Adlerian Interventions for Stress Management and Autism Spectrum Disorder

A Literature Review

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirement for

The Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

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Date

September, 2017
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STRESS AND AUTISM SPECTRUM DISORDER

Abstract

This paper includes an overview and discussion of autism spectrum disorder (ASD), current community challenges faced by those affected with ASD, and a brief synopsis of current interventions for ASD symptom management. The purpose of this project is to review ASD, parental stress induced by ASD, and the use of Individual Psychology as a possible intervention technique to reduce parental stress.

Keywords: autism spectrum disorder, parental stress, Individual Psychology
Acknowledgements

The following individuals and organizations are recognized as major contributors of opportunity, promotion, and dedicated support with regard to the completion of this Master’s Project. I would like to thank Nicole Randick and Beverly Lutz for accepting my project proposal and assisting me in organization of the project. Additional thanks to Sarah Flatten, David Stern, and The Village Family Service Center in Alexandria, MN for assistance in topic selection, research assistance, presentation opportunity, and use of recording equipment. Thank you to Meg Whiston for contributions to resources for project support. Thank you to Meg Williams for being the project reader and providing topic expertise. For project reorganization, managing, and editing I would like to express my sincere gratitude to Dr. Rachelle Reinisch. Lastly, I would like to thank Adler Graduate School for the knowledge, use of research materials, technology, and the opportunity to promote Alfred Adler’s Individual Psychology to others.
Dedication

For my family, friends, teachers, colleagues, and organizations that want to help others learn, grow, and succeed. For those who continue forward despite the setbacks, and for those who offer up their unconditional support to turn goals into reality.
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Adlerian Interventions for Stress Management and Autism Spectrum Disorder

More common than Down syndrome or childhood cancer, Autism Spectrum Disorder (ASD) is causing the community at large to question the disorder’s long-term impact (Russell, Kelly, & Golding, 2010). The population of those diagnosed with ASD is growing rapidly and at a pace that has steadily increased over the last 20 years (Russell et al., 2009). This sudden increase has captured the attention of researchers, medical doctors, mental health professionals and lay people alike. With the growing rates of ASD diagnoses, a need exists to address the definition of ASD, the impact of ASD on families, especially parents and community caretakers, and useful interventions to manage ASD symptoms.

The confusion and debate about the causation of ASD remains unsettled even though the diagnostic criteria continue to be altered and refined (Lord & Jones, 2012). Focused on supports and services to manage symptoms that impede daily functioning, doctors, professionals, and educators categorize ASD in slightly different ways (Lord & Jones, 2012). The stigma related to receiving the recommended support and services often ostracizes not only the child with ASD, but those caring for children with ASD (Hall & Graff, 2010). Additionally, the cost associated with support services does not guarantee alleviation of symptoms. Caring for the needs of a child with ASD, the cost of intervention, and the uncertainty of the future for individuals with ASD, typically falls to parents of children with ASD. The increased risk of anxiety, depression, or other mental health conditions is common among parents and inadequately addressed in research related to ASD (Neely-Barnes, Hall, Roberts & Graff, 2011).

A therapeutic intervention for parents of children with ASD is outlined in the form of two templates with a thorough explanation regarding the content for each counselor-client session. Adler’s Individual Psychology emphasizes a person-centered approach that simultaneously
incorporates interventions geared toward the systemic family system. By utilizing Individual Psychology techniques, parents may be able to manage personal symptoms and support a child managing the symptoms of ASD.

**Autism Spectrum Disorder**

For the purpose of this project, ASD will be defined as a combination of symptoms (along a continuum and ranging in severity as it pertains to necessity of intervention), which generally includes: social interaction impairment, patterns of behavior that are repetitive and/or restrictive, limited interests, and sensory reactivity (American Psychiatric Association, 2013). Symptoms present in early childhood (i.e., infancy to 5 years of age) and will cause significant clinical impairment that affects the child’s ability to partake in normal development. *Childhood* will be defined as any individual under the age of 18 years. There may be slight differences in symptomology across cultures due to differences in societal norms and expectations (e.g., eye contact).

To better understand autism spectrum disorder (ASD), the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) defined ASD as a diagnosis that affects nearly 1% of the population. Research shows that ASD is so prevalent that 1 in 68 individuals have some varying degree of ASD (Emerson, Morrell, & Neece, 2016; Yuan, Holtz, Smith, & Luo, 2017). In addition, ASD affects males four times more than females, which may be due to the comorbidity of intellectual disability, symptomology differences, or societal and cultural factors (Jiang et al., 2014). Detection of the disorder is most beneficial during early childhood to assist, support, treat, and increase the potential to alleviate long-term developmental impairment (Van Daalen et al., 2009). ASD is considered a chronic disorder with no identified cure or causation at this time.
According to the DSM-5, ASD is managed through compensation and coping strategies learned in treatment; however, most strategies are used to assimilate into one’s cultural norms (APA, 2013). The age of diagnosis and the initiation of intervention strategies contribute to the severity of ASD symptoms. The DSM-5 stated without proper monitoring and healthy support services, ASD symptoms could become more difficult to manage over time (APA, 2013).

Behavior assessments determine whether or not an individual will be diagnosed with ASD (Guthrie, Swineford, Nottke, & Wetherby, 2013). There has been ongoing debate as to whether or not ASD is more appropriately assessed through neurobiological and genetic testing (i.e., a medical model) versus a behavioral model within the mental health field. Currently, substantial and reliable evidence suggests that neurobiological and genetic testing cannot effectively determine an ASD diagnosis (Jiang, et al., 2014; Lord & Jones, 2012). For instance, medical testing to determine an ASD diagnosis would not be considered effective because ASD is specific to every individual. A few studies exist regarding twins and other forms of genetic and neurological testing; however, nothing can achieve an ASD diagnosis without looking again at behavioral tendencies (Lord & Jones, 2012).

Frequently, questioning whether or not a child has ASD begins when the child is in a social atmosphere such as daycare, preschool, or elementary school (Emerson et al., 2016). Childcare providers and educators are typically aware of normal developmental patterns and abilities. In daycare or school settings, differences may be noticed that might otherwise go unnoticed in the home (Emerson et al., 2016). According to the DSM-5, ASD frequently presents with other diagnoses or will have certain features that are specific enough to address. To meet the DSM-5 diagnosis for ASD, an individual will present symptoms across environments, within multiple relationships, and the symptoms will affect almost all areas of
daily functioning (APA, 2013). Research reveals that the ASD diagnosis is constantly evolving within the social and medical sciences (Lord & Jones, 2012).

According to Emerson et al. (2016) White Americans are diagnosed with ASD more than people of color. Minority populations, such as African Americans, are either misdiagnosed or have a delayed diagnosis. This misdiagnosis may be due to numerous factors such as: socioeconomic status, symptom differentiation (due to cultural norms) limited access to health care, lack of parental education, and/or racial attitudes of those providing health care services.

Emerson et al. (2016) stated ASD is one of the most difficult disorders to diagnose because no two individuals with ASD have exactly the same symptoms. As a result, the term spectrum is used to include all potential variations of the diagnosis (Jiang, et al., 2014). Emerson et al. (2016) suggested mental health professionals must rule out any other diagnosis and complete a full assessment (developmental milestones, familial history, cultural differences, environmental factors, outlying information specific to the individual, other medical conditions, etc.). Additionally, Emerson et al. noted multiple assessments can be used by multiple professionals to ensure an accurate diagnosis.

For children, the average age of an ASD diagnosis is approximately 4 years of age (Bilaver, Cushing, & Cutler, 2016); however, an assessment can be completed and a diagnosis reliably assigned by 18-24 months of age (Guthrie et al., 2013). An ASD diagnosis is not included in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Zero to Three, 2005). In place of an ASD diagnosis, a group of disorders classified as regulation disorders of sensory processing (RDSP) is used to determine a child’s response to sensory stimulation (i.e., taste, sound, sight, smell, touch, and individual orientation of movement and position) within the child’s relationships and environment (Zero to
Three, 2005). Similar to ASD, a diagnosis of RDSP includes an assessment of sensory processing, motor skills, and behavioral patterns that cause significant difficulty for a child to maintain a normal developmental trajectory.

