# Special section: School counselling

## 1

# A culture of care

## The pastoral care of high-functioning ASD students

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**Abstract**

**Autism Spectrum Disorder (ASD) is a pervasive neurological brain difference that primarily affects the way the brain receives, processes, and responds to sensory information. A familiar expression in the ASD community is to describe the disorder as a brain that is not "deficient" but "differently wired." Students with high-functioning autism experience challenges in the mainstream schooling environment due to delays or difficulties in two areas of development: social communication and abstract thinking skills. Co-morbidity with anxiety and depression is prevalent, and academic potential can be unfulfilled without adequate extra support. School-age high-functioning autism is diagnosed most commonly when the complex demands of the sensory, social, and academic environment exceed the child's capacity to cope. Therapeutic understanding of ASD is a developing field and thus far there is no "gold standard" approach in clinical treatment. Working with ASD students in a school environment requires a strengths-based, holistic culture of care. In addition to client therapy, school counsellors need to incorporate advocacy, education, connection with family, and strong links to outside services. Drawing on my own experience both as a parent with a 12-year-old ASD son and as a school counsellor, this article considers the clinical expression of ASD in the school setting and then looks at both research-based and practical approaches for enhancing the pastoral care of ASD students.**

**Keywords:** Autism Spectrum Disorder (ASD), Asperger's, anxiety, school counsellors, culture of care, pastoral care

More than 40,000 New Zealanders have been diagnosed with autism (approximately one in seventy people), with four times more males affected than females (Ministry of Health [MoH], 2016). To qualify for a diagnosis, onset must be evident in early childhood, although the symptoms may not manifest developmentally until later years when social expectations exceed capabilities (McPartland, Reichow, & Volkmar, 2012; O'Reilly & Wicks, 2016). Educational strengths may include visual learning, factual memory, and specialised interests, yet these may be overshadowed as the student struggles with social communication, organisational skills, abstract thinking, and sensory overwhelm (MoH, 2016). ASD students are more likely to be of average or high intelligence, potentially with exceptional ability in some areas and learning support needs in others. They tend to fall into the realm of coping with a "hidden disability"—their autism is not immediately visible yet the difficulties they face are significant. Anxiety underlies many of the behavioural responses that can cause distress for ASD students. Intensive research in recent years has led to a deeper understanding of the brain difference associated with ASD, but as yet there is no known singular cause or cure (MoH, 2016; Silberman, 2016).

Keri Opai (2017), a licensed Māori language interpreter, drew on his own experience with a close autistic friend to provide the Māori definition of autism—"takiwatanga"—which translates to "a person who experiences life in his or her own time and space." The capacity for parents, health professionals, educators, and peers to fully grasp that an ASD brain fundamentally interprets the world differently is a critical paradigm shift in understanding behaviour and communication considered "outside the norm."

This article discusses the counselling role and pastoral care of ASD students at the high-functioning (Asperger's Syndrome) end of the autism spectrum, acknowledging that individuals with severe autism are more likely to be assisted by Special Education Needs Coordinators (SENCOs) in specialised learning environments.

## History of ASD diagnosis

Looking back at unique individuals throughout history, autism has long existed in significant numbers; however, young autistic children were often confined to institutions with a diagnosis of childhood schizophrenia (Eyal, Hart, Onculer, Oren, & Rossi, 2010; Potter, 1933). Even as recently as 30 years ago, autism was still considered an obscure condition (Silberman, 2016). Hans Asperger, an Austrian paediatrician, first described the characteristics of what later became known as Asperger's Syndrome. His published articles were an attempt to protect the lives of his young patients from a Nazi law intended to terminate hereditary diseases (Frith, 2003). For many years, the work of Hans Asperger went unnoticed, in part because German writing post-World War II was not internationally acknowledged, and also due to the prevailing view that autistic children were a result of cold "refrigerator" mothers (Kanner, 1949; McDonnell, 1998; Short, 2005).

