Potential Implications for Policy, Practice and Training

It is important to note that the current study involved a small sample size and that the findings of this study were context specific. Therefore, these findings are not readily generalisable, and of course the researcher acknowledges that it is *not* the aim of IPA that they should be generalisable. However, having considered and evaluated the current findings through the lens of extant literature, the researcher will now discuss the potential transferability that these findings might have for policy, practice and training in relation to similar groups and/or contexts.

5.5.1 Potential Implications for Policy

There is considerable evidence showing that people with AS/HFA are very susceptible to developing mental health issues, most notably depression and anxiety (e.g., Attwood, 2006a; Gaus, 2007, 2018; Woods, Mahdavi, & Ryan, 2013). With a greater awareness of AS/HFA in recent years and increasing rates of diagnosis, more adults with AS/HFA are now presenting for psychotherapy (Gaus, 2018). In the current study, most of the participants' AS/HFA clients had been referred by their GPs, and one client was waiting to see a psychiatrist, suggesting that not only did these clients have mental health issues, but that these issues had been present for some time before they presented for

psychotherapy. Taken together, such findings clearly have potential implications for policies regarding the continuing funding and provision of psychotherapeutic supports and interventions for adults with AS/HFA, and also with regard to training and support for the psychotherapists who provide these services.

5.5.2 Potential Implications for Practice and Training

Woods, Mahdavi, and Ryan (2013) note that clients with Asperger Syndrome present a unique set of challenges for the therapist, a view echoed by a number of other authors (e.g., Attwood, 2006a; Gaus, 2007, 2018; Ramsay et.al. 2005). This clearly was the experience of the participants in the current study and to try make sense of these unique challenges, many of them compared their experiences of working with the AS/HFA clients with that of working with other clients. These unique challenges included, difficulty reading the clients, difficulty getting the clients to consider or understand others' perspectives, being expected to have an intellectually-based relationship. Many of the participants experienced self-doubt when working with these clients and questioned their clinical competency. Some participants felt that if they have had specific training in the area of AS/HFA that they would have been better equipped to work with these clients. Indeed, Leather and Leardi (2012) argue that the challenges of working with these clients can be even more problematic for therapists who are unfamiliar with the characteristics and features of AS/HFA. According to Lipinski, Blanke, Suenkel, and Dziobek (2019), "a low level of expertise with autism was the main reason for being declined by therapists and a contributing factor to the overall treatment dissatisfaction of patients with ASC[4]". (p. 1154). It is worth noting that a lack of relevant training does not

[4] ASC is an acronym for "Autism Spectrum Condition"

only appear to be a problem in Ireland. According to a recent paper by Brookman-Frazee, Roesch, Chlebowski, Baker-Ericzen, and Ganger (2019), there is also a dearth of ASD-specific training courses for clinicians in the United States.

In light of these various findings, including the findings of the current study and given the increasing demand for psychotherapy for people with AS/HFA, there is clearly support for a strong recommendation for the provision of more evidence-based ASD (including AS/HFA) specific training for psychotherapists. Institutions and organisations that provide professional training programmes could consider how they can best facilitate and support therapists (and other clinicians) in becoming equipped to work with this client group. For example, undergraduate and graduate programmes could incorporate one or more modules on ASD/ASC which would cover various topics including the heterogeneous nature of autism and the different phenotypic expressions of the condition (including AS/HFA), current diagnostic procedures and psychometric assessment tools, how to interpret diagnostic reports, as well as information about evidence-based interventions and supports for the different types of ASD/ASC. Similarly, professional bodies for psychotherapists and other clinicians could provide more Continuing Professional Development (CPD) events (such as workshops, seminars) in the area of autism which also cover the topics discussed above. This would help to ensure that already qualified psychotherapists (and other clinicians) who have limited knowledge of AS/HFA would have the opportunity to learn more about the condition. Such training events would also help to clarify many of the misconceptions and confusions about autism (especially since the subsuming of all autism disorders into one category in the DSM-5). Professional Supervision training courses could also include a module on ASD/ASC (including AS/HFA) to enhance supervisors' knowledge of the condition enabling them to facilitate and support any of their supervisees who may be working with

this client group. For example, the supervisor could provide the supervisee with guidance about what type and depth of empathy they should expect back from an AS/HFA client who might be experiencing difficulty reading them (the therapist). Such potential scenarios or issues could also be explored in therapists' training programmes/modules to help therapists feel better prepared when working with clients on the autism spectrum.

