How can psychotherapists meet the needs of Autistic adults with PTSD in Aotearoa New Zealand?

I have been a Certified Transactional Analysis (CTA) in Psychotherapy for 8 years now, although I spent most of my early career as an Occupational Therapist working with children with Autism/ASD and mental health. More recently I am noticing my drive towards research and highlighting some knowledge gaps and needs concerning Autistic women in NZ, as well as non-binary and gender diverse people within the context of sexual violence here in NZ.

As an assessor and provider for ACC Sensitive Claims, I am seeing more clients come through with either a formal or informal diagnosis of autism. Overseas research has highlighted (Hoover & Kaufman, 2018, Cazalis et al., 2022) that sexual violence is likely to impact Autistic women two to three times more than allistic (non-autistic) women in the general population (Brown-Lavoie, Viecili & Weiss, 2014; Rumball, 2021). We also know that Autistic people may show more severe emotional responses to traumatic events because of several vulnerability factors (Hoover, 2015) and, subsequently, PTSD or C-PTSD symptoms (Haruvi-Lamdan, et al., 2018). Autistic individuals are also likely to have incredibly strong emotional responses but these are not necessarily aligned with what may be seen as a typical response to that situation. This doesn't mean however that their response isn't valid. Some also might not exhibit their responses externally but feel them at a heightened intensity internally.

So, what more do we need to know and do as psychotherapists so as we can meet the needs of Autistic clients with PTSD?

What appears to be lacking, is New Zealand specific data and the unanswered question of is our prevalence rate of sexual violence the same as Autistic women and how do we currently meet their needs following sexual violence? In addition, within this vulnerable community, what do we know about Māori with Autism/Tangata Whaitākiwātanga and their experiences of sexual victimisation? Important questions I believe as ACC heads into a new era of Sensitive Claims services for Aotearoa New Zealand.

Autism Spectrum Disorder (Autism) refers to a lifelong neurodevelopmental condition characterised by persistent social and communication differences, sensory issues, and restricted repetitive patterns of behaviour or interests (American Psychiatric Association, 2013).

Autistic differences in social communication, such as decoding hidden intentions and emotions of others, understanding implicit communication and elements of context, it is expected that autistic women may be at considerable risk for sexual victimization, a hypothesis confirmed by previously published studies on this topic as mentioned previously. For autistic individuals, differences in language comprehension, information processing, emotional regulation differences and somatic processing differences as well as increased likelihood of social isolation suggest that they are at far greater risk of experiencing symptoms of trauma (Peterson, et al., 2019).

It is more recently recognized that autism can overshadow a PTSD diagnosis (Reuben et al., 2022; Quinton et al., 2024). If an Autistic person is presenting clinically, an exacerbation of their autistic presentation may be the consensus and the possibility that someone has is both Autistic and has PTSD is rarely considered. And of course, the same can also happen in reverse. Mostly the research tells us that this is due to both exhibiting high levels of distress, dysregulation and dysfunction which can get in the way of considering differing diagnoses. It can also be because of the considerable overlap of presentations which is often seen and experienced in the therapy room. Both involve difficulties with emotional regulation, irritability, sleep, avoidance and somatic or interoception differences. The other consideration here is on how clinicians can often just take things at face value, without recognising what is behind these experiences and how they are being experienced by the person,

Research on psychotherapy to support neurodivergent people has largely focused on therapies which seek to address core symptoms of these conditions, ie. which pathologize differences as deficits to be 'fixed', with only a few studies exploring the lived experiences of and the preferred adaptations to psychotherapy amongst neurodivergence including Autism. In two qualitative studies (Camm-Crosbie et al. 2019; Bowers & Widdowson, 2023) several themes were found which also looked at Autistic adults' experiences of accessing mental health services. Paucity of research in this field means we do not know how effective the current PTSD treatments are for Autistic individuals, although some research is suggesting that we cannot necessarily generalise the treatments we current employ with neurotypical individuals (Rumball et al. 2021). For now, expectations are that treatments should be appropriately *accommodating* for Autistic adults and their individual needs in areas such as communication and language used, processing of information, sensory preferences and through utilising one's intense interests. Importantly, therapists need to be flexible and knowledgeable about neurodivergence. Assumptions will invite masking and conforming to being the 'best client ever' (Oates & Moores, 2021). From a phenomenological perspective, recent research conducted by Murray and colleagues (2023) revealed that trust and reliability were held in high regard, not too different from that of neurotypical clients only it is worth mentioning because of the significance for autistic clients who have experienced repeated misattunements, repeated invalidation, repeated relationship ruptures and repeated misdiagnoses or overshadowing diagnoses experienced. Oates & Moores (2021) explore the importance of therapist and client just *authentically* being together as opposed to being change focused, with effectively *allowing* the client to be able to feel safe enough to unmask in the therapy room with you. Masking is a protective mechanism and it is the therapist's role to enquire as to 'what can I do to make you feel comfortable' to support the possibility of unmasking. Masking is often not a choice that one makes and therefore removing the mask is not always something that the Autistic client can control – even when told that they can do in a therapeutic context. The experience of Autistic individuals in therapy or clinical settings of being invalidated is frequently reported in clients I have seen. The importance of believing your client –

even when their appearance or expressions are incongruent to what they are saying – cannot be overstressed.