The *spectrum* of autism was not recognised until 1981 when Lorna Wing, a renowned psychologist and parent of an autistic daughter, challenged the narrow parameters of autistic psychopathy as defined by the "father of autism," Leo Kanner (1943). Wing (1981) coined the term Asperger Syndrome to account for children displaying the relatively high-functioning autism symptoms Hans Asperger had identified nearly 40 years earlier.[1]

The history of ASD is particularly relevant for counsellors who may need to address the popular discourse in the general public that we have seen an "explosion" of autism diagnoses. There is still an element of surprise that a condition that "didn't exist when I went to school" can now be so apparently prevalent. Following Lorna Wing's work, the introduction of broadened diagnostic criteria in the fourth edition of the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM-4)* (APA, 1994) had a significant impact on awareness, resulting in a dramatic increase in clinical diagnoses. This widening of the diagnostic criteria to accommodate a spectrum of symptoms now includes people who would previously have been inaccurately omitted from an ASD diagnosis.

In 2013, the APA released the *DSM-5*; in this edition the term Autistic Spectrum Disorder amalgamated the former subcategory disorders of Autistic Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) (MoH, 2016). What was previously a triad of symptoms has been reduced to two core areas of difficulty:

- Impairment in social communication and social interaction, and
- Restricted, repetitive patterns of behaviour, interests or activities.

People diagnosed with autism will be given a further subcategory of level 1 (high functioning), level 2, or level 3 (low functioning), reflecting their ability to manage their daily life, adapt to new situations, expand restricted interests, and communicate with others. Assigning levels is not only difficult but also subjective, ignoring the possibility of an individual's changing over time as skills improve and other issues (such as anxious reactions to stressful sensory environments) decrease (Auger, 2013). While the DSM definitions can be beneficial to give some structure and understanding around the behavioural traits of autism, Grandin and Panek (2013) encourage parents and therapists not to get locked into labels, stressing the importance of understanding each child's unique brain in order to respect their limitations and build on their strengths.

The language used to describe autism can be a divisive topic. As one autistic person commented, "Who wants to be labelled as a 'low-functioning' human being?" For many, including those with ASD who identify as "Aspie," the term Asperger's Syndrome is still legitimately used by clinicians, parents, teachers, and therapists. It is also worth noting that for many parents, the term Asperger's may feel more socially acceptable as a label for their child. As a rule of thumb, counsellors should adopt the terminology that the client or parents first use to refer to the young person's ASD diagnosis. Understanding that autism is inherent in a person's brain functioning can be reflected in the language we use to discuss ASD. An autistic person is likely to prefer to be called "autistic" rather than "a person with autism" (Grandin & Panek, 2013). We don't call a left-handed person "someone with left-handedness;" we accept they are inherently oriented to use their left hand when writing. While they may be taught (at some cost) a behavioural adaptation to use the right hand, their essential brain orientation prioritises the left hand.

The cause of ASD continues to be an area of research and exploration and is not the focus of this article. One point must be noted, though. A decade-long public health scare that connected vaccines to autism was the result of an infamous research paper published in 1998 in the *Lancet* (Wakefield et al., 1998). This research has now been fully debunked (Deer, 2011) and the article was retracted by the *Lancet* in 2010. Vaccines do not cause autism.

## The sensory-challenged ASD student in the school environment

### *Impairment in social communication and social interaction*

The social deficits of ASD present the greatest challenge for school-aged children and adolescents, particularly reciprocal social and non-verbal communication and verbal interaction (Auger, 2013; Goodman-Scott & Carlise, 2015). Social skills are critical to school engagement and impairment can affect both academic achievement and peer friendships. The social difficulties in part stem from an impaired "theory of mind," or a difficulty in taking others' perspectives (Auger, 2013). Tony Attwood (2015) describes theory of mind as "the ability to recognise and understand thoughts, beliefs, desires and intentions of other people in order to make sense of their behaviour and predict what they are going to do next" (p. 124). The ASD person's immature theory of mind, or "mind blindness," can incorrectly be perceived as a lack of empathy (Baron-Cohen, 2007). This stereotypical view of an "unfeeling" autistic demeanour is harmful to the sensitive ASD person who simply struggles to be able to read complex mental states or to recognise subtleties in social signals and facial expressions.

Learning to manage interpersonal relationships and interpret social cues involves skills that often do not proceed at a developmentally age-appropriate pace for ASD children. This can have significant implications for their ongoing mental health, friendships, and educational success and, all too often, their personal safety at school. Research investigating the prevalence of bullying in schools has shown that compared to neurotypical students, those with ASD are at an increased risk of peer and even teacher victimisation (Schroeder, Cappadocia, Bebko, Pepler, & Weiss, 2014).