**The Evolution of Autism Spectrum Disorder**

When parents begin the process of assessment and diagnosis for ASD, parents typically use the phrase, “Something just feels off, like he is in his own little world” (S. Flatten, personal communication, May 2016). When parents use this phrase, they are referring to the lack of social interaction and reciprocity in relationships (S. Flatten, personal communication, May 2016). In 1943, these crucial social interactive pieces triggered research regarding individuals with “autistic” features or psychopathy (Lyons & Fitzgerald, 2007). Hans Asperger and Leo Kanner noticed some individuals lacked social skills, appeared self-interested, and excluded themselves from the world (Lyons & Fitzgerald, 2007). Asperger and Kanner continued to research individuals with “autistic” features to assess additional peculiarities and causation. Later, Wing and Gould incorporated factors such as imaginative play, social interaction comprehension, and language comprehension within the study of autism (as cited in Lord & Jones, 2012). Furthermore, Lord and Jones stated an Autism diagnosis, and the categorization of “autistic” features, had been originally added to the *Diagnostic and Statistical Manual of Mental Disorders* as a pervasive developmental disorder.

Lord and Jones (2012) stated a range of disorders known as pervasive developmental disorders could be found in the revised fourth addition of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; DSM-IV-TR; APA, 2000). These disorders included: autistic disorder, Asperger’s syndrome, and pervasive developmental disorder not otherwise specified (PDD-NOS). A diagnosis of PDD-NOS would account for new findings that centered
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around the severity of an impairment in developmental functioning (Lord & Jones, 2012). A diagnosis of Asperger’s syndrome was considered less severe than a diagnosis of autism (APA, 2000; Lord & Jones, 2012). When an individual did not meet the criteria for Asperger’s syndrome or autistic disorder, but had similar features, he or she was diagnosed with PDD-NOS (Lord & Jones, 2012). Currently, the DSM-5 includes one general category known as ASD with qualifiers for the diagnosis (APA, 2013).

The ASD diagnosis includes variations in severity, characteristics, and symptoms. The primary differences between the DSM-IV-TR and the DSM-5 include (a) the change in the name of the diagnosis; (b) the severity of the diagnosis is determined by the need for intervention; and (c) the social-communication impairment and repetitive or restrictive behavioral patterns are used to determine the diagnosis (APA, 2013). Lord and Jones (2012) found one criticism regarding the changes in the DSM-5. Lord and Jones stated that previously, when individuals did not meet the full criteria for ASD, they would have been diagnosed with PDD-NOS. Lord and Jones maintained that a stigma is associated with the ASD label and could have a negative impact on individuals with minimal impairment.

**Current Community Challenges**

Community challenges associated with ASD include, but are not limited to, the following: controversial theories on causation of ASD, best practices for effective and appropriate diagnostic procedures, obtaining adequate support and resources, and the associated cost of support and services. While these challenges seem typical of any disorder, ASD is unique due to the dramatic increase in the number of children affected by the disorder (Russell et al., 2010). According to Anderson (2015) limited research exists regarding possible theories
surrounding the cause of ASD; however, emerging themes involve genetic and environmental factors, and immunizations in early childhood (0-5 years of age).

Matson and Dempsey (2008) stated current research does not support a causal relationship between immunizations and ASD. Similarly, a specific chromosome has not been identified as the cause of ASD in genetic research. Determining a specific cause for ASD may be difficult because features and symptoms are individual to each child. For instance, the perception and reaction to a child’s environment largely depends on the child’s sensory related impairment (Hartshorne & Herr, 1983). Overall, definitive causal factors do not exist for ASD. Clinicians are asked to make a diagnosis based on clinical judgment of the child’s current issues affecting multiple areas of life, familial history, medical history, and physical or environmental stressors (Anderson, 2015). Computer generated symptom identification systems have been used to objectively determine a diagnosis, but current behavioral assessments (addressed as current issues above) through clinical observation are used as the most efficient means of diagnosing (Anderson, 2015). In addition, the clinician has a general set of criteria outlined in the DSM-5 used to achieve an ASD diagnosis.

Co-morbidity among children with ASD is acknowledged in the DSM-5 as well as in research literature (APA, 2013). For example, children with ASD may have intellectual disabilities, associated anxiety and/or depression due to sensory related issues and social interaction, and attention deficit hyperactivity disorders (ADHD). Most commonly, ASD and intellectual disability contribute to educational and social impairment (Lindsey, Proulx, Thomson & Scott, 2013). Further complications regarding an appropriate ASD diagnosis stem from differences between a medical diagnosis and educational diagnosis of ASD (Prykanowski, Gage, & Conroy, 2015).
Special education teachers have the responsibility to identify students with intellectual and behavioral educational delays, offer support and resources, and maintain a level of education similar to that of the child’s peers (Lindsey et al., 2013). Additionally, when educators have a child with an ASD label, the child receives additional supports that differ from state to state. It is unclear whether or not the educational or medical diagnosis of ASD is more prevalent. Further research could determine whether or not the difference between the two diagnoses has a critical impact on children with ASD; however, with the increase in childhood ASD diagnoses, accommodations through support, services, and resources have increased in schools and communities (Ravindran & Myers, 2012).

Due to the individualistic approach necessary to address the spectrum of symptoms associated with ASD, establishing proper support and services is an ongoing process (Ravindran & Myers, 2012). Thus far, research has been able to pinpoint several strategies that work better than others. Effective treatment strategies include: applied behavior analysis, implementation of highly structured routines and environments, sensory therapy, and art therapy (Ravindran & Myers, 2012). The challenge is the ability to train educators and community helpers assisting children with ASD regarding methods and approaches that can be used while working with children in an inclusive environment (Lindsey et al., 2013).

School concerns include significant provider turnover rates and social exclusion (Lindsey et al., 2013). What works for one child with ASD may not work for another, and the continual advancement of resources quickly becomes outdated (Lindsey et al., 2013). In addition, it is difficult to secure adequate funding to upgrade support, services, and resources to keep up with the demands of an increasing ASD demographic.
According to Hansel (2013), the financial responsibility for an individual with ASD is estimated at $3.2 million for all costs related to the disorder. The United States spends $175 billion annually on services aimed at treating ASD (Buescher, Cidav, Knapp & Mandell, 2014). Insurance companies do not necessarily cover the needed specialists to fully assist a child with ASD. There are additional costs related to the following: inconclusive testing, potential counseling services for parents’ stress management, parental unemployment due to the need to stay at home with the child because of behavioral issues, medications (e.g., natural, herbal, and trial), and additional costs associated with community involvement to improve social interactions and well-being (Hansel, 2013). The financial burden is especially difficult for lower income families.

**Stigma**

The stigma associated with ASD begins as soon as the diagnosis is established (Mogensen & Mason, 2015). Although clinician’s attempt to remain objective, they have a subjective understanding of how the disorder will affect the individual and then act accordingly. The clinician has internal expectations once a child is diagnosed with ASD. While the child with ASD is not necessarily cognizant of how others view the diagnosis, the way others react and communicate initiates a set of expectations when people view individuals with ASD differently than others (Matson, Neal, Fodstad, & Hess, 2010). For this reason, controversy exists regarding the change in the autism classification within the DSM-5 (i.e., from specific distinctions and separate disorders to the spectrum, or continuum). Previously, children diagnosed with Asperger’s disorder had minimal negative social implications (APA, 2000; Lord & Jones., 2012). Currently, all diagnoses are now categorized as ASD (APA, 2013) and individuals with fewer
symptoms now receive an ASD diagnosis. Increased awareness and knowledge concerning ASD is needed to eliminate the negative connotation of the diagnosis within society.

