

**“Different *not* less”**

(Temple Grandin)

Young people, Autism Spectrum Disorder  
And Narrative Therapy

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# FROM THE EDITOR

## A bit about me as Teacher and Narrative therapist

I have for the past eight years been working in the secondary school context as a classroom teacher and a dean (pastoral care/guidance teacher). In my classroom and deaning work it has been both a pleasure and sometimes challenging to work alongside an invariably unique and distinct bunch of young people. For many, their uniqueness and distinctiveness marked by the presence of what most might name as a “disability” or an “intellectual problem”. A group of young people also being identified as autistic or having an autism spectrum disorder (ASD) condition.

In March of 2013 I was given the opportunity to work with a small group of 17 young people who each received a diagnosis of ASD. The course was a practical food technology course that required team work, a high level of communication, good self-management skills and an ability to work independently. If you, the reader, know even the slightest amount of information about ASD then you might be able to imagine with sense of humour just how **challenging** working with this class turned out to be. I had been given the option of saying no to teaching this class. But I declined that option.

Why? Well, in January 2013 I began the Master of Counsellor program at the University of Waikato and this pretty much changed everything for me. The first two papers I undertook were Counselling Skills & Discourse and Counselling Psychologies where I was introduced to ideas of post-modernism, social constructionism and narrative practice. Quite unexpectedly, my approach to teaching was revolutionised even though this was counsellor training. The most significant change in my thinking came from my learning around the influence of discourse and its shaping affects and the concept of externalization i.e. the problem is the problem not the person (White, 2007).

2013 was without a doubt the most difficult year of teaching I have had to date. But it has also been the

most rewarding. Armed with a teeny bit of narrative theory (that grew over the year) about co-creating meaning, a very slight idea about how to shape externalising conversations, a commitment to “not-knowing” (Anderson & Goolishian, 1992) and always maintaining a position of curiosity in relation to each of my students I learned two important lessons. My students didn't have a “disability” they were just different. And their differences didn't make them any less of a person than their peers who did not share their particular set of differences.

The significance for my students was a discovery that they were more than the labels that had been assigned to them. Though my narrative practice was in its infancy at the time, it offered me a different position from which to teach and learn about the lives my students were living.

Currently, my narrative practice is being shaped within the context of a family, children and young person's social service agency. My counselling work is primarily with young people within school contexts and they each bring with them a bunch of *differences* that I have run into before. This has motivated me to focus the work and words of this practice paper on young people, ASD and narrative therapy. Where I keep in mind that different does not mean less.

One aspect of my writing and use of words I want to draw your attention to is my intentional use, at times of ‘people with ASD’, ‘autistic people’ or any similar term that, as you read makes you think that I am speaking with labels. In my initial writing of this paper I had made every effort to externalise and separate ASD from the person believing ASD to the problem. However, what became clear from my research was that those with ASD do not see the disorder as a problem. ASD, in their eyes, as much a part of who they are as the colour of their hair or the size of the hands. If they were to be cured of ASD (even if it was possible) they believe they would no longer exist as themselves (Broderick & Ne'eman, 2008).

It is my hope that there may be something of interest for you in the pages that follow!

Vicki

# AUTISM SPECTRUM DISORDER

## Introducing ASD

In 1943, Leo Kanner (Kanner, 1943) first described autism as a singular, emotional condition that was the result of ineffective parenting, mostly like attributable to mothers. However, over time with robust debate and focused biological research it became clear that autism was in fact a neurological developmental condition (Mesibov, Adams, & Schopler, 2000). In the 60 years following Kanner's description of autism the medical/scientific communities understanding of autism began to shift. Prompted by research autism related conditions once described as being singular conditions evolved to that of one disorder with multiple conditions across a spectrum of varying degrees and differences. This leading to the merging of all autistic related disorders under one name Autistic Syndrome Disorder with the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013).

## What the DSM-5 says about ASD?

With the publication of the DSM-5 diagnostic manual in 2013 a decision was made to merge the previously recognised conditions of autistic disorder, childhood disintegrative disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS) and Asperger syndrome under one common diagnosis of ASD (American Psychiatric Association, 2013). The thought behind one single umbrella for autistic related disorders was in the hope that it would more accurately reflect the unique and distinct variations within in each individual and the fluid nature of ASD within different contexts and environments (American Psychiatric Association, 2013; New Zealand Council for Educational Research, 2016, p. 2).