Students start to lag even further behind in social involvement towards the end of primary school (Rotherham-Fuller & MacMullen, 2011). Reduced tolerance from neurotypical peers for an ASD friend with social differences, and an increase in situations involving unstructured and unsupervised play, can contribute to anxiety-induced isolation (Auger, 2013; Hutchins, 2012). Social interactions are confusing and often exhausting for ASD people and they will seek solitude to recover from the effort of processing these complex sensory inputs.

Internet friends have become an attractive alternative and Attwood (2015, p. 99) likens the internet to the "modern equivalent of the dance hall" for ASD people to meet like-minded friends. When conversing via the computer, a teenager can concentrate on the verbal exchange without being overwhelmed by confusing social demands and sensory signals. Multiplayer gaming enables ASD children to engage in online playdates, often with friends from school. There is, however, a real risk that ASD tweens and teens may rely on internet relationships to the exclusion of face-to-face interactions and, in the process, miss out on further developmentally appropriate social skills (Grandin & Moore, 2016).

### *Restricted, repetitive patterns of behaviour, interests or activities*

Cognitively, ASD people are able to accumulate large amounts of factual information and may display remarkable abilities regarding a topic of special interest (Baron-Cohen, 2003). Whereas neurotypical people will merely have a hobby, for ASD people their "hobby" may represent an intense fixated interest that dominates both their free time and their conversation, potentially becoming a barrier to social inclusion (Smith, Donlan, & Smith, 2012). Viewed positively, these special interests can be a way to relax and reduce anxiety, and they can also provide a sense of identity for the ASD person with low self-esteem (Sansosti & Sansosti, 2013). In counselling, engaging with a special interest can provide an opportunity for opening communication and building a relationship with the student.

While online gaming talent can facilitate respect and friendships for teenagers with ASD, left unchecked these online worlds can cause considerable disruption to the daily life of an ASD person who is likely to lack the self-management skills to moderate their compulsive interest. Auger (2013) highlights research that suggests that the majority of an ASD teenager's free time is spent on screen-related activities, which can lead to sleep disruption as well as physical and mental health complications.

As intermediate schools and even primary schools require students to have their own device for curriculum work, addictive and inappropriate screen use is becoming an increasing concern for ASD families. Parents report difficulties disengaging their ASD children from computer time, anticipating the extreme anger that will follow (Purkis, Goodall, & Nugent, 2016). A challenge for pastoral care teams is to appreciate the complexity parents face, especially around screen usage, and work to find creative interventions with families who need more supportive solutions. In my professional experience counselling a 14-year-old girl with ASD, I observed her gradual withdrawal from friends and family as her uninhibited attachment to her online world took over her life, while her caregivers felt powerless to stop it.

Rigid thinking and a resistance to change is a hallmark of the ASD mindset and can influence learning and education from an early age. Novel situations, modification to existing routines, and transitional change can create heightened states of anxiety and oppositional behaviour, reducing the ASD student's ability to absorb new learning. Understanding that routines, rules, and structure are safety mechanisms that provide a sense of stress-reducing predictability about the world is critical for pastoral care teams working with ASD students (Wilkinson, 2010).

### *Executive functioning challenges*

Many students with ASD struggle with executive functioning (the ability of the prefrontal cortex to execute complex tasks) which is a critical brain function for success in school and tertiary education. Executive functioning deficits affect planning, time management, organisation, prioritisation, inhibition, focus, task initiation (and persistence), transitions, working memory, and attention to detail (Perler, 2018). The challenges become more evident from Year 9 as the complexities of high school coincide with reduced parent involvement in daily school life. An ASD student who has survived the primary years with a caring teacher and/or parent acting as "executive secretary" may become overwhelmed in the demanding high school environment.

School refusal, especially around transitional change such as starting a new school, is one of the most common types of anxiety experienced by ASD children (O'Reilly & Wicks, 2016). The impact of transitions between primary, intermediate, high school, and the workforce cannot be underestimated. The combination of routine change, sensory overload, and greater expectations of self-management skills are significant for ASD students. These changes must be anticipated and carefully managed by the pastoral care teams at each school.

