When Being Normal Isn't the Goal: How Therapists Co-Transform Beyond Normal with their Autistic Clients

James Ian Skipper Tillett

Dissertation submitted to the faculty of the Virginia Polytechnic Institute and State University in partial fulfillment of the requirements for the degree of

Doctor of Philosophy
In
Human Development and Family Science

Jody M. Russon (Chair)
Erika L. Grafsky
Caroline M. Sanner
Carolyn M. Shivers
Nick Walker

December 5th, 2023
Blacksburg, Virginia

Keywords: Autism, Neurodiversity Paradigm, Phenomenology, Systemic Therapy

When Being Normal Isn't the Goal: How Therapists and their Autistic Clients Diverge from Social Normativities Together

James Ian Skipper Tillett

ABSTRACT

For over a century, attempts to fix, capture, and control a way of being now known as "autism" have haunted and harmed countless autistic people, all under the guises of medical care and treatment. These unjust events precipitated from rigid Western scientific and cultural paradigms about what is real and what is normal, leading to the deep misunderstanding and social oppression of autism and other non-normative ways of being. Presently, autistic people still endure oppressive and traumatic behavioral interventions and minority stressors (such as internalized prejudice and discrimination) in consequence of living in an "autistiphobic" world – a world that is preoccupied with being normal. Yet, non-normative ways of being such as autism generate new possibilities, which can liberate and facilitate connections between people. Systemic and cybernetic therapy frameworks – in combination with insights from the neurodiversity paradigm of autism – may offer insights into co-transformative psychotherapy practices with autistic clients and people close to them, enabling more authentic autistic being in the world. This study used interpretative phenomenological analysis to explore how neurodiversity paradigm-embracing therapists retroactively make sense of their co-transformations with autistic clients; specifically, their reinterpretations of social normativities and connectedness. Results showed that participants came to both 1) recognize and oppose normative oppression in their therapeutic practices and 2) align with neurodivergent authenticity, autonomy, and connection as therapists and people. Implications of this research for therapeutic practice and broader sociopolitical issues are discussed at the end of the project. The goal of this research is to offer curious therapists possible paths for ethical, liberatory, and generative work with autistic clients.

When Being Normal Isn't the Goal: How Therapists and their Autistic Clients Diverge from Social Normativities Together

James Ian Skipper Tillett

GENERAL AUDIENCE ABSTRACT

For over a century, attempts to label and control a way of being now known as "autism" have haunted and harmed countless autistic people, all under the guises of medical care and treatment. These unjust events precipitated from rigid, historically rooted belief systems about what is normal, leading to the oppression of autistic people and anyone else labeled non-normal. Presently, autistic people still endure harmful behavioral interventions and social prejudice and discrimination, as a consequence of living in a world preoccupied with being normal. Yet ways of being considered "not normal," such as autism, allow for new and vital possibilities in relationships and society. Relationship therapy frameworks – in combination with the concept of neurodiversity – may offer insights into providing more ethical therapy for autistic clients and people close to them. This qualitative study explored how ethical therapists – who do not view autism as a disorder – look back at their experiences of changing along with their autistic clients. Specifically, the study will examine how these therapists and clients, during the course of therapy, change their perspectives about what it means to be normal and to connect with others. Results showed that participants came to both 1) recognize and oppose the enforcement of being normal in their work as therapists and 2) align with authentic ways of being neurodivergent as therapists and people. Therapeutic and broader implications of this research are discussed at the end of the project. The goal of this research is to offer therapists ways of liberating themselves and their autistic clients from being normal during therapy.

When Being Normal Isn’t the Goal: How Therapists and their Autistic Clients Diverge from Social Normativities Together