On an optimistic note, the last few years have seen an explosion in academic and training programmes provided via online learning platforms. This is something that will undoubtedly facilitate psychotherapists and other clinicians' access to relevant courses more and more over the coming years, and hopefully lead to more programmes specifically focusing on AS/HFA. The participants in the current study appeared to be generally unfamiliar with the literature on AS/HFA and it is important that the content of any such course would provide an accurate depiction of the condition that is based on the findings of systematic research studies. Furthermore, it is important that any recommended therapeutic strategies/techniques are evidence-based and effective; that is, have been shown to enhance therapist-client relations and/or therapy outcomes. As noted earlier, several academics and clinicians such as Attwood (2006a), Gaus (2018), and Ramsay et al. (2005) recommend strategies that therapists can use when working with this client group. However, many of these strategies are primarily based on the said authors' own clinical experiences and have not been supported by research studies. Thus, future research (qualitative and/or quantitative) could help determine the efficacy of any such proposed strategies. This would not only provide greater support for their use in clinical practice, but would also offer validation for their inclusion in relevant evidence-based training programmes.

5.6 Strengths and Limitations of the Study

The main strength of the current study is that it captured the participants' lived experiences of working with adult clients with AS/HFA. It illuminated particular challenges they experienced, and identifies any rewards or influences they felt they gained from working with these clients. The small sample size allowed for the in-depth exploration of each participant's experiences, ensuring that each single case was analysed within its own unique context, one at a time, before emergent themes across the nine cases were explored and identified.

A potential limitation of the current study is that the data is open to different interpretations from different researchers. The researcher's interpretation and making sense of the current data was undoubtedly influenced by both her position as an IPA "insider-researcher" and as a clinician with a specialisation in the area of AS/HFA. However, it is accepted that there is no single definitive way to do IPA. For as Smith, Flowers and Larkin (2009) remind us, "overall, the analytic process is multi-directional; there is a constant shift between different analytic processes. As such, analysis is open to change and it is only 'fixed' through the act of writing up" (p. 81). That said, Smith, Flowers and Larkin note that every attempt should be made to ensure that interpretations are reasonable, free from researcher biases, and follow on logically from the data, which were all adhered to by the researcher in the current study. The researcher engaged regularly in a process of reflexivity and worked closely with her supervisors to help highlight any such biases and prevent them from creeping into her analysis.

Another potential limitation of the study is that the nine participants had varying therapeutic orientations/backgrounds as well as varying years of experience working with AS/HFA clients. Thus, while all participants were accredited psychotherapists, it could be argued that they did not constitute a truly homogenous sample. Furthermore, one of the participants was a psychoanalyst and his AS/HFA clients lay on the couch during

therapy with their eyes looking away from him. As such, unlike the other participants, he did not discuss any nonverbal interplay between himself and his clients because he had not experienced it, which could raise another question about the homogeneity of the sample.

5.7 Directions for Future Research

One of the most interesting and novel findings of the current study, was the participants' difficulty reading their AS/HFA clients. Future research could aim to devise new psychotherapeutic strategies or techniques that could help facilitate relations between therapists and their AS/HFA clients. For example, one of the participants in the current study, a psychoanalyst had his AS/HFA clients lie on a couch with their gaze away from him. This approach clearly limits the nonverbal interplay between therapist and client, and given the important role nonverbal cues play in the formation of social bonds (Bull, 2002), it could be argued that this arrangement is not particularly conducive to the formation of an emotional connection in the therapy room. However, in light of the mutual difficulties that psychotherapists and AS/HFA clients experience reading each other, making use of such non face-to-face approaches (e.g., sitting back to back, or behind a screen) in other therapeutic modalities (e.g., CBT or Rogerian) may help to circumvent the problem posed by the clients' atypical behaviours. In other words, this technique may help bring about a scenario in which interactions between the therapist and AS/HFA client are based solely on verbal discourse, without allowing nonverbal cues becoming a confounding factor. Whether or not this approach might prove beneficial for use with this client group would need to be explored and tested via systematic investigation. For example, research could use a mixed method approach, that would first explore the therapists and the ASHFA clients' subjective experiences of using such

strategies or techniques in the therapy room, and then examine and provide an objective measure of any possible differences both within and across the two groups.