### *Sensory sensitivity*

Hyper- and/or hypo-sensory processing sensitivity is a significant complication for an ASD person navigating the school environment. Hypersensitive students will have a low threshold for the sensory stimulus of noisy and complex open spaces such as school playgrounds or assembly halls (Nader-Grosbois, 2011). Tactile defensiveness can be challenging in crowded hallways, while a sensitivity to smell in cafeterias and intense visual stimulation in classrooms may induce adverse behavioural stress responses. The stereotypical image of autistic hand-flapping or spinning is a coping mechanism called stimming that is an innate response to manage sensory overwhelm.

Hyposensitivity occurs when someone seeks out sensory information because they are underwhelmed by the world around them. This may manifest as excessively touching objects, speaking very loudly or out of turn, leaning on people or furniture to “find themselves in space,” or constantly putting objects in their mouths (Attwood, 2015).

These behaviours in the close confines of a school classroom can negatively impact how the ASD student is perceived by others. Living in a world of potentially terrifying sensory experiences can result in students becoming hyper-vigilant, contributing to the extreme or seemingly unprovoked reactions to stimulus. Pastoral-care-led education can help students and teachers to understand these responses, reframing them as adaptive behaviours that enable the autistic person to self-regulate, and looking for solutions to make the environment more ASD-friendly.

### *Co-morbidity: anxiety and depression*

Children and adolescents with ASD are at an increased risk for a variety of co-morbid mental health problems and associated ongoing issues (Auger, 2013; Rotherham-Fuller & MacMullen, 2011; Wood et al., 2009). “For teenagers with Asperger’s syndrome, an additional mood disorder is the rule rather than the exception” (Attwood, 2015, p. 141).  Accurate and valid identification of these conditions can be difficult with ASD children due to diagnostic challenges such as reluctant emotional expression and limited self-reporting systems (Auger, 2013). Anxiety is considered the most prevalent co-morbid mental health condition that affects ASD people. It will often exacerbate the disorder traits, reducing the person’s expression of their strengths and having a profound effect on quality of life (Sansosti & Sansosti, 2013; Scattone & Mong, 2013; Wood et al., 2009). The most common triggers for anxiety in an ASD child or teenager can be attributed to social isolation, changes in routine, transitions, schoolwork stress, and sensory overload (Auger, 2013).

Anxiety affects the central nervous system, influencing the way people think and respond in situations, leading to the anxious person’s developing strategies to reduce their heightened feelings. In a relaxed state, a child will tend to be physically and cognitively flexible, yet in a state of anxiety they will experience tense physical reactions along with cognitively rigid or tunnel-vision thinking, thereby reducing their problem-solving capacity (Wood et al., 2009). This can lead to non-compliant and oppositional behaviours such as tantrums, emotional blackmail, withdrawal, and rigid defiance to avoid situations that induce anxiety (Attwood, 2015).

Danny Raede, a young autistic adult and founder of Asperger Experts, accurately depicts this anxiety state for an ASD person, using his term "Defence Mode:"

> *In Defence Mode someone with Asperger's is scared, frustrated, or angry, as well as shut down and withdrawn…everything is harder because you are constantly trying to protect against an imminent, perceived, but extremely vague threat…you spend the majority of your resources fighting your feelings, the outside world and anything you perceive as threatening; you have very little leftover resources for day to day functioning. . .Someone who is in Defence Mode also has a hard time regulating their emotional state, connecting with others, not obsessing over one singular thing completely and finding their way in life (both metaphorically and physically). . .So until you get out of Defence Mode, it is very hard to learn social skills, make friends, be productive in school or a job, and take care of yourself and manage the overwhelm and stress that can come with everyday life. (Raede, 2018)*

Attwood (2015) describes families as walking through a minefield of anxiety with their child who has a tendency to "press the panic button" too quickly. In a study of parents, anxiety episodes of ASD children were found to be longer in duration and more intense than neuro-typical siblings (Auger, 2013). In general, anxiety has a substantially negative impact on families, with a flow-on effect to ASD children who are often very dependent on their caregivers to help them regulate their emotions (Auger, 2013; Wood et al., 2009).