## What does ASD look like?

ASD is the umbrella term given to the group of developmental disorders that are often characterized by significant social, communication and behavioural difficulties, as well as rigid thinking. People on the ASD are often described as having communication deficits, such as responding inappropriately in conversations, misreading nonverbal interactions, or having difficulty building friendships appropriate to their age. In addition, people with ASD may be overly dependent on routines, highly sensitive to changes in their environment, or intensely focused on inappropriate items (Azeem & Imran, 2016).

## Diagnosing ASD

Currently there are no definitive medical tests that can detect ASD. Typically, a diagnostic evaluation is undertaken by a multi-disciplinary team of specialists and professionals. A diagnosis of the disorder comes from a set of changing diagnostic criteria (Lester, Karim, & O'Reilly, 2014).

*"There's a saying within the Asperger community: if you've met one person with Asperger's syndrome, you've met one person with Asperger's syndrome ..... Within this condition, beneath this label, the variety of personality, of humor, of behavior, is infinite."*

*Hugh Dancy, star of the 2009 film about a man with Asperger's syndrome, Adam*

**The same can be said of a person with ASD**

# MAINSTREAM APPROACHES TO WORKING WITH ASD IN NEW ZEALAND

## Introduction

For the most part mainstream therapeutic approaches used to work with ASD aim to assist young people and their families with the 'management' and/or 'improvement' of their specifically associated set of deficit based behaviours or outcomes. Contemporary approaches to treating or counselling a young person and ASD are most commonly located in behavioural, speech and language development programmes, sensory integration (occupational therapy) and social skills training.

In the case of New Zealand, the Ministries of Health and Education strongly recommend the use of behavioural approaches when working with young people and ASD such as applied behaviour analysis and suggest the possibility of cognitive behaviour therapy (New Zealand Council for Educational Research, 2016).

## Applied behavioural analysis (ABA)

The underlying basis of behaviour analysis is to understand the actions and skills of a person with ASD and the ways in which any physical and social influences change their behaviour (Matson, et al., 2011; Broadstock & Lethaby, 2008). The idea being that physical or social influences can be specifically designed or altered to effect positive changes in behaviour. ABA has been shown to be increasingly successful in supporting young people with ASD in acquiring increased or new language skills, increasing positive social behaviour and decreasing problematic social/emotional behaviour (New Zealand Council for Educational Research, 2016).

There are a variety of ABA models used to target specific areas or contexts in the life of an individual with autism – discrete trial training, incidental training, pivotal response training, verbal behaviour approach, response intervention redirection, antecedent-based interventions, social stories, social skills training and video modelling. In the context of secondary school, the use of social stories has been a commonly used approach in supporting young people to develop and maintain relationships with their peers and teachers.

## Social Stories

Social stories (SS) are structured stories created with a young person that present social concepts and rules in the form of a story. This approach could be useful for teaching a variety of social and behaviour concepts usually experienced in a classroom such as engaging in group learning activities, going on class trips, listening to others speaking and asking questions. Successful SS employ the following essential components:

- be written in response to the young person's need
- be engaging, encouraging a young person to what to read it on their own
- be commensurate with their ability and comprehension level
- should avoid the use of directive terms such as "will" or "must" instead using "can" or "could"

The use of images in the construction of the story or the use of a computer to create the story can also be useful tools in increasing a young person's engagement with this approach. To further support the development of social skills practicing

the skills after reading the stories can also be useful in reinforcing the social skills. For example, a story about “working with others” could be followed up by a small scale group work activity providing the young person with opportunity to practice the skill of “working with others”.

*For more comprehensive information about SS see Gray (1998; 2015).*

## **Social Skills Strategies**

The Children’s Autism Foundation (CAF) NZ provides the JOIN IN programme which has been developed specifically to help parents and children aged from 7 to 16 years of age to practice and develop social and friendship skills together. This programme runs over a period of 10 sessions combining shared and individual session work that focuses on:

- Understanding together the feelings and behaviours of self and others
- Learning social skills to support improved interaction in school and community settings
- Develop a proper understanding of the feelings and behaviour of self and others.
- How to problem solve relational/social problems
- Learning about what individuals are good at i.e. their potential
- Supporting parents to be able to help their children with emotions and how to deal with them in a proper way.