James Ian Skipper Tillett

ACKNOWLEDGMENTS

I am sincerely grateful to my entire dissertation committee for the time and energy they put into supporting me across the last several years, and for supporting my authenticity as a researcher. Thank you to my advisor, Dr. Jody Russon, for your deeply thoughtful engagement with my dissertation topic, offering warm guidance whenever I got stuck, and the tremendous amount of supportive brainstorming and editing you contributed as a mentor. Additionally, I would like to thank Dr. Erika Grafsky for always believing in, expressing enthusiasm, and remaining curious about my research, especially when I info-dumped about it in class. Thank you to Dr. Caroline Sanner for bringing me into your research lab, being so generous with your time and resources during our work together, and for showing me a path to being authentic as a qualitative researcher. Thank you to Dr. Carolyn Shivers, my first advisor, for making me feel so seen and heard as a disabled student, for your patient mentorship in quantitative methods, and for your refreshingly candid presence, which helped me to be more earnest. Thank you to Dr. Nick Walker for your time as a research sample informant, for welcoming me into neuroqueering work within the research world, and for everything you have done on behalf of autistic and neuroqueer people to help us envision a future with more possibilities. Additionally, I would like to thank my former committee member, Dr. Ashley Shew, for your previous participation in my committee and for inviting me into and nurturing the incredible disabled community at Virginia Tech.

I would also like to thank both my found and birth families for all of the love and support they have shown me over the years, which made this arduous process possible. Thank you to Mari, Shalini, Lauren, Kayla, Angie, and ViK for showing me what it feels like to belong, and for being with me through so many beautiful and painful moments in the last five years. I greatly appreciate my aunt Carolyn for loving my inner rebel and for continuing to show up and care so much. I am also appreciative of my sisters: Kristi for the countless hours spent understanding and witnessing my struggle as a graduate student, Lauren (and kids) for being so playful and nurturing to the little kid in my soul, and Kira for being authentic with me and reminding me I’m not alone. I am very grateful to my parents for the gift of mutual healing and co-transformation, and for a lifetime of loving me in the face of the unknown. Much appreciation to my fur children for their endless mayhem and cuddles, which made some dark times much brighter. I am without sufficient words to thank my life partner Matt, who truly embodied the phrase “in sickness and in health,” helped fight my darkest battles, literally made this journey possible by contributing so much to our household, and role-modeled unconditional love when I had a hard time loving myself. Finally, thank you Jade, for the honor of being in your life.

Table of Contents

Chapter 1 - Introduction

The following chapter sections will: 1) review the deep, systemic problems with – and gaps in – the contemporary climate of autism 'care,' 2) explore what problems autistic people genuinely experience and might seek psychotherapeutic help for, and 3) outline the relational paradigm shift necessary for meeting autistic client's needs and explain how systemic therapy frameworks may help facilitate such a shift.

How "Treatment" Has Failed Autistic People

Applied Behavioral Analysis as Social Oppression

Over the last several decades, Applied Behavioral Analysis (ABA) has become known as the most extensively researched, popular, and effective empirical "treatment" for autistic individuals by the mental health professions (Leaf et al., 2021; Gorycki et al., 2020; Politte et al., 2015). This approach focuses on identifying "problem behaviors" in autistic children and teens (and occasionally dependent adults) and attempting to "extinguish" them through a rigid, systematic, and long-term program. One main treatment goal of ABA and other behaviorist interventions is the "independent" or "autonomous functioning" of its autistic clients (Sandoval-Norton & Shkedy, 2019, p. 3). It attempts to produce said functioning through "behavioral modification;" a combination of authority figure and institutional "prompting" towards certain behaviors and "conditioning" (rewards and punishments). ABA is usually administered by a behavioral technician for several hours per week spread across several days, and is also recommended and sometimes used for up to 40 hours per week with "patients" deemed to need a higher "dosage" – and whose families can afford the cost (Choi et al., 2022). In some cases, a child is enrolled in ABA for only months or several years at a time, but many are enrolled until adulthood or even beyond (Sandoval-Norton & Shkedy, 2019). The timing and reasons for terminating ABA vary widely, and much of this information remains unknown. Choi et al. (2022) recently found that – amongst a large random stratified sample (*N*=334) of children referred for ABA in Southern California between 2016 and 2018 – 13% never received ABA, and of those remaining, 66% were still in ABA after 1 year and 46% after 2 years (p. 6). For clients who discontinued before 1 year, only 14% had met treatment goals, while only 21% did after 2 years. Other common reasons for discontinuation included families declining ABA services (their given reasons for doing so were not reported) and problems affording ABA. Sandoval-Norton & Shkedy (2019) add that U.S. law requires non-speaking and/or intellectually disabled (often called "non-verbal") autistic children be offered autism services until they are "aged out" in young adulthood (p. 3).