### *Girls on the spectrum*

Public perception regarding autism is largely focused on the presentation of boys on the spectrum, with limited understanding regarding the female expression of ASD (Miller, 2003). The profile for girls suggests they often fly under the radar, as they employ superior camouflaging methods of observation and imitation (Attwood, 2015). In females, the diagnosis of Asperger's may be overlooked by professionals as the full extent of their social difficulties is only apparent when they are interacting with friends. The female Aspie teenager may relate well with adults, be less disruptive, and learn to "act" in social situations in an attempt to achieve "normality," while still remaining inwardly puzzled about the complexities of social life (Baker, 2003). The effort for ASD girls to cope with the complex and treacherous social world of the modern teenager can come at a huge personal cost to mental and emotional health.

## A personal story

Before talking about strategies for pastoral care I would like to offer the story of our primary school journey with our own ASD son to illustrate some of the challenges that high-functioning autistic children and their parents might experience.

When we arrived from an expat life overseas to live in New Zealand four years ago, our son struggled to cope with the enormity of the transitional change—new home, school, and even country! His schoolwork slid backwards; he struggled to make friends, spending every school break in the library and every afternoon in his bed reading; and his meltdowns at home were epic and regular. As parents we could sense that our kind, sensitive, intelligent, funny, and "quirky" eight-year-old boy was gradually withdrawing from the world around him as his self-esteem plummeted. At that point, after years of various occupational therapy, speech therapy, and learning support interventions, we believed our son had "a sensory processing disorder;" we had not even considered autism. The "rain man" effect and the stereotypical non-verbal autism image had shut our minds to it even being a possibility.

Our efforts with the school were met with resistance and judgement; it was perceived to be his failure to adapt to the school system that was causing the trouble and therefore it was firmly our problem. Our Individual Education Programmes (IEPs) and Special Educational Needs (SEN) reports from overseas schools were dismissed as outdated and irrelevant to the New Zealand system. The message we were getting was "your kid doesn't fit in, he needs to change." The school's culture of care, coupled with an inexperienced SENCO, was to keep struggling parents and their problematic children at arms' length. We were provided with very little in the way of advice or information as to how the New Zealand special education system worked, where to turn, or what to do next.

What the school didn't realise was that we were drowning in all areas of our life as our son's school stress and anxiety peaked: disrupted holidays with extended family; home life that was an anxiety- and explosion-ridden minefield; and attempts at engaging in after-school activities completely derailed. Due to escalating behavioural issues in the classroom, an external Resource Teacher Learning and Behaviour (RTLB) was appointed, and through her recommendation we started a journey of assessment and diagnosis. Over the course of the next six months our son was diagnosed with Asperger's Syndrome. By that stage it was simultaneously an expected outcome and a profound sense of shock. How had we missed it? What had we done wrong? What would his future look like?

Gradually the relationship with school improved, primarily because our psychologist came in to talk to the SENCO and teacher, giving specific strategies for how to support our son. She had the professional kudos and "expertise" of our son that we as parents apparently did not. At school, the adapted teaching strategies, managed transitions, and more compassionate understanding of his differently wired brain all helped to ease his anxiety and settle him back into learning. The diagnosis gave me permission to push harder for my son; finally, we parented the child we had, not the "neuro-typical" child of generic parenting books. Although the school ran numerous in-school clubs, my son didn't have the skills or confidence to join a new group. I worked with the teacher to help him choose a lunchtime club he enjoyed (chess); I actively initiated friendships, asking the teacher to help choose kind boys with similar interests and facilitating the playdates; over time I advocated for my son to be given appropriate responsibilities (reading monitor in the library) to build his self-esteem and sense of value. I also worked with the SENCO, who was willing to improve her awareness and understanding of ASD, recommending seminars and resources to build her repertoire and resource bank of knowledge.

My son is now in Year 6. He has a couple of close friends, is captain of the chess club, is in accelerant maths, and has a wonderful teacher who "gets it." He has learning support for writing, but he wrote a piece on his special interest topic of "Pokemon" that was good enough to be published in the school newsletter; his ambition to play in a school team was achieved when he made the third cricket team for zones; and just this morning he raced to school early to receive his hot chocolate in the staffroom in recognition for his road patrol duties.