An ASD diagnosis could be less socially oppressive if people did not fear the disorder and had a better understanding of ASD (Hedges et al., 2014; Lindsey et al., 2013). For instance, some individuals with ASD have accomplished many positive and impressive acts that some neurotypical individuals would be unable to accomplish. As evidenced by great minds throughout history, many people find non-stereotypical ways to contribute and solve problems. The ability to view the world in a different way and produce different results is a valuable trait; however, it is often overlooked by the need to belong and feel loved (Hartshorne & Herr, 1983).

Stigma associated with ASD includes the following: (a) ASD is difficult; (b) people with ASD are socially unacceptable; (c) ASD leads to a lifetime of dependence on others; (d) independence is limited if not impossible; (e) people with ASD will never marry, have children, or being able to assist others in purposeful and effective ways; and (f) people with ASD are behaviorally inappropriate (Hall & Graff, 2010; Hedges et al., 2014; Lindsey et al., 2013).

Another form of stigma associated with ASD is within the school system. It is assumed that children with ASD disrupt the learning of the non-diagnosed children (Lindsey et al., 2013). For instance, educators and students observe and dislike behaviors such as flapping of the hands, self-injurious behavior, repetitive or mirrored verbal communication, need for sameness, sensory seeking, or avoiding tendencies. In addition, behaviors or blunt communication can be viewed as purposeful behavior when in fact, the child with ASD may not have the ability to verbally and effectively communicate. Children with ASD may lack understanding regarding social cues and engage in soothing behaviors when the environment is difficult to fully process (Nash & Nash, 2010). Hypersensitivity and hyposensitivity to external stimuli cause reaction-based behaviors in
an effort to regulate and bring the body back to homeostasis (Elwin, Ek, Kjellin, & Schröder, 2013).

Individuals with ASD may engage in repetitive behaviors, repeat words (i.e., echolalia), insist on maintaining a routine, and display inappropriate social behavior (Turner, 1999). There are multiple theories about why certain behaviors occur; however, causation remains undetermined (Turner, 1999). One explanation for the aforementioned behaviors is that individuals with ASD use the behaviors to regulate a homeostatic state when sensory stimuli exceed the ability to process the stimuli. Additionally, this method of regulation allows for control over sensory stimuli. Another explanation for behaviors commonly used by those with ASD is that the person desires control over a situation hopes to receive attention. Yet, the concept of operant behavior suggests behaviors are exhibited and reinforced in a manner that perpetuates the behavior, but the behaviors are not necessarily controlled by the individual. Instead, behaviors become habitual without an understanding as to why the behavior began in the first place (Turner, 1999). Additionally, an individual with ASD may be unaware of the reason for behavior, but the individual may be innately motivated or compelled to engage in the behavior. Typically, behaviors identified as characteristic of ASD manifest in unfamiliar situations or undesired situations (Turner, 1999).

Children and adults with ASD look like everyone else. People notice the behavioral symptoms associated with ASD and make assumptions or place judgment on parents or caretakers of children with ASD (Kuhn & Carter, 2006). When adults care for children with ASD, they may be subjected to criticism and ridicule when a child engages in an attention-seeking behavior. This stigma affects a caretaker’s stress level and takes a toll on the caretaker’s well-being.
The Impact on Caretakers

The impact of ASD on a parent or caretaker is recognizable when a caretaker begins to notice sensory related behaviors in early childhood that affect the relationship between the child and the caretaker, other children, other adults, and the child’s environment (Emerson, et al., 2016). For example, parents may feel less attachment to the child, desire to help the child without confident knowledge of how to help, and lack necessary support and resources. In addition, resentment and exhaustion may develop due to caregiving demands and financial hardship. The financial responsibility for services, supports, and insurance do not necessarily cause additional stress for caretakers unless the caretakers were already financially burdened prior (Hartley, Papp, Blumenstock, Floyd & Goetz, 2016).

Parents can experience guilt about the child’s diagnosis, severity of impairment, and perceived inability to effectively parent (Neely-Barnes et al., 2011). Neely-Barnes et al. stated this guilt can be traced to the first ASD studies where parents were accused of poor parenting skills that either caused ASD or increased the severity of the diagnosis. Since then, research clearly shows that parents are not to blame for a child’s ASD diagnosis, and the cause of the disorder (while still not definitive) is due to other factors. Although research is clear, parents still experience feelings of guilt as a result of continued community misperception and a lack of understanding among extended family members (Neely-Barnes et al., 2011). While many parents feel a sense of guilt due to perceived inadequacy of parenting skills, parents of children with ASD experience a greater prevalence and severity of guilt and stress (Kuhn & Carter, 2006). Parents of children with ASD have an increased risk of developing depression and anxiety due to the implications of an ASD diagnosis. Developing parental self-advocacy decreases guilt, anxiety, and depression among parents of children with ASD (Kuhn & Carter,
Researchers define parental self-advocacy as perceived competency in the role of the parent. According to Kuhn and Carter, parents are increasingly included in the treatment of a child with ASD to increase parental knowledge and feelings of competency.

**Stress.** As a result of the stigma associated with ASD, parents and caretakers develop a considerable amount of stress (Hartley et al., 2016). This stress has an impact on relationships with significant others, children, and other individuals outside of the family. Research shows that caretakers experience exhaustion when burdened by behavioral issues and costs associated with ASD (Hartley et al., 2016). The financial burden was the most significant factor related to parental separation or divorce when parenting a child with ASD. In contrast, financially secure parents reported martial success when caring for a child with ASD. Frequently, a caretaker is unable to work full-time outside the home while caring for a child with ASD because of the constant supervision and needed support. This need creates substantial stress for families with limited financial resources (Hartley et al., 2016).

According to Hall and Graff, (2010) parents frequently think about the future of a child with ASD and the inability of the child to live independently. Parents may experience excessive worry and anxiety because the well-being of the child with ASD is dependent upon the parental ability to provide adequate care. Additionally, parents are worried about providing the “right” care for the child, which adds even more stress. Some parents compensate for the child with ASD, and some are determined to treat the child as if the diagnosis does not exist.

Within the educational system, Hedges et al., (2014) found that caretakers experienced difficulty maintaining the same level of care throughout elementary, intermediate, and high school years. Confidentiality can have a negative and stressful effect on all caretaking parties when plans are developed and not shared with those involved in supporting the child with ASD.
That is, confidentiality standards must be maintained, and when the child becomes an adolescent, he or she will have several teachers that may not be educated or fully equipped to assist every student diagnosed with ASD (Hedges et al., 2014). At times, due to the diffusion of responsibility within the school system, parents experience increased stress because their child does not meet educational requirements even with an individualized education plan (IEP) to assist the child in meeting those requirements (Hedges et al., 2014). Parents express confusion and frustration when faced with the concept of confidentiality in this situation because they dedicated the time to make sure the child would meet the requirements.

Parents reported that they feel unsupported by the educational system because of the continual explanations for necessary support, continual efforts to connect with teachers, and constant efforts to maintain a consistent level of education within each class (Hedges et al., 2014). In addition, once the child graduates, parents experience stress associated with future education, careers, or living arrangements.

Hedges et al. (2014) stated parents of children with ASD continually advocate for the same opportunities as those without ASD. Opportunities include the ability to attend college or pursue a career after high school. Students with ASD frequently do not receive post-secondary education due to the environmental changes and the change in expectations (Hedges et al., 2014). Parents argue that high school does not adequately prepare children with ASD for the transition into the “real world.” Many young adults with ASD (depending on the severity of symptoms) either continue to live at home or transition into a group home setting (Hall & Graff, 2010).