## **Cognitive Behavioural Therapy (CBT)**

At the heart of CBT is the concept that our thoughts about something will shape our feelings and ultimately our behaviour both negatively and positively. The work of CBT is to identify negative or distressing thoughts, evaluate how realistic these are and then bring about positive or more helpful thoughts leading to more useful behaviours for an individual (Spiegler, 2013).

Though there are commonly used CBT interventions including “self-instructions (e.g. distraction, imagery, motivational self-talk), relaxation and/or biofeedback, development of adaptive coping strategies (e.g. minimizing negative or self-defeating thoughts), changing maladaptive beliefs about pain, and goal setting) these mainstream interventions are not necessarily accessible or useful for adolescents and ASD.

In recent times there has been some work towards adapting CBT approaches for use in the context of adolescents, ASD and anxiety (Ozsvadjian & Knott, 2011; Drahotka, Wood, Sze, & Van Dyke, 2011; Wood, et al., 2015) taking in to consideration this group’s specific differences in relation to cognition, communication, social and emotional understandings/responses and self-control (Anderson & Morris, 2006).

Developing a CBT approach that is individualised, more repetitive, visual and concrete is likely to be useful when working with young people and ASD within the therapeutic context (Ozsvadjian & Knott, 2011) such as:

- Use of visual aids/techniques to show links between thoughts, feelings and behaviour – drawings, thought bubbles
- A visually structured plan for a session showing a visual beginning and end-point.
- Frequent breaks to assist with focus and reduce the need for eye contact
- Adjustment of therapist’s expectations during session in terms
- Giving individuals the choice of two alternative thoughts in place of expecting them to generate their own ideas
- Use of special interests in a therapeutic way (what would Dr Who do in this situation?) or to regain interaction if lost during session (tell me about Dr Who’s latest assistant?)

(Ozsvadjian & Knott, 2011, pp. 7-8)

# TEAMING UP

## Young people, ASD and Narrative Therapy

### Introduction

One of the aspects of narrative therapy that invites me to be hopeful in my work with young people with ASD lies in the therapeutic work of exploring the stories of these young people's lives from **their** perspectives and experiences. From my position as a teacher I have observed the ways in which young people with ASD are subjected to and shaped by the discursive practices of the dominant discourses associated with ASD (such as autism, disability, illness, medical and mental health). These practices frequently invading their lives, obscuring their view of self and our view of what it might really mean to be living as a person with ASD.

But it is early days yet. As my understanding of narrative practice and how it might team up with young people and ASD develops it is for all intense purposes still in its infancy. It's not so much my understandings of narrative theory/practice or ASD that find me taking baby steps but more my thinking and the practice behind how I might team up with young people and ASD. In some ways narrative therapy could be viewed as being out of reach or inaccessible to young people with ASD given the potential challenges of understanding and communicating. So how is it then that a narratively informed counselling approach might be both accessible and useful to young people and ASD?

In attempting to answer my previous question I have drawn on a growing focus in literature on narratively informed therapy for those with ASD (Gillam, Hartzheim, Studenka, Simonsmeier, & Gillam, 2015; McGinty, Armstrong, Nelson, & Sheeler, 2012; Cashin, 2008; Cashin, Browne, Bradbury, & Mulder, 2013; Hoole & Morgan, 2008;

Lester, Karim, & O'Reilly, 2014; Hodge, 2012; Broderick & Ne'eman, 2008), my experience as a classroom teacher of young people with ASD, literature focused on the neurological descriptions and explanations of ASD and finally the experiences of those who live with ASD in their everyday life.