Participants in the current study experienced feelings of frustration, self-doubt and the feeling they needed to adapt for their AS/HFA clients. This raises the question about how important therapists' flexibility, ability to tolerate uncertainty and confidence is when working with this client group. Therefore, one potential avenue of future research could focus on how the personality-traits or the personal attributes of therapists affects or impacts on the quality of the therapeutic relationship with their AS/HFA clients. Interestingly, Ackerman and Hilsenroth (2001, 2003) conducted such a study in relation to therapists generally. They examined the therapists' personal attributes and how they correlated with the therapist-client relationship (with general clinical populations). Through a series of review studies, they determined that honesty, respectfulness, flexibility, confidence, trustworthiness, friendliness and warmth are all associated with a positive alliance, while uncertainty, rigidity, criticalness, aloofness, tenseness and distractedness are associated with a poor alliance. However, to date there appears to be no research conducted on this phenomenon with regard to the therapist-AS/HFA client relationship, so this could potentially be another avenue of future research; possibly also using a mixed method approach. For example, an IPA study could first explore the therapists' experiences of their own personal attributes and how they feel these attributes affect or impact on the quality of the therapeutic relationship with their AS/HFA clients. Following this, a survey-based correlational study could be conducted to examine both the therapists and their AS/HFA clients' experiences of the therapeutic relationship. The findings of such research could be beneficial for both accredited and trainee psychotherapists when considering whether or not they might be suitable candidates to work with this clinical population.

While all nine participants in the current study were accredited psychotherapists and all had experience working with adult AS/HFA clients, there were differences in their therapeutic training/orientations (as outlined in Table 3.1 in the Methodology Chapter). As mentioned earlier, it was the participants trained in humanistic psychotherapy who seemed to have the greatest desire for a mutual empathic relationship with their AS/HFA clients, and they seemed to be the most self-doubting when this bond or connection failed to develop. There appears to be no research which has specifically focused on how the therapist's training or orientation might impact on the therapist-AS/HFA client relationship. Future research could focus on the different modalities used by therapists who work with these clients, and for example, explore whether there is a correlation between the therapists' orientation and their expectations of the relationship with their AS/HFA clients. Again, using a qualitative study first, the therapists' expectations of the therapeutic relationship could be explored, and this could be followed by a quantitative approach examining the relationship between the therapists' orientations and expectations.

5.8 The Quality and Rigour of the Current Study

As discussed earlier in the Methodology Chapter, Yardley's (2000) four principles namely *"sensitivity to context",* "*commitment and rigour", "transparency and coherence"*, and "*impact and importance"* has become one of the most widely used and accepted criteria for assessing the quality and rigour of qualitative research, including within IPA research (Smith, Flowers & Larkin, 2009). The researcher utilised these four principles to assess the quality, rigour and trustworthiness of the current study.

The first principle, "sensitivity to context" concerns how the researcher shows sensitivity for the context in which the study is conducted. In IPA, this includes the

cultural or social setting/situation in which the research is conducted, as well as the material obtained from the participants, and the selection and review of any existing literature pertinent to the research topic. In the current study, the researcher demonstrated sensitivity to context in a number of ways. Firstly, via her selection and review of the academic literature related to the research topic. That is, she sourced and selected literature which had relevance to the research topic and enhanced her understanding of the phenomenon being investigated. This body of literature helped create context and a rationale for the current study, and also assisted in the development of the research questions and the selection of the research methodology.

The researcher also showed sensitivity to the social situation/environment in which the study was conducted. The face-to-face interviews were conducted in either the participant's office or the researcher's office; whichever was the most convenient and most comfortable for the participant. With regard to sensitivity to material obtained from the participants, the researcher ensured that all sensitive information was omitted and/or removed from the transcripts. The researcher also demonstrated sensitivity and awareness to her own behaviours and responses during the interview process. Specifically, she reflected upon how her own behaviours or characteristics may have affected the responses of the participants (e.g., her efforts to make the participants feel relaxed and comfortable, her age, her gender, and her professional status).