**Individual Psychology**

In 1911, Alfred Adler, who had been an esteemed associate of Freud, broke away from Freud’s psychoanalytic view of the mind and human nature (Ansbacher & Ansbacher, 1956).
Adler began to look at human striving as a means of power attainment within a social context where the individual moves in a forward motion toward a goal (i.e., a subconscious fictional goal formed during early childhood). According to Ansbacher and Ansbacher, Adler’s theory of Individual Psychology placed extensive emphasis on autonomy in the tasks of life (social, love, and work). The tasks of life are based on perceptions of the world and the first social interactions with caretakers to meet the basic need to belong, feel significant, and contribute to society. Through early childhood experiences, the individual developed his or her identity in society and acted according to the fictional goal that enabled the individual to belong, feel significant, and contribute to society (Ansbacher & Ansbacher, 1956). Two additional tasks have been added to the tasks of life and include: spirituality and self (Gold & Mansager, 2000).

Fulfilling the life tasks is based on the individual’s subjective interpretation of his or her well-being within the constructs of social interest (Ansbacher & Ansbacher, 1956). According to Vaughan (1927) when an individual begins to strive toward fulfilling the tasks of life without social interest, neuroses develop. When the individual develops neuroses and continues to strive without social interest, the potential exists for the individual to become psychotic (Vaughan, 1927). The lack of social interest can stem from a concept known as organ inferiority. Organ inferiority refers to an individual’s organ deficiency and the compensation for the deficiency to meet a perceived homeostatic state (Vaughan, 1927). For example, the inferiority causes discouragement and through compensation the individual feels that he or she will feel superior after reaching a goal. The goal is created from the individual’s private logic and private logic is developed from a mistaken belief (e.g. “If I meet my goal I will be worthy of love” or “If I figure the meaning of my existence then I will be able to find the right job”). This inward focus can lead to striving on the useless side of life (Vaughan, 1927).
Shifting the goal from self-interest to social interest is the aim of an Adlerian therapist (Huber & Zivalich, 2004). In addition, an Adlerian therapist will empower the client to move forward on a horizontal line of movement (equality) toward the future versus a vertical line of movement (inferior to superior). Clients are encouraged to develop new insight and apply it to life. Adlerian therapists frequently use early recollections and dreams to reshape meaning and mistaken beliefs (Pomeroy & Clark, 2015). The use of early recollections (memories) and dreams allows the clinician to gain an idea of the client’s perspective and to empathetically help the client let go of negative experiences. The client is viewed as the expert of personal experiences and is allowed to process and develop insight at his or her own pace.

In Individual Psychology, a lifestyle analysis covers every area of the client’s history and experience (Ansbacher & Ansbacher, 1956). Therapists will continue to add information to this analysis for the duration of the therapeutic sessions. The lifestyle analysis is used to uncover mistaken goals or beliefs, fictions, and cognitions of how the world is, and how men and women should be. Ultimately, the client determines what fictions inform his or her private logic (Vaughn, 1927).

**Life Tasks**

The life tasks as described within Individual Psychology include: social, love, work, spirituality, and self (Gold & Mansager, 2000; Griffith & Powers, 2007). Adler described the tasks of social, love, and work inherent upon birth (Griffith & Powers, 2007). These tasks are fulfilled through a social context (Ansbacher & Ansbacher, 1956). Consequently, depending on the individual’s focus, certain areas of life may flourish while others are may not contributing to unhappiness in certain areas of life.
Social. The embedded need to develop friendships and alleviate the dissatisfaction of loneliness generates a social life task (Ansbacher & Ansbacher, 1956). More primitively speaking, the desire to be social is based on meeting the desire for belonging, significance, and safety. The process of reproduction and survival of the species relies on the social task. To meet basic needs, humans must interact (Ansbacher & Ansbacher, 1956). The ability to meet this life task dictates overall well-being and the difference between neuroses or psychosis (Vaughn, 1927). The other life tasks, although listed as separate tasks, provide further clarity on how social interest affects all aspects of life. Interactions and the motivations behind interactions, affect how one strives forward within the social task (Scott, Kelly, & Tolbert, 1995). Decreased social interest increase the risk of mental health disorders (Ansbacher & Ansbacher, 1956).

The DSM-5 criteria for ASD includes the aversion to social interaction or perceived impaired social interest (APA, 2013). For example, communication differences, behavioral inappropriateness, and blunted affect have an impact on the ability to function at a socially appropriate level. The research also states that people perceive those with ASD as lacking in empathetic communication skills and the ability to interpret aspects of communication such as humor or sarcasm (Nash & Nash, 2010). While children and adults with ASD can learn to cope with communication and other various social difficulties, successful social interaction necessitates opportunities and reactions from others that provide continual motivation for social interaction (Hedges et al., 2014). Unique differences in social interaction with others provoked inquiry and the development of an ASD disorder classification (Lyons & Fitzgerald, 2007).

Work. Ansbacher and Ansbacher (1956) stated Adler defined the work task as the need to contribute to society in some capacity that promotes societal progress. The work task begins for many individuals in an educational setting. The motivations for work during the early
Educational years of a person’s development are influenced by parents and other members of society (Del Corso, Rehfuss, & Galvin, 2011). No one can force anyone to fully contribute; however, most understand the consequences if they do not contribute and this becomes a driving force for the individual. The work task necessitates the need to be; therefore, an individual must develop skills and flexibility that enable him or her to function within an unpredictable social context and fulfill the work task (Del Corso et al., 2011). According to Del Corso et al. individuals should have: (a) initial concern for helping society, (b) control to make decisions, (c) curiosity to spark interest, (d) confidence to act, (e) commitment to cope with uncertainty, and (f) the ability to cooperate with others.

The domain in which one decides to work; however, is based on interest that is motivated by movement toward an individual’s private logic (Del Corso et al., 2011). For instance, Adlerian therapists focus on areas of interest via life themes to help clients achieve career or “life assignments.” For individuals with ASD, both verbal and nonverbal communication should be considered when addressing the life task. For example, non-verbal children with ASD may use sign language, pictures, actions, and various sounds to assess areas of focus and interest (Lindsey et al., 2013). The nature of ASD in general may make identifying interest slightly easier because it is associated with initial diagnosis of the disorder (narrowed or varied interests). For an individual with ASD, social interest and the ability to cope in changing environments is challenging; however, given the proper support, it is attainable (Huber & Zivalich, 2004).

**Love.** The task of love is arguably the most primitive task because of closeness desired at birth from an infant’s mother (Griffith & Powers, 2007). The desire for closeness represents the need for a relationship with another and is perpetuated through the display of affection (Scott et al., 1995). Through the basic need to feel close (e.g., skin-to-skin contact, breastfeeding, etc.)
children are conceptualizing the feelings associated with intimacy and the need to be social. Proper development of feelings of love and intimacy are being formulated in these early years of childhood and set the stage for later relationships (Scott et al., 1995). If a child does not develop a healthy bond with his or her mother or caretaker, there is a risk of future complications including the inability to love another in a healthy way (Ansbacher & Ansbacher, 1956). For example, American cultural expectations regarding couples typically include an expectation for a monogamous relationship; however, if an individual cannot develop the interpersonal skills, respectful social skills, or problem-solving skills, it may be difficult to maintain a monogamous relationship. According to Ansbacher and Ansbacher (1956), when Adler when gave advice to his daughter, he stated she needed to promote selflessness, and maintain equality through a mutual selflessness, with her husband. As a result, selflessness perpetuates a way of being with others that can manifest in social movement.

Griffith and Powers (2007) stated parents’ guide and educate children regarding intimacy with others through the use of the senses, and in turn, the child receives and returns affection. When the physical senses are impaired due to either fetal development, lack of parental affection, or other outliers, it can disrupt proper maturity in the task of love (Ansbacher & Ansbacher, 1956). Children with ASD have sensory issues that can negatively interrupt the process of growth in this area (Elwin et al., 2013). Sensory issues can have a lasting impact on the task of love, and ultimately, the social task. Sensory differences would not mean that a child or individual with ASD cannot love or display affection, instead, the child or individual may not adhere to cultural norms regarding love and the intimate display of affection.