Even so, it is with tentative hopefulness that I offer my own insights (alongside the gems of hope I have discovered in literature) into how I am currently attempting to shape my work with young people with ASD guided by narratively informed practice. In the pages that follow I will explore selected aspects of my thinking and practice that are currently being shaped by narrative theory. They are:

1. **Knock know. Who's there?** - Getting to know the client outside the problem
2. **Taking a peek from the inside looking out** | Curiosity & Not Knowing
3. **Taking a step back** | Externalising conversations
4. **It takes a village** | Outsider witnessing
5. **Team work** | Co-construction, Co-creating & Collaborating
6. **Becoming the best version of yourself** | Identity positions

### **I. Knock Knock. Who's there?**

#### **Getting to know the client outside of the problem**

One of my first experiences of young people and ASD was in 2013 when I was allocated a combined year level vocational food technology class. There were 17 students in total, each bringing with them their own unique brand of ASD Self. My initial few weeks were incredibly difficult because I had no idea about ASD and what little I had been told by

the learning disabilities leader didn't help because each student seemed to be quite different from the next in spite of everyone 'having ASD'. One small ray of hope quickly emerged – I had recently completed a counselling skills paper, was part way through a discourse and psychologies paper and had a beginning understanding of narrative therapy. The ray of hope I was offered in this situation and which I now hold closely in my teaching and counselling work is based on the concept that “the problem is the problem, the person is not the problem” (White & Epston, Narrative means to a therapeutic ends, 1990). While this concept also informs the basis of externalizing conversations, in my practice it shapes my initial conversations with young people in such a way as to allow the exploration and sharing of who the client is not in relation to the problem (Freedman & Coombs, 1996) . It also supports the development and growth of a connected therapeutic relationship. It's a practice I maintain throughout my work and conversations with young people – always regularly and curiously enquiring about what they have been up to in between the times we are together.

In my experience this can also offer potential alternative and unique stories that can be revisited a future point in the therapeutic relationship. In the case of young people and ASD this 'connecting' is of vital importance for trust to grow. Often ASD can easily hijack how we see our clients and how they see themselves. Taking time to know the young people sitting in front of us can open a door that is otherwise left closed. A door that lets us explore who the young people is not who ASD might lead us to believe.

**“Autism can't define me.  
I define autism.”**

**Kerry Magno**

## **Taking a peek from the inside looking out**

### **Curiosity & Not Knowing**

In my experience as a teacher I have noticed how often we as the outsiders struggle to look or see young people with ASD in the same ways we see other young people. We look at them through a frame of what we understand natural/normal development to be. This outside looking in approach being our primary means of understanding, contextualising, evaluating and ultimately determining what may be motivating young people with ASD to act and speak in the ways we experience. But what if we asked the young person? What if we found a way to speak about ASD with a young person to find out what's going on? What if we took a breath and for just a moment made a little room from the young person and ASD to share with us their experience from the inside looking out?

Mainstream research and literature readily provides us with possible explanations, reasons and even solutions for managing ASD and its bag of tricks. While these can and do prove to be useful it has been in the midst of my classroom when it seems like “all hell is breaking loose” and ASD is trying to get the better of them and me that simply asking “what's happening for you?” offers my students an unexpected chance to speak. Drawing on Anderson and Goolishian's (Anderson & Goolishian, 1992) concepts of 'curiosity' and 'not knowing' in my teaching practice has proved incredibly useful; giving me all the evidence I need to make use of this positioning in my therapeutic work with young people and ASD. It seems to me that positioning a young person (even one with ASD) as the one who knows their experiences best provides them with the opportunity to speak of how it really is to have ASD and me the chance to hear the 'inside story'. I suspect that's likely to be a different experience for young people who are

expecting me to know or make judgements about them and their experience.

In my growing work within the discourses of education, mental health and autism; shaping my therapeutic practice with young people and ASD from a position of curiosity and not knowing is challenging. But it is a challenge that I believe narratively informed practice encourages and supports us to engaged in. This position of being curious and not knowing placing our young person at the centre of their story.

## **Taking a step back**

### **Externalising conversations**

In my experience of working within education and alongside medical/mental health professionals a person and ASD are frequently understood or believed to be inextricably linked. Labels of who they are and who they are often shaping their own understandings and the meaning they taking up from their problematic experiences. What escape does a young person with ASD have from both the discourses that bind their notion of self and ASD as if they were one and the same? It seems to me that “taking a step back” and engaging in externalizing conversations has the potential to allow the young people to know themselves as something other than the problems ASD sometimes hands out of its bag of tricks. In their work with people and intellectual disabilities Scior and Lynggaard (2006) found externalizing conversations to be useful in their work despite the intellectual and communication differences encountered with their clients. Visual aids provided a concrete way to support clients in richly describing of the “problems” visual aids “gestures and drawings”.