Similarly, the researcher was sensitive to, and aware of, the participants behaviours and responses during the interviews. She paid attention to how comfortable, or uncomfortable, the participant appeared during the interview. For example, a particular experience or an aspect of an experience that they might have dwelled on during the interview, or how strongly the participant may have conveyed a particular experience verbally or nonverbally (e.g., via the use of language/phrasing and/or nonverbally via

facial expressions, gestures, tone of voice etc). The researcher also showed appropriate sensitivity and awareness during her analysis of the data. She remained aware and sensitive to any potential preconceived influences or biases she may have had. She engaged in a process of reflexivity from the outset and worked closely with her supervisors to help highlight any such biases and prevent them from creeping into her analysis.

The second of Yardley's (2000) principles, "commitment and rigour" concerns the researcher's level of commitment, knowledge of, and engagement in, the research topic and the methodology. With regard to the current study, even prior to commencing her doctoral studies the researcher was already well informed in the areas of ASD (incl. AS/HFA) and psychotherapy due to her own reading of the academic literature and her clinical work. Her knowledge of IPA and its methodological approach was attained via her attending lectures, workshops, consulting with her supervisors and reading relevant literature. This ensured that she was knowledgeable about this qualitative approach before starting the research project. She regularly reviewed the said literature and her lecture notes to ensure that she fully grasped the technicalities and appropriate procedures of conducting IPA research and analysing the data. She also continuously updated her knowledge by reading recently published papers relevant to her chosen topic.

Yardley's (2000) third principle is "transparency and coherence". Transparency concerns how well the stages of the research are described in the written account. In relation to the current study, the researcher clearly described the inclusion criteria, how she recruited participants and how she conducted the interviews. She also provided a detailed description of how she analysed the data. She also included tables in the thesis to help enhance and illuminate certain components of the study (i.e., participant demographics, and the study's superordinate and subordinate themes). To ensure

coherence of the final thesis, the researcher read and reread drafts of her work numerous times, all the while thinking of how it might come across to readers. Coherence was also achieved by ensuring that all methodological procedures and forms of data analysis were consistent with IPA, rather than some other qualitative approach.

The last of Yardley's (2000) principles "*impact and importance"* contends that regardless of how well a piece of research has been carried out, the ultimate test of its validity is whether it imparts something of interest or utility to the reader. In relation to the current study, it is hoped that the readers of this thesis will not only agree that the research findings are interesting, but will also appreciate the potential implications these findings have for policy, clinical practice, training and future research. Most notable that the key or novel findings to emerge from the study will contribute to the much under-researched topic of AS/HFA and psychotherapy.

5.9 Researcher's Reflections

Undertaking the current study proved to be both an enlightening and demanding journey for the researcher. She had not conducted an IPA study before, and her experience of qualitative research was quite limited (i.e., in comparison to her experience of quantitative research), so she was cognisant that undertaking an IPA study at doctorate level may well present some unforeseen challenges. In order to produce a quality piece of research, she remained aware that she would need to be patient, open and sensitive to the worlds of the participants, be careful and rigorous in her data collection and analysis, and would also need to be very attentive to details in her writings.

The researcher played an active role in the interpretation of the research data, and one of her main concerns was that she might misrepresent the participants' experiences by jumping to some unfounded assumptions or claims in her interpretations or analysis. This

was a concern that she reflected on regularly, and discussed with her supervisors. Given the potential implications her study could have for policy, practice, training and future research, the researcher was very aware of how important it was to engage in analytic work with the highest integrity and give the participants' accounts the due respect they deserved. She found that engaging in such reflection helped her remain cognisant of her role and ethical responsibility as a researcher, thus ensuring that the findings of the current study were indeed a true representation of the participants' own accounts/narratives.

The process of recruiting the participants and conducting the research interviews proved to be a relatively smooth experience for the researcher. However, given her own clinical work there were moments during the interviews when she needed to remind herself that her role was now that of researcher and not a clinician, and as such she needed to resist any temptation to act otherwise. The participants were experienced and accredited psychotherapists who were very self-aware individuals, and the researcher found each one of them a pleasure to interview. The flexibility within IPA facilitated the fluid nature of the interviews, which created a sense of ease in the researcher and allowed her provide the participants with the space and time they needed to reflect and make sense of their experiences.