**Spiritual.** The concept of spirituality refers to the belief that there is something greater than oneself and the world (Dreikurs & Mosak, 1966/1977). According to Dreikurs and Mosak,
the spirituality life task refers to the belief in the cosmos, the universe at large, and the idea that there is a grand design or creator responsible for the people, animals, and objects in the world. Questions associated with the spiritual task usually relate to questions regarding the purpose of life. The spirit is the essence within the physical form that allows one to use his or her mind (Gold & Mansager, 2000). While founding theorists typically ignored spirituality within the realm of psychology, the impact of spirituality on goals and personality made spirituality more applicable within psychology (Gold & Mansager, 2000). Therefore, spirituality helps an individual formulate ways of being based on an internal compass partially dictated by beliefs in a greater power.

The spirituality life task can correlate with expectations and beliefs associated with the perception regarding the causality of mental disorders, specifically, ASD and intellectual disabilities (Salkas, Mañana, Marques & Mirza, 2016). Salkas et al. found the average Christian religious belief was that ASD and intellectual disabilities are part of “God’s plan” and children are a blessing from God. Additionally, those who maintained a faith-based point of view experienced less stressed and focused on controllable variables of an ASD disorder. Although less common, Salkas et al. found some Christian parents ascribed a negative connotation to ASD and viewed ASD as punishment from God. Salkas et al. stated religious parents were less likely to seek support and resources and left the outcome to fate or “God’s will.”

**Self-care.** More recent than the other life tasks, the self-care task became a fundamental task because of the need to maintain physical and emotional health and to prevent discord within the other life tasks (Myers, Sweeney, & Witmer, 2000). As society advances, so do the demands placed on individuals within society. Myers et al. suggested people must intentionally monitor self-happiness and well-being to avoid disrupting the happiness and well-being of others. Stress-
reducing activities decrease increase the ability to reach full potential and contribute to the community (Myers et al., 2000).

Strategies for maintaining self-care can be difficult for people with ASD depending on the severity of symptoms, age, and other associated disorders (Nash & Nash, 2010). The self-care life task presents unique challenges to people with ASD. For example, Elwin et al. (2013) found those with ASD suffer from hyper or hypo sensory differences that can cause an overwhelming amount of stress. Sensory differences exist among all individuals with ASD, but not every individual with sensory differences has ASD (Prykanowski et al., 2015).

Children and individuals with ASD suffer from irregularly developed sensory organs (Elwin et al., 2013). Because of sensory differences, a child with ASD may experience sounds, lights, textures, tastes, and smells more or less intensely than the average child on a normal developmental trajectory (Elwin et al., 2013). When this happens the child will begin to self-sooth or attempt to regulate the discomfort through aversion or sensory seeking behavior. Focusing on limited interests is another way to regulate stimulation and control environment (Hartshorne & Herr, 1983; Nash & Nash, 2010). In an effort to regulate surroundings and the interaction with others, some people with ASD may shows signs of behavioral regression. In addition, people with ASD may require monitoring of physical self-care because of sensitivities to food that could cause nutritional deficiencies (Rogers, Magill-Evans, & Rempel, 2012) or the lack of sensitivity to certain stimuli, such as temperature, that could lead to safety concerns (Nash & Nash, 2010). In an effort to maintain physical and mental health, coping strategies, such as routine picture boards and social stories, can reduce stress and increase independence (Lindsey et al., 2013).
Organ Inferiority

When organic material does not develop appropriately, or matures at a slower rate, there is a perceived inferiority when compared to advanced or appropriately developed organic material (Ansbacher & Ansbacher, 1956). Adler made a case for Individual Psychology based on this concept (Nash & Nash, 2010). That is, given the infinite possibility for different anomalies, an individualistic approach was necessary to assess organ inferiority. When one part of the body is deficient, the body and mind self-correct to compensate for the inferiority (Hartshorne & Herr, 1983). Ansbacher and Ansbacher (1956) stated organ inferiorities originate at conception as well as later in life as the result of an unfortunate experience (i.e., an accident). The mind and body attempt to compensate for the inferiority and return to a homeostatic state of well-being. Overcompensation can occur when the mind and body continually focus on the deficit and private logic (or mistaken goals) begin to dictate an individual’s way of being in the world (Ansbacher & Ansbacher, 1956).

Mistaken Goals

An individual’s lifestyle determines how he or she will strive toward life goals. According to Adler, children create a style of life at age 2, and by age 6, establish perceptions about how the world works, how others are, and how they fit in the world (Ansbacher & Ansbacher, 1956; Scott et al., 1995). Children conceptualize male and female roles and act in accordance to how they experienced such roles (Ansbacher & Ansbacher 1956). Mistaken goals are defined by an individual’s private logic and the comprehensive understanding and categorizing of life experiences during early years of childhood. When a child feels discouraged, he or she will strive to reach a state of superiority through power, attention, or revenge (Griffith & Powers, 2007). Some children feel inadequate and succumb to a feeling of hopelessness
When children feel worthless, unloved, and insignificant, these feelings contribute to mistaken goals. In contrast, encouraged children seek goal attainment through problem solving, cooperation, and an interest in social contribution.

Children and adolescents achieve self-worth through friendship (Kasari, Locke, Gulsrud, & Rotheram-Fuller, 2011). Kasari et al. found children with ASD were more likely to experience difficulty developing relationships that included companionship, intimacy, and affective closeness. In addition, Kasari et al. stated many adolescents with ASD do not define themselves within the context of friendship and may have difficulty understanding and defining friendship. Although adolescents with ASD did not report a decreased number of quality friendships, Kasari et al. noted this could be because adolescents with ASD have fewer friends, but place higher importance on those friendships. Kasari et al. suggested assessment and exploration of friendships could help individuals with ASD learn how to contribute and cooperate with others. Overall, Kasari et al. noted a lack of friendship was associated with higher percentages of perceived loneliness and depressive affect.

**Early Recollections**

One way to determine an individual’s convictions and affirmations about the self, the world, and others within the world is through a technique called *early recollections* (Ansbacher & Ansbacher, 1956). An early recollection is a past memory from early childhood and described to the therapist (Griffith & Powers, 2007). The clinician will ask follow-up questions to clarify and elicit additional information regarding emotional responses. The therapist will ask the client to recall the most vivid image within the memory. This information is then assessed for private logic and symbolism related to the client’s style of life. An Adlerian therapist will describe client strengths to affirm and validate the client’s self-perception, view of others, and how he or
she perceives the world (Griffith & Powers, 2007). The therapist will allow the client to maintain a sense of control, lead the process, and determine whether life views are correct or incorrect (Pomeroy & Clark, 2015). This process of exploring an early recollection can encourage a client to gain insight, assess how he or she came to conclusions in life, and provide motivation for change. Early recollections enable self-efficacy and create an ambiance of equality as the therapist obtains increased understanding about the client’s inner motivations and striving (Pomeroy & Clark, 2015).

Memory recall may be different for individuals with ASD. For example, an individual with ASD may have difficulty remembering social content (Brezis, Galili, Wong, & Piggot, 2014). The plausible reason for inability to remember social content would be that individuals with ASD experience and interpret social interaction in a different manner than neurotypical peers. The individual with ASD may recall memories that neglect social content and focus on factual details. It is more difficult for individuals with ASD to recall feelings of self and others unless emphasis had been placed on labeling or naming the emotion (Brezis et al., 2014). For instance, it may be easier to remember a word rather than the emotion; however, Brezis et al. stated individuals with ASD have the ability to improve social content recall within an appropriate environment, support, and structure.

**Movement**

The law of movement within an Adlerian context describes an individual’s actions in relation to getting from one point to the next (Griffith & Powers, 2007). For instance, an individual is physically moving and responding to thoughts with the intention to create an improvement upon perceived circumstances. Movement encompasses the mind and body and directs the individual to move from moment to moment. During movement, a person will
engage in continuous problem solving to obtain a state of felt plus, or rather, a sense of worthiness (Griffith & Powers, 2007; Wingett & Milliren, 2004). When individuals feel “stuck or lost” within movement, they experience a felt minus (i.e., a feeling of inferiority or worthlessness). Social interest is a critical piece in managing successful forward movement (Griffith & Powers, 2007). Without social interest, an individual becomes self-interested and attempts to move toward an unsatisfying feeling of superiority (i.e., felt plus). In a state of felt plus, mistaken goals provide hope that a particular experience, tangible object (e.g., money, house, car, etc.), or person will lead to feelings of worthiness or a fictional felt plus (Griffith & Powers, 2007). Adler stated all humans are inherently worthy at birth, regardless of his or her circumstances (Ansbacher & Ansbacher, 1956).