In my own experience thus far externalizing conversations with young people with ASD are more easily supported through the use of visual aids (gestures, drawings and physical objects). It

can be more helpful to ask “can you show me how bad the angry was by picking one of these faces on the whiteboard?” than “how bad was the angry?”. Or even demonstrate a gesture of big versus small by increasing or decreasing the space between our outstretched hands.

*If you are interested in recent research that explores the use of externalising conversations and metaphors in working with autism see McGinty, Armstrong, Nelson & Sheeler (2012) and Cashin, Browne, Bradbury & Mulder (2013).*

## **Team work**

### **Co-creating & Collaborating**

The medical/mental health approach to working with young people and ASD seems to incline itself more towards the development and implementation of appropriate strategies and plans that will fix, treat and manage a young person's behaviour (and its effects) with an aim to improve their quality of life.

These plans and strategies may not be developed in collaboration with the young person but instead based on ‘best practice’ approaches privileged by science and psychology. However, narrative therapy offers the opportunity to work alongside young people with ASD, co-creating the meanings they make from their relationships with life events, people and objects. Placing this young people at the centre of their own lives and stories, enabling us to create together strategies and plans that might improve their everyday life.

## **It takes a village**

### **Outsider witnessing (of sorts)**

It has been long said that “it takes a village to raise a child” (Igbo and Yoruba (Nigeria) Proverb) and it is in harnessing the idea of “others” being involved in the therapeutic process that narrative therapy offers the possibility of outsider witnessing as means for young people living with ASD to have

their words heard, listened to and acknowledged. Given what seems like the inherently experience of young people with ASD where they are frequently being spoken about, spoken to, managed and “treated”, outside witnessing exactly the opposite.

By inviting family, friends, teachers and professionals to engage in this process of listening, hearing, acknowledging and then offering their reflections we can promote a therapeutic experience for young people that sees them separate from the ASD.

It is my position that in our work with young people and ASD opening up spaces for new stories about their lives requires a “village” approach.

## **You’re simply the best!**

### **Identity positions**

A common experience in my teaching context when is for young people with ASD to introduce themselves this way “hi I am Cheryl. I’ve got ASD”. Within my counselling context I have found a similar situation when parents first introduce their teenager they will usually start with “this is John and he has ASD”. It always bothered me that they were drawn to defining their identity in this way. I found the concept of “ableism” (Hodge, 2012) useful in demonstrating how through the “categorisation and regulation” (p. 108) discourse associated with ASD defined and determined a person’s understanding of self (and others understanding of a person) through the creation and application of ‘labels’ as definitive descriptions of who a person is in relation (Simblett, 2013). Quickly, people take up these labels and their identity becomes inextricably linked to the what the labels speaks about them ignoring them as individuals and unique.

What I love the about narrative therapy is the invitation it provides space for therapeutic conversation where people can discover those

aspects of themselves that constitute them as both individual and unique and contrary to the “label”.

Narratively informed practice offers young people with ASD the opportunity to challenge and disentangle themselves from the label(s) associated with ASD. Through our careful listening we might pick up on those things that do not quite fit and then work towards enriching these exceptions to a young person’s identity stories. When we shape our practice in this way we may be able to make use of concept of **identity as a spectrum of possibilities**, where a young person with ASD can be one, the other or even another.

In our work to deconstruct the labels that entangle a young person’s sense of identity promoting a single-voice version of self, we can also call on the practice of re-memembering conversations and the ‘club of life’ (White, 2007) metaphor as means of privileging the voices of others in a young person’s life who contribute to a multivoiced sense of identity. This offering the young person the possibility of coming to know themselves as more than a person with ASD. That they are in fact simply the best!