As mentioned earlier, the researcher made every effort to ensure that her analytical work was of the highest integrity so as to give the participants' accounts the due respect they deserved. Using IPA for the first time was a journey of enlightenment for the researcher, and she feels that the experience has increased her appreciation of the valuable role that qualitative research plays in the field of psychology and psychotherapy. The findings of the study have greatly enhanced her own insight into the experiences of other psychotherapists who work with clients with AS/HFA, and has certainly deepened her

understanding as to why some therapists may feel reluctant to work with this client group. It has also strengthened her belief that more evidence-based AS/HFA-specific training should be provided for psychotherapists, and that more information about AS/HFA should be made available for supervisors.

The researcher truly feels very privileged at this stage of her life to have undertaking such a study, particularly in an area she feels so passionately about, thus fulfilling one of her long-held goals.

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Appendix A: Ethical Approval

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University

DCU

Ms Linda Doody
School of Nursing and Human Sciences

2nd November 2018

REC Reference: **DCUREC/2018/196**

Proposal Title: **Psychotherapists' experiences of working with adult clients with a diagnosis of Asperger Syndrome /High Functioning Autism)**

Applicant(s): **Ms Linda Doody, Dr Evelyn Gordon & Dr Aisling McMahon**

Dear Linda,

Further to expedited review, the DCU Research Ethics Committee approves this research proposal.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

Donal O' Gorman

Dr Dónal O'Gorman
Chairperson
DCU Research Ethics Committee

DCU
Research & Innovation

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Appendix B: Recruitment Poster

Are you an accredited psychotherapist who works, or has worked with adult clients with a diagnosis of Asperger Syndrome/High Functioning Autism? If so, would you be interested in partaking in a research study?

My name is Linda Doody and I am a Chartered Psychologist and Psychotherapist. I am conducting a research project which is exploring psychotherapists' experiences of working with adult clients with Asperger Syndrome/High Functioning Autism. I would like to talk to accredited psychotherapists who work or have worked with this client group within the last year. Participants will be asked to partake in an interview which will take approximately one hour to complete.

What to do next?

If you wish to partake in this study or if you would like more information, please contact me by phone at ######## or email at ########

Thank you.

Researcher: Linda Doody
Contact number: ######## Email: ########

This research project is in part fulfilment for a Doctorate in Psychotherapy, and it is being supervised by Dr Evelyn Gordon at the School of Nursing and Human Sciences, Dublin City University email: evelyn.gordon@dcu.ie & Dr Aisling McMahon at the School of Nursing and Human Sciences, Dublin City University email: aisling.mcmahon@dcu.ie

Appendix C: Information Sheet

My name is Linda Doody and I am a Chartered Psychologist and Psychotherapist. I am conducting a research project which is exploring psychotherapists' experiences of working with adult clients with Asperger Syndrome/High Functioning Autism. The project is in part fulfilment for a Doctorate in Psychotherapy at the School of Nursing and Human Sciences in Dublin City University. The research project is being supervised by Dr Evelyn Gordon (email: evelyn.gordon@dcu.ie) and Dr Aisling McMahon (email: aisling.mcmahon@dcu.ie) at the School of Nursing and Human Sciences, Dublin City University.

The research title: Psychotherapists' experiences of working with adult clients with a diagnosis of Asperger Syndrome / High Functioning Autism.

The purpose of this study is to gather information about psychotherapists' experiences of working with adult clients with Asperger Syndrome/High Functioning Autism.

How can you contribute?

You can contribute by volunteering to discuss your experience of working with an adult client/or clients with Asperger Syndrome/High Functioning Autism. You will be asked in partake in an audio-recorded interview which will take approximately one hour to complete. The interview will take place in your own office, the researcher's office or in a private room in the School of Nursing and Human Sciences, Dublin City University, Glasnevin, Dublin 9, whichever is the most convenient for you. Note: You will have the right to withdraw from the study without explanation, at any time before the data is analysed.

What are the benefits and risks of participating?

Possible benefits of participating in this research project include:

- Participating in the study will provide you with the opportunity to reflect on your own experience of working with clients with Asperger Syndrome /High Functioning Autism. This opportunity for reflection may prove to aid your personal and professional development as a therapist.
- It is hoped that the findings of this study will (1) contribute to the existing literature on Psychotherapy and Asperger Syndrome /High Functioning Autism, and (2) it will help to inform psychotherapy practice for this client group. Both could have indirect benefits for you as a therapist.