**Current Interventions**

Treating individuals with ASD can be cumbersome because of the inconsistency of the severity of ASD symptoms (APA, 2013). Treatment interventions are aimed at providing individuals with the necessary means to manage symptoms. The ASD symptoms will persist; however, effective interventions allow those with ASD to engage in daily life functions (Nash & Nash, 2010). Some of the current interventions are used to treat co-occurring diagnoses such as anxiety, depression, and ADHD, behavioral symptoms such as social delays, motor skills, and physical sensitivities, and cognitive or intellectual disabilities. Spillane-Grieco (2000) stated family members could benefit from interventions designed to address issues such as lack of parental attachment and stress-induced anxiety or depression. Therapeutic interventions do not guarantee symptoms will subside and the progress can be slow (Leaf et al., 2016). Without intervention, symptoms continue to affect daily functioning and could increase over time, damage relationships, and prevent achievement of full potential (APA, 2013). Varied
therapeutic interventions exist and have mixed reviews within the literature, which suggests the need for additional research to determine the validity of the approach (Losinski, Sanders & Wiseman, 2016; Davis et al., 2013).

**Cognitive Behavioral Therapy**

Cognitive behavioral therapy (CBT) involves the restructuring, reorganizing, reevaluating, and redefining of experiences (Grumet & Fitzpatrick, 2016). Grumet and Fitzpatrick stated CBT is most often used to reduce symptoms related to anxiety or depression. Cognitive behavioral therapy is a variation of talk and exposure therapy that involves clinical judgment, assessment of an individual’s ability to deal with experiences that trigger dysregulation, and the client’s ability to change behavior (Grumet & Fitzpatrick, 2016). The client receives education, experiential opportunities, and techniques to encourage insight. Through exposure to new experiences, the client attributes new meaning to the experience. This ascribed meaning enables (or disables) future engagement in similar experiences. One limitation of CBT is that there can be little to no client improvement unless the client exhibits a moderate amount of motivation to change (Grumet & Fitzpatrick, 2016). Grumet and Fitzpatrick found a decreased success rate among clients with cognitive delays or those mandated to participate in therapy.

**Applied Behavior Analysis**

Applied behavior analysis (ABA) is an evidence-based treatment approach used to analyze behavior (Leaf et al., 2016). In addition, through the use of ABA, therapists determine productiveness of behavior and if the behavior will achieve desired results (i.e., the client’s treatment goals). The clinician attempts to determine causality of behaviors, and through reinforcement, attempts to replace inappropriate behaviors with socially appropriate behaviors.
Leaf et al. stated ABA is typically used when individuals struggle with a disability. For example, the goal is to manage behaviors, engage in behaviors that will meet one’s needs, and maintain behavior that will improve social functioning. Leaf et al. suggested with appropriate motivation, behaviors become habitual over time. Additionally, the key to long-term success is the utilization of an appropriate means of reinforcement.

**Parent-Child Interaction Therapy**

Addressing parent and child interaction is a crucial element in dissolving problematic behavioral issues with children (Cooley, Veldorale-Griffin, Petren, & Mullis, 2014). Although it may be unintentional, parents may contribute or amplify problem behaviors that cause conflict within the family. Parent-child interaction therapy (PCIT) is a behavioral approach used to encourage desired behaviors and decrease resistance (Cooley et al., 2014). During PCIT, parents are trained to interact, communicate, set expectations, and provide logical and natural consequences for children engaging in misbehavior. Cooley et al. stated PCIT eventually becomes preventative in nature. Parent-child interaction therapy is geared toward children between 2 years and 6 years and 11 months (Cooley et al., 2014). The PCIT therapy is highly structured and repetitive making PCIT applicable for children with ASD (Lesack, Bearss, Celano, & Sharp, 2014).

Lesack et al. (2014) emphasized the assessment of behavior during PCIT. For instance, the clinician is constantly coaching and training parents to engage in specific ways during interactions (e.g., labeled praise, behavioral descriptions, and reflections for desired behaviors). Lesack et al. stated parents are to avoid negative remarks and questions or commands directed toward the child. In addition, parents will have structured settings including designated areas for natural consequence (e.g., time out chair, time out room). The PCIT therapy process moves from
the office to the home after requirements are met in a monitored setting. Lesack et al. explained potential exists to monitor PCIT within the home when clients are unable to go to an office due to varying circumstances (e.g., unable to travel, lack of transportation resources).

**Sensory Therapies**

Developed in the 1970’s by Jane Arye, sensory integration therapy (SIT) is a relatively new method of used to address physical needs that, in turn, alleviate emotional and behavioral impairment (Schaaf & Miller, 2005). Schaaf and Miller believed emotional and behavioral impairment can affect the social functioning of a child. One theory behind SIT therapy is that a hyper or hypo sensitivity can cause an individual to manipulate his or her own behaviors in an effort to bring the body back to a state of homeostasis (Schaaf & Miller, 2005). Schaaf and Miller stated occupational therapists began treating symptoms associated with sensory processing disorders with different forms of sensory stimulation in an attempt to reduce behaviors associated with impaired daily functioning. Currently, the literature does not fully support the claim that SIT effectively reduces abnormal behavior (Schaaf & Miller, 2005). Regardless, Schaaf and Miller reported parents and professionals observed differences in behavior after services aimed at meeting an individual’s sensory needs.

One technique used within SIT is deep touch pressure which typically incorporates the use of weighted garments such as vests, brushing (i.e., brushing arms, legs, etc.), and swaddling (Losinski et al., 2016); however, Davis et al. (2013) stated sufficient evidence does not exist regarding the usefulness of a weighted vest. Davis et al. reported a lack of standards regarding the required amount of time to wear the vest, when to wear the vest, etc. The inconsistency regarding requirements of use and differing sensory needs contribute to the inconsistent research in the use of weighted vests (Davis et al., 2013).
Strengths-Based Perspective

Carter et al. (2015) defined the strengths-based perspective as therapeutic intervention with a focus on the client’s positive attributes. Strengths-based therapists focus intervention on familial relationships, self-esteem, and transitional support to decrease conflict, co-occurring disorders, and increase resiliency, dedication, and self-advocacy (Carter et al., 2015). Diener, Anderson, Wright and Dunn (2015) suggested a strengths-based perspective is a shift from typical assessments that look closely at negative and undesired behaviors. Instead, strengths-based therapists promote effective rehabilitative strategies. Diener et al. found most disabilities and mental health disorders are assessed and diagnosed predominately through the lens of differences and areas that need improvement. As previously mentioned in this paper, children suffering from ASD are at risk for developing co-occurring mental health disorders such as anxiety and depression. Diener et al. found a strengths-based approach increased the positive outlook of parents, siblings, and clients with ASD.

When students with ASD want to transition into life after high school, Carter et al. (2015) suggested a strengths-based perspective to facilitate the development of individual education plans (IEPs). Due to the decrease in available supports, Carter et al. proposed a person-centered approach to IEPs to better prepare students for the transition after high school. A strengths-based IEPs may increase the amount of opportunities to practice and develop strengths and talents (Carter et al., 2015).

Discussion

Given the prevalence of ASD, and implications of ASD symptoms, a holistic intervention can decrease stress and assist with symptom management within all areas of life. Autism spectrum disorder has an impact on individuals, parents, siblings, and the community. For
example, when an individual is diagnosed with ASD, people invest money, time, energy, and resources into managing symptoms associated with the disorder (Lindsey et al., 2013).