**“Preferred claims about people’s identities are embedded in the alternative stories of their lives.... This reading of our lives through narrative structures provides the opportunity for us to render meaningful that which previously wasn’t, and to re-conceive of that which has already been rendered meaningful”**

**Michael White (2001)**

## **Me, myself and ASD**

### **Positioning myself in relation to ASD**

As a narrative counsellor and teacher I find myself frequently confronted with the question of how I might position myself in relation to a young person with ASD in the eyes of others. Like my students and clients with ASD, I too am subjected to the shaping forces that inhabit the discourses and discursive practices associated with ASD. I am not free from the surveillance (and advice) of the medical, psychological and education professionals who, like me, are engaged in the treatment and care of young people with ASD. Constantly, reminded of their “disability” and “differences” in ways I experience as “negativity”. Often being ‘asked’ to modify how I might work with these young people instead using currently ‘best practice’ determined medical/health models.

But, for me, it is in always remembering that wherever power seeks to operate so are the opportunities for resistance. As a narratively informed teacher and therapist I embrace the idea of “opposing strategies” (Foucault, 1998, p. 101) that “make it possible to thwart” the work of discourse and power in my work with young people and ASD.

You see my understanding of ASD is that it just makes a young person different. It doesn't make them less than anyone else. At a neurological level their brains are wired differently. Sometimes a lot differently and sometimes a little differently. But either way how is that different to how our brains are wired? They won't be the same – I am pretty sure of that.

I have come to understand is that there has always been pressure on people with ASD (and their families) to act and be ‘normal’. To conform to culturally and socially accepted ways of acting and being. They are trained and expected to communicate with us in ways **we** understand. But why? Why can't we take some time to learn how to

communicate and be with them in the ways that work for them?

And this is precisely what I believe narrative therapy offers a young people with ASD. Someone who is genuinely willing to learn about them and their world in a way that works for them and is about them.

So where do I position myself in relation to ASD and young people? I'm on their team all the way!

## **My final thoughts**

I have discovered that my teaching practice and narrative practice share a symbiotic relationship. They each inform and reform the other. This discovery both delights and encourages me as I observe my narrative practice growing and changing, even outside the counselling room.

My hope in selecting this particular area of interest has been to further inform and shape my future practice as a narrative therapist working with a range of *differences* that I might encounter. This is what I love the most about narrative therapy – the embracing of difference as our own brand of ‘normal’.

It might be, that like me, you were hoping to find in this paper a set of well-defined narrative practices that could be used specifically when working with young people with ASD. But each young person is so incredibly different, working with their ‘maps’ requires an innovative and constantly evolving approach to therapeutic work. Instead, I hope to encourage you to reflect on the underlying philosophy and principles of narrative therapy and how these might shape the specific work of our practice with young people with ASD.

Though my words have come to the end. For me this is not the end. And before you leave these pages I invite you to turn one more page and share in the words and story of Gordy, a non-speaking teenager as he explains autism to us.

# Gordy's Letter

My name is Gordy, and I am a teenager with nonspeaking autism. I prefer this term rather than low functioning, because if I am typing you this letter, which I am, I am clearly functioning. I felt very strongly about writing you today, to give a little extra insight on the disconnected links that were supposed to make my brain and body work together in harmony. But, they don't and that's okay. You see, life for me and others like me is like a daily game, expect not fun, of tug-of-war. My brain, which is much like yours, knows what it wants and how to make that clear. My body, which is much like a drunken, almost six-foot toddler, resists.

This letter is not a cry for pity, pity is not what I'm looking for. I love myself just the way I am, drunken toddler body and all. This letter is, however, a cry for attention, recognition and acceptance. With your attention, I can help you recognise the signs of nonspeaking autism. If you can recognise the signs, then you will be able to recognise our difference which then leads to the understanding of those differences which brings us to the wonders of acceptance. With these simple ingredients, together we can create a safe, welcoming and happy environment for both autistics and neurotypicals alike.

The physical signs to look for are flapping hands or some other socially unacceptable movement, words, noises or behaviour in general. That's uncontrollable. With a mind and feelings much like everyone else's, do you truly believe we like acting that way? I don't, that's for sure.

If one becomes aggressive, with biting or hitting for example, obviously protect yourself but there is no reason to use aggression in return. Remember, this aggression, is an uncontrollable reaction, most likely triggered by fear.

Nothing means more to people like us than respect. I can tell you with almost on hundred percent certainty the situation will go down a lot easier with this knowledge.

I have nothing but respect for you all and everything you do. If it weren't for you, I would never have had this opportunity to advocate for myself and other autistics. I look forward to meeting you.