Most training institutions provide frameworks for being able to work with neurotypical clients and not neurodivergence. When language is understood concretely or literally then developing greater awareness of one's internal processes and sensations will require a bit more creativity beyond using the terms "notice what happens" or "look inwards". More likely than not, your Autistic client will simply agree with whatever you need them to notice and continue to mask and camouflage all the while, remaining at a loss as to what they are not getting "right" or worse, that they are 'failing' at therapy.

The other consideration is known as the double-empathy problem (or phenonium as I prefer) that highlights the mutual challenges in understanding and relating between autistic and allistic/non-autistic individuals. Milton (2012) accurately emphases there being an archaic assumption on Autistic individuals having a "deficit" in 'theory of mind' rather than this working both ways and being of mutual responsibility. The onus is on both – it concerns the autistic client *AND* the therapist (Milton, 2012). This reminds us that it is possible and probable that we can be a part of the solution when working with autistic clients as oppose to their being the persistent notion of 'disorder' and 'deficit' in autistic individuals that serve to only reinforce alienation, stigma and marginalisation.

Another important aspect to remember is that gender differences are just as vast as autistic differences. It's all about recognising that your therapeutic approach needs to be individualised. Autistic women and girls are more often diagnosed later in life compared with males (Cook et al., 2024) so there is every chance that your client may not formally have a diagnosis. This can be for a host of reasons and it may not be a priority or need for them to have it formally recognised although they may self-identify as being autistic or they just know that they are 'different'. This is just as important as a formal diagnoses. Often those diagnosed with Autism in adulthood have been already been through a mental health crises and carry the burden of misdiagnoses and a history of seeing various therapists.

It is important to know that an autistic client may have been told they have "low support needs" however this qualitative viewpoint of how an Autistic individual experiences life can be awfully shaming, inaccurate and condescending. Just as saying, *"oh I think we are all a little bit on the spectrum aren't we?"* is also belittling, insulting and ignorant to the efforts that it takes for any autistic individual to function in a neurotypical world. A world full of misleading and ambiguous language, unwritten social 'rules' and countless contradictions. And in order to get support after experiencing trauma, they now are expected to 'know *how to do* talking therapy'?

There are some unique challenges when working with the complexities of autism and frequently we are faced with limited resources and outdated systems that can impact on *how* to work with Autistic clients. Additional considerations in the therapy room includes the understanding of challenges related to your Autistic client having alexithymia, as well as interoceptive processing differences. What this means is that

there are differences in how they process internal body signals and sensory information that may also impact one's ability to interpret and understand internal emotional states. Difficulties in processing sensory information can also determine the effectiveness of such modalities such as EMDR and somatosensory therapies although with some adaptations and fitting in with the needs of your Autistic client, these can still be effective therapeutic options. Co-occurring learning disability can also significantly increase the challenges autistic individuals face. Of interest, one study completed by Lipinski and colleagues (2019) cites the most frequently reason for non-engagement with psychotherapists by autistic individuals was the therapist's lack of understanding/experience of working with autism.

Findings collated so far from a number of sources and Autistic scholars (Camm-Crosbie et al., 2019; Rumball et al. 2021; Rumball, 2022; Hume, 2022, O'Brien et al., 2024) reveals important aspects of working with Autistic adults and their experience of trauma and PTSD symptoms. Many of the symptoms were similar to the general population but some other important themes did emerge that are unique to working effectively with Autistic individuals. The concern is the overlapping symptoms and recognising with accurate assessment, the distressing sequalae of negative symptoms known to accompany PTSD. To date, there are no assessment tools that have been validated and reliable for the accurate assessment of likelihood of PTSD in Autistic adults.

On a personal note, my 13-year-old daughter has recently been diagnosed with autism (she is what I call awesomely Autistic) and she was happy with me mentioning her in this article. Since our diagnosis – which I thought was the hardest part – we have been scolded with "why would you want to label them with that?" or perhaps thinking they are complementing her by saying "oh it must be very mild" is dismissive and diluting of the challenges that she faces in a neurotypical world. I feel infuriated at times with the misconception and misinformation on Autism, especially the gender bias that continues although is slowly being discussed more openly and honestly as we recognise how differently autism will present in girls and women when compared to their male peers. Of interest, the most significant findings of late shows a significant number of underdiagnosis of Autistic girls which directly challenges the traditionally cited male-to-female autism ratio of 4:1 which in itself is a bit of flawed concept. McCrossin's (2022) analysis actually suggests a more accurate male-to-female ratio might be closer to 3:4. My daughter has reinforced my need to further educate others and look at developing greater understanding - if not in society, then in the psychotherapy community - about how to work with and understand autism in the therapy room. It is not the clients responsibility to teach you about autism. To ethically work well with an Autistic client, as psychotherapists we can be expected to have a sound – a robust – knowledge of autism and how it can present in the therapy room with us (Te Pou o te Whakaaro Nui, 2019).

Autism is not a dirty word or even a scary word! There is no 'protective shell' encasing the individual, it is not a trend or a fad, there is no cure which is required and there are no character flaws and <u>no</u> deficit - just <u>difference</u>.

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