Meeting the needs of individuals through interventions such as CBT, behavioral therapies, sensory related therapies, and strengths-based therapy can assist with managing symptoms of ASD. Therapists have to decipher and experiment because every individual with ASD is different. Therapists must consider personal traits, past experiences, familial support and understanding, level of motivation and cognitive and intellectual abilities. When interventions and services are implemented during early childhood, people with ASD (and family members) experience greater resiliency (Van Daalen et al., 2009). Collaboration, consistency, sameness, and routine are key features associated with ASD symptoms and are key features of successful intervention and progress (Ravindran & Myers, 2012).

Incorporating a person-centered, strengths-based perspective within services for those diagnosed with ASD could eliminate negative perceptions and improve healthy relationships among family members. Adlerian theory and intervention is aimed at reducing feelings of inferiority and encourages empowerment (Huber & Zivalich, 2004). If provided the opportunity, individuals with ASD may be able to contribute to society, utilize personal strengths, increase independence, and deter costs of services. If symptoms are managed and viewed differently during early childhood, individuals with ASD can feel comfortable contributing and engaging with others (Nash & Nash, 2010). Contribution could promote a feeling of significance and belonging and eliminate the ostracizing behavior experienced by many individuals with ASD (Hartshorne & Herr, 1983).

As previously discussed, many children with ASD experience an array of symptoms including: verbal language difficulties, intellectual impairment, sensory regulation difficulties,
and decreased motor skill capabilities (APA, 2013). Finding the right intervention for children with ASD can be difficult due to the changing developmental status of the child. Parents and caretakers frequently need additional support when raising children with ASD. Preventative support services could contribute to a decrease in stress and mental and physical health concerns for those caring for children with ASD.

**Implications for Practice**

Therapists can provide an effective means of intervention to relieve current problems associated with ASD using the proposed templates. Individual Psychology is incorporated in the therapeutic process and contributes to an effective intervention designed to reduce parental stress associated with parenting a child with ASD. The first template could provide a structured tool for therapists to use throughout the intervention process. The second template could be used as a parent workbook with psychoeducational materials and activities for use within and outside of the intervention sessions. In addition, the parent workbook could be used as a reference when the intervention process ends. Because intervention can include the parent and family members, specific interventions should be modified to appropriately accommodate the parent and family.

This potential intervention tool is directed toward the parent and services can be initiated in two different ways. That is, parents could be referred with the child diagnosed with ASD, or parents could self-refer for mental health services. In the following narrative of the intervention process, the “client” will refer to either the child receiving an ASD diagnosis, or a parent engaging in a separate assessment. Parental consent is required to engage in services with a child and building rapport with the parent, child, or family is the goal of the initial therapeutic process.
**Intake part one.** The therapist gathers general information about the client. The therapist completes a diagnostic assessment that includes the identified problem, a history of previous services, a current medical history, prescribed medications, family history, substance use history, and cultural considerations.

**Intake part two.** The therapist and client review the assessment and recommendations for services. Recommended family sessions would be noted and discussed. At this point, the client and therapist determine if services are appropriate at this time. If deemed appropriate, and the client agrees to participate in services, the counselor explains policies, rights, expectations, and costs of services. The therapist would complete a brief overview of Adlerian psychotherapy and provide the parent workbook used in conjunction with the counseling process.

**Session one.** The first session is designed to establish an initial baseline and the client’s therapeutic goals. In this counseling process, the baseline will be determined by the completion of a modified version of the wheel of wellness (Meyers et al., 2000). The parent will rate the tasks of life from 1 to 10 (10 as the best possible score). Life tasks included on the wheel of wellness are: spirituality, self-direction, work and leisure, friendship, and love (Meyers et al., 2000). After the baseline is established, the parent will complete a journal exercise to reflect on the score for all life tasks.

**Session two.** Session two begins with the client choosing a life task he or she wants to address. Typically, the parent and therapist review the wheel of wellness ratings (Meyers et al., 2000) and decide which life task causes the most distress. The parent is encouraged to discuss current emotions and behaviors that contribute to the level of stress. If the parent has a difficult time discussing emotions or behaviors that contribute to stress within a life task, the therapist will engage the parent in an early recollection (Griffith & Powers, 2007). As mentioned above,
the therapist records the memory word for word and asks additional questions such as: “What is the most vivid image from the memory?” and “What emotions do you associate with this memory or the particular image you selected from within the memory?” The parent’s answers to the questions, and the memory itself, are used to draw conclusions about how the parent views the world, self, and others. In addition, the therapist facilitates a discussion regarding mistaken beliefs and goals (Ansabacher & Ansbacher, 1956).

**Session three.** The therapist and parent review mistaken beliefs and goals and begin to examine the current impact of the early recollection on emotions and behaviors. The parent and therapist explore the impact of emotions and behaviors on relationships within the family, especially the relationship between the parent and child with ASD, friends, and the community. The therapist and parent complete a genogram to visually depict family relationships and documents any dynamic changes or critical life events.

**Session four.** The parent will complete the first activity in the parent workbook, examine established goals, and decide if goals have changed since session one. The number of goals established should remain reasonable with no more than one goal per life task on the wheel of wellness (Meyers et al., 2000). The therapist will focus on one to three goals, and brainstorm with the parent about possible options to achieve the goals. The therapist will present an overview of intervention methods and address questions.

**Session five.** The parent will complete the second activity in the parent workbook. The therapist encourages insight, personal responsibility, courage to confront worries and fears, and attempts to foster an increase in self-esteem. The therapist will choose a suitable therapeutic technique to facilitate horizontal movement (Griffith & Powers, 2007). Prior to the close of session five, the parent will complete a journal entry and discuss this with the counselor.
Session six. After the parent completes the third activity in the parent workbook, the focus during this session shifts from the parent to the child with ASD. Psychoeducation includes instruction regarding Adlerian parenting concepts regarding child behavior. Therapist and parent discuss misbehavior and the parent’s personal reaction to the behavior. The therapist and the parent practice co-regulation strategies (i.e. social stories, sensory related activities, reinforcement for desired behaviors, structured communication skills, and identifying strengths). The therapist encourages the parent to write a reflection about how he or she will use the techniques in the home. Prior to the end of the session, the parent will be asked to practice co-regulation skills, complete a journal exercise evaluating what did or did not work, list questions, and comment on personal insight.

Session seven. Therapist and parent review the homework assignment from the previous session and the parent completes the fourth activity in the parent workbook. Next, the parent learns skills directed at providing labeled praise, describing behavior, and reflecting the child’s appropriate behaviors and ignoring the inappropriate behaviors (Lesack et al., 2014). Additionally, the therapist teaches the parent how to eliminate commands and questions while communicating with the child during a child-led activity or playtime. Incorporating this PCIT technique dissolves the hierarchy within the relationship and enables the child to respond with behaviors that are both regulated and appropriate to gain positive attention (Lesack et al., 2014). Parents are asked to complete a journal exercise after every activity to evaluate the technique.

Session eight. After a review of the previous session and the parent completes the fifth activity in the parent workbook, the therapist and parent determine useful behavior that exists within the parent-child relationship. The counselor and therapist identify and problem-solve specific behaviors to increase useful behaviors through this use of categorization. If the behavior
is considered useless, the therapist and parent brainstorm possible ways to replace the useless behavior with useful behavior. The therapist will teach additional strengths-based techniques and practice the techniques during the session. The parent complete a journal reflection is asked to practice the techniques prior to the next session.

**Session nine.** As in previous sessions, the therapist will review information from the last session and ask the parent to complete the sixth activity in the parent workbook. The therapist’s focus during this session is self-esteem, overcoming guilt, and increasing confidence. Positive affirmations are identified for the parent and the child. The parent creates a positive power statement or personal motto designed to help with forward movement.