Life is not without challenges, meltdowns, and daily frustrations. He sees an outside counsellor intermittently, and the school transition ahead to our large local intermediate is daunting, but we now have a child who believes in himself, who is a valued part of school life, and who is liked and accepted by peers and teachers and respected for his considerable strengths and talents. The road was significantly harder because we had to pave the way at school. An understanding, compassionate, knowledgeable, and ASD-educated pastoral care approach could have saved many lost hours of classroom learning, frustration, and heartache.

What is important to note here is that we didn't "fix" our son. As we learnt about ASD, we addressed the underlying causes of his anxiety by making changes. We adjusted our own parenting to be more ASD–sympathetic, we evaluated and adjusted his environment, we educated the people in his life, and we focused on his strengths. It required support from caring teachers, supportive friendships in the community, and understanding sports coaches, involved wider family, and experienced outside professionals. It required a holistic culture of care from the important people in our son's life.

## Pastoral care of ASD students

Given the diversity and range of individuals with ASD, no single approach to pastoral care intervention appears to be favoured above others; the variety of different approaches used in schools is surprisingly high (Auger, 2013). There is a common saying in the ASD community—"If you've met one child with autism, you've met one child with autism"—and this particularly applies to pastoral care. Of specific importance is that the approach adopted be tailored to meeting the needs and characteristics of each individual, their family, and the social environment (Larkey & von Ess, 2010). This next section combines both research-based literature and practical suggestions from New Zealand ASD counsellors. The recommendations include strategies from a telephone interview conducted in 2018 with Dave McMillan, an experienced school counsellor who has worked extensively with ASD clients.

There is universal agreement in the ASD literature that early intervention is essential for improving developmental delays (MoH, 2016). However, recognition of higher-functioning ASD often depends on behaviours such as language and social skill delays and ritualistic behaviours that may not be apparent until later in childhood (O'Reilly & Wicks, 2016). As such, schools tend to be the "first responders" to children and adolescents showing signs of ASD, presenting substantial pastoral care challenges if the school staff are not well resourced or knowledgeable.

### *Life skills: social interaction and communication*

The New Zealand ASD guideline (MoH, 2016) considers developing socialisation, communication, and play goals as key recommendations for work with ASD children and adolescents. Training in social skills can be most effective if it takes place in natural environments such as home or school (Auger, 2013; MoH, 2016). One-on-one social skills therapy, social communication groups, peer modelling, and video modelling are useful ways to teach strategies that will help ASD students learn key social conventions (Larkey & von Ess, 2010; O'Reilly & Wicks, 2016).

A social group may be as informal as a lunchtime activity group that enables ASD students to interact through a shared interest, or a student support "chill out" area where students can come to relax and self-regulate. An adult presence is generally required to create the right environment, help facilitate friendships, and protect the space. Timothy Folkema (Gill, 2018), who suffered from bullying in high school, describes a teacher who "changed his life" by opening up her classroom three lunchtimes a week. "It was a safe space. Even those kids that used to wind us up, they'd come and get involved. They wouldn't press our buttons because she was sitting there, eating lunch, chatting with students, she was really chill" (p. 14).

Dave McMillan pioneered a strategy in his school to help ASD students create links with their tribe. Recognising the sensory overload some students were facing during large school assemblies, he set up a safe-space group that ASD students were invited to attend while assembly was in progress. What began with three students four years ago has grown to incorporate two groups with up to 50 students involved. The relaxed group encompasses informal psychoeducation, shared-interest play, and facilitated socialisation. McMillan noted that peer mentoring with ASD students who have "walked the journey" has been invaluable in supporting the younger teenagers.

Social Stories™ and Comic Strip Conversations developed by Carol Gray (1998) are popular strategies and have practical application within the school environment (Attwood, 2015; O'Reilly & Wicks, 2016). Social Stories™ uses both text and images to break complex social situations into smaller bite-sized concepts and is suited to ASD children who generally do better processing concrete and visual information (Kokina & Kern, 2010; Larkey & von Ess, 2010). Limited research studies have concluded that Social Stories™ and Comic Strip Conversations are best used in combination with other interventions such as social skills training and video modelling (Kokina & Kern, 2010).