Possible risks include:

- If your experience of working with adult clients with Asperger Syndrome/High Functioning Autism has been anyway negative, it is possible that you may feel uncomfortable when you are recalling this experience. Should this situation arise, we will discuss what you would like to do. This might involve taking a short break during the interview. Note: participants will *not* be pressurized to discuss an experience or event that they do not wish to discuss. In the event that you may continue to feel uncomfortable or uneasy when talking about your

experiences, you may decide to meet with your supervisor after the interview to discuss this issue. It is also possible that you may decide to withdraw completely from the study. As stated above, you will have the right to withdraw from the study without explanation, at any time before the data is analysed.

- Partaking in a study that will use a small sample size (between 8 – 12 participants) and will include direct quotes (all anonymised) in the reported findings may pose a level of risk to your anonymity, insofar as it is possible that you may be identified. However, it important to note that I (the researcher) will make every effort to protect your anonymity. I will make every effort to remove any data from the transcripts of your interview that may potentially identify you or any other third party (e.g., your clients), although I cannot guarantee that I will be able to catch all potentially identifying data.

- It is also important that you understand that it may not be possible to protect the confidentiality of all information provided during the research study. Confidentiality is not absolute within the law and may in exceptional circumstances be overridden by more compelling duties such as the duty to protect individuals from harm. Thus if you were to provide information that was deemed to be unethical and/or posed a risk of harm to an individual or individuals, I would have a duty to disclose this information by following appropriate legal requirements and ethical protocols set out for such events. The limits of confidentiality would continue to apply even if you were to withdraw from the study.

Who will have access to the information that you share?

- The researcher (Linda) will be the only person who will have access to the raw research data (within the limits of the law as discussed above). Dr Evelyn Gordon and Dr Aisling McMahon, the researcher's supervisors will have access to the anonymized data. The external examiner(s) may also have access to the anonymized data, if they request it.

- It is expected that the research findings will be disseminated through a number of routes:

  (1) The research findings will be presented in the researcher's (Linda's) completed dissertation which will be placed in the DCU Library. The dissertation will also be available on Doras, DCU'S Open Access Institutional Repository which provides free online access to research publications and theses from Dublin City University (DCU). .

  (2) Selected findings will be submitted for publication to relevant academic peer-reviewed journals (e.g., *Journal of Autism and Developmental Disorders*; *Journal of Contemporary Psychotherapy; Journal of Human Behavior in the Social Environment; Journal of Psychotherapy: Theory, Research, Practice and Training.*

  (3) The researcher also plans to present the findings of her study at various conferences (e.g., *Psychological Society of Ireland* annual conference, *British Psychological Society* conferences).

  (4) You will be provided with a summary of the research findings (by email or by post) when the research is fully completed, if you so wish (at your request).

  (5) All information gathered during the research will be destroyed completely five years after the completion of the research project in accordance with DCU's data protection guidelines.

Should you have any concerns about this study and wish to contact an independent person you can contact the Secretary, at Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel: 01-7008000 or Email: **rec@dcu.ie**. In addition you can contact Mr Martin Ward, DCU Data Protection Officer, Tel: 01-7007476 or Email: **martin.ward@dcu.ie**.

What to do next?

You can now consider all the information provided before deciding whether or not you wish to partake in the study. If you agree to participate, please contact me directly at ####### or email me at linda.doody3@mail.dcu.ie. You will be asked to sign and date a Consent Form before partaking.

If you choose not to participate, you do not need to do anything.

Thank you.

Researcher: Linda Doody

Contact number: ######## Email: ########

Appendix D: Informed Consent Form

I. **Research Study Title:** Psychotherapists' experiences of working with adult clients with a diagnosis of Asperger Syndrome (AS) /High Functioning Autism (HFA).