Sincerely,  
Gordy

You might like to read the article about how Gordy's non speaking autism had led his parents to believe that he could not comprehend anything. That was of course until he typed this letter.

The full article can be located here: <http://www.a4.org.au/node/1226>

# USEFUL RESOURCES



Altogether Autism is a nationwide autism spectrum disorder information and advisory service provided Life Unlimited and Parent to Parent New Zealand. A key service they offer is “tailor-made” ASD information packs relating to an individual needs and requirements from verified and credible sources. They also provide professional development opportunities for professional working in the area of ASD (training programmes and workshops), a quarterly published journal and links to services and events.

## **Dancing with the DSM - The reflexive positioning of narrative informed psychiatric practice.**

*Simblett, G. (2013). Dancing with the DSM—the reflexive positioning of narrative informed psychiatric practice. Australian and New Zealand Journal of Family Therapy, 34(2), 114-128.*

Gary Simblett writes a compelling and highly readable article that highlights the potential influence of positioning theory, power and resistance alongside the DSM discourse in his work as a psychiatrist. He uses the metaphor of a dancing to illustrate and demonstrate the different positions that can become available through narratively informed psychiatric practice. What was most compelling for me as I read Gary's article was the idea that he as psychiatrist who must work with the DSM discourse was using narrative ideas to offer himself and those he works with multiple positions within the therapeutic relationship. At times that of the dance lead or the dance partner. What makes this article useful is its demonstration of how space can be found or made when one understands positioning theory, power and resistance in way that allows us to make things “dance” to our own tune even when we work within dominant discourses.



The Autism NZ sites provides a wealth of information and resources for anyone who is affected by autism. It contains the locations of nationwide branches, easy to read information about autism, autism spectrum disorder and Asperger syndrome. They also provide training programmes and seminars for parents/caregivers, whanau, individuals with ASD and professionals in the mental health, medical and education sectors. As well as providing downloadable ASD related resources they also provide links to other support agencies and a variety of tools and strategies useful in living or working with ASD.

## **Autism: A brief history**

*Mesibov, G. B., Adams, L. W., & Schopler, E. (2000). Autism: A brief history. Psychoanalytic Inquiry, 20(5), 637-647.*

Autism: A brief history is an interesting read that provides historical information detailing how the understanding of autism changed over a period of 60 years from the point where it was first described by Leo Kanner. What was most useful about this article was the insight it provided into how and why autism was originally described as a psychological and emotional condition and then the circumstances leading to the concept of autism being a neurological condition. In my reading of this article we are given the “nuts and bolts” of Kanner's research leading him to describe autism as emotional, as are we giving the “nuts and bolts” of how subsequent researchers provided evidenced based argument for autism as a neurological condition. The “nuts and bolts” providing me with a deeper understanding of how any type of “condition” is identified and then codified in the DSM. This article supported me in understanding and interpreting subsequent articles relating to autism.

## Temple Grandin

<http://www.templegrandin.com/>

Temple Grandin is really cool! She is a well-known author and speaker on the topic of autism. Her website contains a detailed biography of her life living with autism and her accomplishments living with autism. She provides a range of useful and educational resources (videos and books) that can be purchased from her website as well as free articles and links to her conferences. She is a sought after speaker and after watching her speak I can see why. What is most compelling about Temple is her speak about herself and how autism makes her different not less and how focusing on her differences as strengths has been a force behind her success. Temple provides a rich picture of insider knowledge for those of us on the outside not from a clinical perspective but from her everyday acts of living.

## Zealand Autism Spectrum Disorder Guideline

<http://www.mentalhealth.org.nz/assets/Attachments/Downloads/NZ-Autism-Spectrum-Guidelines-MOH-NZ.pdf>

This guideline has been developed by the Ministries of Education and Health for the use of professionals, whanau, specialists and carers engaged in providing care for children and adults in New Zealand who live with autism spectrum disorder (ASD). This guide is useful in that it provides a summary of evidenced based guidelines relating to identifying and diagnosing ASD, ongoing assessment and access to interventions and services for individuals with ASD within the New Zealand context. An overarching aim of this guideline is to support informed decision-making to improve the health, educational and social outcomes for individuals with ASD.

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