A creative, person-centred, and sensorially sensitive approach to working with ASD students is essential. Attending to the environmental aspects of the counselling room (noise, smell, visual stimulation) is important, as is appreciating that dialogue to express thoughts and feelings can be difficult for an ASD person to engage with. Tactile and visual therapies such as drawing, sand tray, and small figure work may be useful methods to explore. Jane Kjersten, a therapist working closely with families and couples with dyslexia, developed an interactive visual drawing therapy called "Drawing Talk" to assist communication for her clients who struggled with verbal dialogue (Kjersten, 2017). This is a valuable therapeutic approach as it provides both an interactive and a visual representation of emotions that may be difficult for the ASD person to identify and express verbally.

Where possible, including the student's special interest in the therapy can help facilitate communication. Dave McMillan described the Special Interest Assessment form he uses to identify and acknowledge a student's strengths in the initial counselling session. He specifically uses this approach to find common ground and build the therapeutic alliance. My son's therapist worked with his interest in and extensive knowledge of Pokemon. She initiated conversation by showing a strong interest in learning about the characters and then won his trust and engagement by purchasing figures for their sessions, gradually introducing them into sand tray work. This then formed the basis of exploring emotional regulation skills as he identified with the personalities of the various characters.

### *An emotional toolbox*

Tony Attwood (2105), a clinical psychologist considered to be a world expert on Asperger's, runs both online courses and one-day workshops detailing his approach to working with ASD people. He advocates creating an Emotional Toolbox to help "fix the feeling" when working with anxiety, anger, and sadness in a clinical setting. The Emotional Toolbox provides a range of tools that the client can use as a personal resource kit to cope with disabling emotional experiences and also tools to help improve thinking. The toolbox can be created in a brainstorming session with the student, using paper and pens to write or draw descriptions of the tools that can "encourage constructive emotion repair" (p. 172). In the school counselling setting, successful adaptation of the individual student's toolbox will be most effective if it includes engagement with both parents and teachers.

Attwood's Emotional Toolbox incorporates a range of different categories of "tools." *Physical Activity Tools* can provide a quick release of emotional energy in the heat of the moment, e.g. creative destruction ideas or identifying appropriate exercise options. *Relaxation Tools* are suitable for a slow release of emotional energy, e.g. teaching meditation or mindfulness to regulate mind/body reactions, acknowledging the need for solitude or time in nature. *Social Tools* include strategies to find and be with a supportive family member or a favourite pet to build affection and enable emotional restoration. Another social activity tool that can assist with repairing mood is altruism—that act of helping someone and being needed. In a school environment this might involve a responsibility role that has a good fit with the student's areas of strength. Included in the Social Toolbox are strategies to help adults best support the ASD person during explosions or implosions, e.g., staying calm, minimal conversation, not trying to solve the problem, or using a special interest as an off switch. *Thinking Tools* are imagined implements such as a screwdriver or wrench, that can be used to change thinking or knowledge. The ASD person is encouraged to develop key self-talk words that are reassuring under stress, e.g., "I can stay calm if I stay in green brain," "I only have to focus on the next step." The category of *Sensory Tools* involves assessing the environment and identifying strategies to cope with sound, light, smell, and tactile defensiveness; for example, moving a student's desk to another area if noise and light are problematic. Attwood also suggests that *Medication* may be an appropriate "tool" when anxiety and mood are clinically significant.

Cognitive Behaviour Therapy (CBT) is used to teach people to alleviate anxiety through recognising and modifying maladaptive thoughts (Scattone & Mong, 2013). In the last decade there has been growing research interest in how CBT could be adapted for ASD people; however, few researchers have investigated its use as a therapeutic approach in the school setting (Auger, 2013; Scattone & Mong, 2013). Rotherham-Fuller and MacMullen (2011) make a case for using CBT to manage ASD-related anxiety in schools, suggesting that all "school-based providers should receive training in both CBT methods and common characteristics of ASD" in order to adjust therapy to the language, emotions, and adaptive skills of the child (p. 270).

### *Academic support and advocacy*

Educational psychology reports for high-functioning ASD students may show an uneven profile of academic giftedness coupled with areas for learning support, a term commonly known as “twice exceptional” (Callard-Szulgit, 2008). In some situations, ASD students will first come to the attention of the school counsellor when anxiety over missed assignments and low grades starts to cause problematic behavioural reactions. If teachers do not have an adequate understanding of the difficulty ASD students have with completing work, self-regulation, processing multi-step tasks and self-advocacy, the students may be stigmatised as being lazy and not trying hard enough. Depending on the experience and resource depth of each school’s SENCO department, it may fall on counsellors to understand and interpret cognitive assessments and ensure relevant information is passed on to teachers.