Through a strengths-based perspective, past situations and interactions are examined as evidence of what went well. While negative situations and interactions will arise, it is the therapist’s responsibility to redirect the parent and describe what is already working. The parent will identify personal hobbies, interests, and recreation outside of the parent-child relationship. Healthy outlets (e.g., exercise, events, talking with friends, engaging in personal interests) will be discussed. In this discussion, the therapist will encourage healthy stress reduction to lessen the tension within the parent-child relationship. The parent is asked to engage in at least one activity write a journal reflection to evaluate the effectiveness of the activity.

**Session ten.** The session begins with a review and the seventh activity in the parent workbook. During this session, the therapist will focus on how to conduct family meetings. The parent receives examples, outlines, information on various techniques used to lead the meeting. The session continues with a discussion regarding how the parent could integrate family meetings. Prior to the end of the session, the parent completes a reflection about thoughts or concerns about using the intervention. The parent and therapist present the family meeting idea
to the remaining family members and practice the intervention outside of session. The parent evaluates the family meeting in a journal entry to discuss in the next session.

**Session eleven.** After a review of the previous session and family meeting, the parent begins the final phase of counseling by evaluating progress and effectiveness of interventions. A new wheel of wellness assessment is completed and reviewed (Meyers et al., 2000). The parent is asked to complete a journal entry about the counseling experience. The counselor and parent address current concerns and determine if the established goals have been met. If goals have been met, the counselor and parent review additional resources and supports to continue maintenance of the achieved goal. A check-in date is scheduled to reevaluate the goals.

**Session twelve.** This final session includes the reevaluation of goals. The parent completes a new wheel of wellness (Meyers et al., 2000) and discusses questions, concerns, and overall progress. If new concerns arise, the therapist and parent determine appropriate action (e.g., additional individual counseling, family counseling, recommendations for other services, etc.). The parent keeps the workbook for future reference and ongoing maintenance of goals.

**Recommendations for Future Research**

To determine the usefulness and practicality of the proposed template and parent workbook, mental health professional could provide feedback through a focus group or survey. The feedback could then be assessed and applied to each template. Following a final revision of each template, an e-Book could be made available along with a published parent workbook. Additional research is recommended to determine the validity of the proposed intervention process.

In the literature reviewed for this project, research limitations include: A lack of research on the topic of parental stress related to ASD, research on valid sensory-related interventions, on
the use of CBT with individuals who have ASD, and limited research articles on the use of Adlerian theory with the ASD population. Future studies could address these limitations. Additional research would support appropriate ASD interventions in school, at home, and in the community. In addition, further research may increase resources and support from the community and promote a sense of safety, belonging, and significance for those diagnosed with ASD.

**Conclusion**

Helping parents and caretakers obtain the necessary and needed supports, services, and resources to adequately address ASD is an ongoing journey. The recommended Adlerian approach could assist families and children with ASD with symptom management and the alleviation of parent/caretaker stress. Through the lens of Individual Psychology, therapists could initiate a paradigm shift that leads to increased acceptance and understanding of those diagnosed with ASD.
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Appendix A
Template One
Appendix A

Template One: Counselors

Define Goal or Name the Problem

Determine Appropriate Services

1. Counseling
2. Coaching
3. Parent support groups
4. Parent education
5. Costs

Explain and Define Mental Health Professional’s Role

1. Provide Brief Overview of the Approach and Process
2. Obtain client agreement to participate
3. Build rapport
4. Determine therapist’s ability to proceed

Identify Severity and Causation of Stress

1. Complete an inventory on each area of life
   a. Life Task Wheel of wellness - rating 1-10
   b. Choose the areas that are the perceived lowest and do some further investigation as necessary.
2. Early recollection
   a. Complete if the client is unaware how his or her sense of being contributes to stress or undesired behaviors
3. Determine mistaken beliefs or goals
   a. Client determines mistaken beliefs or goals
   b. Determine undesired behaviors caused by belief
   c. Explore how mistaken beliefs or goals affect caretaker and child relationship, family members, friends, and community

Complete a Genogram

1. To assist with clarity and understanding

Review Original Goal or Problem

1. Hypothesize, brainstorm solutions for achieving goal or problem solving
2. Has the goal or problem changed?
3. How has it changed?
Incorporate Adlerian Methods of Intervention

1. To overcome inferiorities
2. To restructure thinking
3. To implement positive behavior changes
   a. Acting As If
   b. Empty Chair
   c. Crucial C’s
   d. Overburdening (vertical vs horizontal striving)
   e. Courage to be imperfect

Homework Activities

1. Crucial C’s – define Triggers
2. Equality boosting exercises
3. Automatic useful vs useless categorization of solutions and actions
   a. To dictate behavior management
4. Courage to be imperfect – journaling exercises and affirmations
5. Family meetings

Evaluate Progress

1. Determine appropriate check-in times
2. Determine schedule of sessions
3. Complete Life Task Wheel (rate 1-10) to determine current stress
4. What homework assignments are working? Which assignments are not working?
5. Review techniques as needed
6. Are there noticeable changes in the home?
7. Lessened or new behaviors?
8. Who is affected by the changes?
9. Resistance to change?

Determine Need for Family Sessions

1. Possible family session or two at the beginning of the process
2. To understand family relationships
3. Create a cohesive family Life Task Wheel (rate areas 1-10) to determine family stress
4. Opportunity for individual family members to create their own Life Task Wheel
   a. Self-assessment via journal entry (dependent on age and ability)

Reevaluation

1. Incorporate evaluation methods at given increments of time
Appendix B
Template Two
Appendix B

Template Two: Parent or Caretaker Workbook

Introduction

1. Identify goals
2. Life Task Wheel ratings
3. Brief explanation of ratings
4. How to document mistaken beliefs or goals
5. Journal entry for thoughts about mistaken beliefs or goals
6. Genogram key for genogram completion
7. How to document significant dynamic changes and life events

Activity One: Restate goal(s)

1. Knowing what you know now: Is your goal the same or different? Why?

Activity Two: Overcoming Perceived Inferiorities

1. Counselor led activity (Adlerian techniques: Acting as if, empty chair, affirmations, courage to be imperfect, etc.)
2. Journal entry on personal thoughts, insight

Parenting Education and Skills

1. Activity one: Identify triggers and understanding the child’s goals
   a. Crucial C’s
      i. Write reflection on how to incorporate at home, insights, etc.
      ii. Practice (implement at home)
      iii. Evaluate (what worked, what did not work, questions, insights, etc.)

Activity Two: Elimination of Perceived Inequality

1. Setting the stage for successful strategy implementation
   a. Adlerian version of PRIDE Skills (praise, reflect, imitate, describe, enthusiasm)
      i. Write reflection on how to incorporate at home, insights, etc.
      ii. Practice (implement at home)
      iii. Evaluate (what worked, what did not work, questions, insights, etc.)

Activity Three: Creative and Logical Problem Solving for Situations

1. Useful vs useless categorization of words, actions, and solutions
   a. Write reflection on how to incorporate at home, insights, etc.
   b. Practice (implement at home)
c. Evaluate (what worked, what did not work, questions, insights, etc.)

**Activity Four: Courage to be Imperfect**

1. Positive affirmations, healthy stress outlets
   a. Write reflection on how to incorporate at home, insights, etc.
   b. Practice (implementation at home)
   c. Evaluate (what worked, what did not work, questions, insights, etc.)

**Activity Five: Getting on Board**

1. Family systems approach to conducting family meetings and eliminating conflict
   a. Write reflection on how to incorporate at home, insights, etc.
   b. Practice (implement at home)
   c. Evaluate (what worked, what did not work, questions, insights, etc.)

**Evaluation**

1. Complete Life Task Wheel (rate 1-10)
2. Written reflection on reasons for ratings per life task
3. Additional questions
4. What parenting strategies worked the best, worst, need more practice?
5. Any areas needing clarification?
6. Did you reach your goal? Why or why not?
7. How confident are you with your new skill set?
8. Journal entry about experience, current feelings, insights etc.

**Reevaluation with Counselor**

1. Self-evaluation with Life Tasks Wheel and journal space