II. **Purpose of research study:** The purpose of this research study is to gather information about psychotherapists' experiences of working with adult clients with Asperger Syndrome/ High Functioning Autism. This research project is being conducted by Linda Doody in part fulfilment for her Doctorate in Psychotherapy, and it is being supervised by Dr Evelyn Gordon at the School of Nursing and Human Sciences, Dublin City University, email: evelyn.gordon@dcu.ie and Dr Aisling McMahon at the School of Nursing and Human Sciences, Dublin City University, email: aisling.mcmahon@dcu.ie

III. **Participation Requirements:** If you consent to be part of this research study, please complete the following by circling Yes or No to each question:

- *By consenting to partake in this study, I agree to participate in one audio-recorded interview which will take approximately one hour to complete.* ***Yes/No***
- *I am aware that during the interview I will be asked questions about my experience of working with adult clients with a diagnosis of Asperger Syndrome/High Functioning Autism.* ***Yes/No***
- *I have read the Plain Language Statement (or had it read to me).* ***Yes/No***
- *I understand the information provided.* ***Yes/No***
- *I have had the opportunity to ask questions and discussed this study.* ***Yes/No***
- *I have received satisfactory answers to all my questions.* ***Yes/No***
- *I am aware that my interview will be audio recorded.* ***Yes/No***

IV. **Confirmation that involvement in the research is voluntary:** I am aware that my participation in this study is completely voluntary and that I have the right to withdraw from the study without explanation, at any time before the data is analysed.

V. **Confidentially and Anonymity**: I understand that partaking in a study that will use a small sample size (approximately 12 participants) and will include direct quotes (all anonymised) in the reported findings may pose a level of risk to my anonymity, insofar as it is possible that I may be identified. However, I understand that the researcher will make every effort to protect my anonymity. She will make every effort to remove any data from the transcripts of my interview that may potentially identify me or any other third party (e.g., my clients), although she cannot guarantee that she will be able to catch all potentially identifying data.

I also understand that information I provide can only be protected within the limits of the law. Confidentiality cannot be maintained if I provide information considered to be unethical and/or poses a risk of harm to myself or to others. In such cases the information will have to be managed in accordance with legal and ethical requirements. I understand that the limits of confidentiality would continue to apply even if I were to withdraw from the study. It is also my understanding that all information gathered during the research will be destroyed

completely five years after the completion of the research project in accordance with DCU's data protection guidelines.

I understand that the researcher (Linda Doody) will be the only person who will have access to the raw research data (within the limits of the law as discussed above). Dr Evelyn Gordon and Dr Aisling McMahon, the researcher's supervisors will have access to the anonymized data. The external examiner(s) may also have access to the anonymized data, if they request it.

I have read and understood the information in this consent form. Any questions (or concerns) I had, have been answered by the researcher. I have been provided with a copy of this Consent Form and the research Information Sheet. Therefore, I consent to take part in this research project.

Participant's Name (Please PRINT):_____

Signature of Participant: _____ Date:_____

Signature of Researcher: _____ Date: _____

Appendix E: Sample of Interview Questions

Participant's Gender _____

Section 1 - Background Questions

1. Can you tell me how long have you been working as a psychotherapist?
2. Do you have a preferred psychotherapeutic model or approach that you use?
3. How long have you been working with adult clients with Asperger Syndrome or High Functioning Autism?
4. Have you had the opportunity to engage in any specialised training or course of study in Asperger Syndrome or High Functioning Autism? If so, can you tell me a little bit about that?

Section 2 - Interview Questions

5. Can you talk to me about your experience of working with adult clients with Asperger Syndrome or High Functioning Autism?
6. Can you tell me about any particular challenges these clients might have presented for you?
7. Can you describe what rewards, if any you got from working with these clients?
8. Can you talk to me about how your work with this client group might have influenced as a therapist?

   Possible prompting question – Can you recall any one specific or memorable experience that might have influenced you?

Section 3 - Closing Question

9. Before we finish the interview, is there any other information that your feel is important about your work with this client group that you would like to discuss?
10. Should I have require an further information, or any clarity about what you discussed during the interview today, do I have your permission to contact you?

Appendix F: Outline of the Debriefing Protocol

The debriefing process commenced immediately after the research interview was completed. The following is an outline of the debriefing schedule: -

(1) The researcher began by thanking the participant for taking the time to partake in the research study.

(2) The researcher asked the participant if they had any questions about the research interview (that they had just completed) or any further questions about the research project. If there were any questions, the researcher made every effort to answer these questions as comprehensively as possible (within legal and ethical limits).