### *A culture of care*

The National Education Goals (NEGs) for schools specify goals such as “enabling all students to realize their full potential as individuals” (NEG 1, MoE, 2004), and “removing barriers to achievement” (NEG 2, MoE, 2013). Bronfenbrenner’s (1979) concentric circles show us that a person is intimately linked with the context of his or her life and cannot therefore be understood separately from their environment. Likewise, in his seminars Attwood (2015) affirms the message that “it is easier to change the environment than it is the child.” Incorporating Te Whare Tapa Wha’s (Durie, 1994) multifaceted concept of health and wellbeing, pastoral teams need to fully appreciate the need of ASD students for holistic care, working simultaneously on school culture and family involvement as integral parts of the pastoral care plan for the individual.

Counsellors also require some understanding regarding the stress and isolation experienced by caregivers who have likely experienced years of frustration and societal blame because of the dysregulated behaviour of their child. Parents will often feel stigmatised and marginalised because of their child’s excessive or explosive behaviour (Major & O’Brien, 2005; McDonnell, 1998) which can have an adverse effect on relationships with teachers and other school staff. At times, a school counsellor’s role may alternate between mediator, educator, and therapist as they assist overwhelmed parents to form productive relationships with school staff.

### *Connection with outside agencies*

Navigating the assessment process and the support available via outside agencies can be a minefield for those unfamiliar with a particular disability system. Below is a brief list of contact points that can help counsellors and teachers with specific questions about how to support families with ASD:

- Altogether Autism (www.althogetherautism.org.nz)—a government-funded service with a core business model to supply information to autistic people, parents, educators, support workers, or professionals working with adults or children on the autism spectrum.
- Autism New Zealand (www.autismnz.org.nz)—a nationwide not-for-profit organisation that provides support, resources, and information on ASD for both families and professionals working with ASD.
- Children's Autism Foundation (www.autism.org.nz)—an Auckland-based organisation that offers services to guide, support, and provide practical, family-centred solutions.
- Explore Services (www.healthcarenz.co.nz)—the national provider for behaviour support services for people on the autism spectrum and their parents.
- The *New Zealand Autism Spectrum Disorder Guideline* (2nd ed.) prepared by the Ministry of Health (2016) provides an evidence-based information guide that includes information about ASD: identification and diagnosis, ongoing assessment, evidence-based interventions, and available services. As a living document it is updated as new information and empirical research is made available.
- *Inclusive Education Guide for Schools* (www.inclusive.tki.org.nz)—an online education resource focusing on areas for ASD-specific support and whole-class strategies. It includes links to specialist support services.

## Conclusion

School counsellors must be skilled in providing a strengths-based therapeutic approach that incorporates ASD-sensitive counselling for clients, group facilitation work, student advocacy, ASD education, and communication with families. Connection with outside agencies, including professionals who can assess and diagnose ASD and (where necessary) provide external clinical treatment is essential. For pastoral care teams to effect change, they must think laterally to remove barriers, and provide each ASD young person with the necessary skills to reach their potential.

The ASD community has an emerging voice that rejects the idea that ASD brains are broken or are puzzles to be solved. That voice asks us to “think smarter about people who think differently” (Silberman, 2015a). It is an appeal for the strength of neuro-diversity, suggesting all forms of human intelligence are needed to tackle the problems that our modern societies face. As Steve Silberman (2015b) asserts, “the cure for the most disabling aspects of autism is found in understanding teachers, accommodating employers, supportive communities and parents who have faith in their children’s potential.” Effective support and pastoral care occur in schools that adopt a paradigm shift to truly embrace autism in the spirit of the Māori concept of takiwatanga—people who are working and living in their own time and at their own pace.

## Note

1. An article published in April 2018 (Czech, 2018) challenges the narrative of Asperger as a courageous defender against Nazi euthanasia, suggesting a far closer alliance with Nazism than has been previously suggested. It is not within the scope of this article to discuss this new revelation, but I anticipate we will see further commentary in the international arena in the coming months.

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