(3) With any participants who reported that they experienced discomfort or unease by participating in the study, the researcher checked with them that they have access to external supports. For example, that their own supervisor was available for support. If such support was not available for the participant, the researcher provided them with a list of suitably qualified psychotherapists for them to contact (note: the researcher ensured that psychotherapists who participated in the research study were not included on this list).

(4) The researcher reminded the participants that a summary of the research findings could be posted or emailed to them when the research study was completed, if they so wished.

(5) The researcher thanked the participant once again for participating in the research study.

Appendix G: Sample of a Transcript Extract with Coding/Analysis

Table G.1
Sample of Transcript Extract with Coding/Analysis

<u>Lack of connection</u> Lack of small talk (chitchat) created anxiety/unease – a lack of reciprocity? **<u>Anxiety</u>** Felt tense on client's arrival up to end of the session **<u>Felt challenged by client's expectations</u>** *"I'm here for a reason and what are you going to do to help me*".	**R. "Any other challenge you could think of, were there any other challenges that you can think of?"** A: *"Even small things like usually I meet my client in the hall and when I'd be bringing them into my office, there's generally some chitchat you know like that, even something about the weather or something else. But just nothing, it didn't happen, the engagement wasn't there with the Asperger clients, so from the time we'd even walk to my office my anxiety would be starting to build because it just felt tense most of time to the end of session. These clients didn't really do small talk, you know, their reasoning was "I'm here for a reason and what are you going to do to help me", so I felt very challenged by this."*	**<u>Descriptive:</u>** AS/HFA clients didn't really do small-talk. Unlike her other clients who would engage in some chitchat (e.g., small-talk about the weather) when she'd meet them in entrance hall, her AS clients didn't do small-talk. Her anxiety level would be starting to build from the time they would arrive and there would be a tension most of the time up to the end of the session. She felt very challenged because their attitude to the therapy was ***"I'm here for a reason and what are you going to do to help me***". **<u>Linguistic:</u>** She used different tenses (e.g., *"I meet*", *"I'd be"*), possibly reliving the experience to try make sense of it. To help convey her perception of the client's expectations, she used the client's words (i.e., her perception of the client's words) saying *<u>"I'm here for a reason and what are you going to do to help me", so I felt very challenged by this."</u>* **<u>Conceptual:</u>** She felt a tension from the time the AS clients arrived up until the end of the session. Their lack of social engagement/small-talk challenged her. When she said she would normally engage in small-talk with her other clients. <u>Is she saying that the real challenge for her was having to engage more formally, or was it just having to adapt and engage in a different way?</u>
<u>Uncertainty</u> - clients' bland facial expressions created uncertainty – a sense she was	**R. "And the other clients you worked with, with Asperger's, was that a similar experience for you?**	**<u>Descriptive:</u>** She found the AS client's facial expressions didn't change a lot of the time.

working in the dark with these clients **<u>Difficulty reading AS/HFA clients</u>** - their facial expressions and body language **<u>Challenged</u> by the clients' abruptness** **<u>Unfamiliar way of working</u>** **<u>Glad (relieved?) - when finished working with them</u>**	A: *"Yeah I just think that even their facial expressions a lot of the time, didn't change. How I would work naturally would be reading somebody's facial expressions that would lead me to go to certain spots, or issues. So I would know where to go based on the body language and just the expression. I didn't have those cues with these clients, so again it made it difficult, I didn't know if I was going down the right road with these clients. And yet if I wasn't, I felt a lot of times that I was cut off abruptly, you know because they were thinking that this doesn't make sense to me. So it was a very unfamiliar way of working and often feeling glad when I was finished with the client as well."*	She would normally read clients' facial expressions and their body language and this would provide her with cues where to go next with the client, the therapy. The AS clients didn't provide her with these cues so she was unsure if was going down the right road (direction) with them. She felt that if she wasn't going in the right direction, they could cut her off abruptly because the work (what she was providing) didn't make sense to them. This was an unfamiliar way of working for her and she would often feel glad when she was finished working with them. **<u>Linguistic:</u>** She expressed herself clearly and was very expressive (in her tone/intonation) when describing her experiences (re: the lack of facial expressions/social cues) When she used the word "*glad*", did she mean relieved? **<u>Conceptual:</u>** Her difficulty reading the social cues (or lack thereof) clearly presented challenges for her. She seemed to be expressing a strong sense of uncertainty, as if she felt she was working in the dark with these clients.