ABA has recently garnered substantial critique from providers, researchers, parents, and clients who experienced it. The most frequently cited critiques are that ABA is: 1) socially oppressive by design, 2) abusive and traumatizing, 3) inefficacious regarding many of its own aims, and 4) largely researched by those with undisclosed conflicts of interest. Starting with the first critique, ABA is conceptually entwined with the socially oppressive origins, philosophies, and practices of queer/transgender "conversion therapies" (Silberman, 2015; Yergeau, 2018). This entwinement is blatant in ABA originator Ivar Lovaas' contributions to the development of the U.S. federally funded "Feminine Boy Project" (p. 29). The project's researchers used behavioral conditioning rewards (i.e., praising "masculine" behaviors) and punishments (i.e., hitting and planned ignoring in response to "feminine" behaviors) as an "early intervention" for "gender confusion," "sissy-boy syndrome" (Silberman, 2015, p. 319), as well as "transvestitism, transsexualism, and some forms of homosexuality" in assigned-male-at-birth children (Yergeau, 2018, p. 29). Put simply, "[ABA] was the predominant therapy used to train out the queer in children perceived to be trans, effeminate, and/or homosexual in the 1960s and 1970s" (p. 29). Given well-established overlaps between autism and queerness/transness (Strang, 2023; Gratton, 2019; George & Stokes, 2018; Strang et al., 2014), Yergeau (2018) further observes that, "what autism provides is a backdoor pathologization of queerness, one in which clinicians and lay publics alike seek out deviant behaviors and affectations and attempt to straighten them" (p. 26). The mission of 'curing' or 'treating' non-normative (autistic) behaviors through what we call "the gold standard autism therapy" (p. 29) is a much more socially acceptable pitch in an increasingly queer/trans-affirming social climate than "curing" non-normative (queer/trans) behaviors through what we call gay conversion therapy.

Such an atrocious history brings into question the ethics of ever using ABA (Sandoval-Norton et al., 2021; Yergeau, 2018) or any "intervention" fundamentally designed to eliminate socially oppressed/non-normative ways of being. To this point, critics have located the intrinsic conceptual failings of ABA in its aims to "intervene" on behaviors cast as autistic. In briefly humoring the notion that autistic behaviors *could ever be* clearly distinguished from other "types" of non-normative behaviors such as queerness (or that it *would ever be* okay to attempt forcibly changing autistic behaviors simply because they are non-normative in our current social world), the original goal of Lovaas' ABA was to render autistic children as "indistinguishable from their typical peers" – or, "normal" – as possible (Silberman, 2015, pp. 324-325). This is supposedly accomplished by "extinguishing" behaviors that are considered non-normative – specifically, non-neuronormative – as opposed to viewing autism as a way of neurocognitive functioning that simply *diverges* from the current norm (Shyman, 2016, pp. 370-372); hence, the term "neurodivergent" was coined by Kassiane Asasumasu to describe people who neurocognitively function non-normatively (Walker, 2021). In this way, *normal is an oppressive ideal* to impose on autistic and otherwise non-normative children when they diverge from it. Furthermore, this oppressive ideal of "normal" is contingent on the dominant trends/values of a given sociocultural time and place, and not actually "natural," but taken-for-granted as such (Chapman, 2020).

In tandem with attempting to render autistics more normal, "professionals" and "experts" have historically conceptualized autism as an involuntary possession acting upon the individuals "with it," leading professionals to seek out solutions akin to exorcizing autism from the individuals who "have it" (Yergeau, 2018). For example, rhetoric by Autism Speaks and other eugenicist organizations will depict horror stories of young children being "kidnapped" from their parents by the 'monster' that is autism, and invoke "interventions" as the means by which to retrieve the supposedly normal child awaiting them inside (pp. 7-8; 54). Such rhetoric misses that autism is merely a diagnostic label attempting to describe an innate way of neurocognitive functioning, and that an individual's neurology and the cognitive/sensorimotor leanings that come with it cannot be removed any more than their DNA; at least not without removing fundamental aspects of their being (Walker, 2021). ABA/behaviorist approaches to autism are problematic because they focus on *suppressing* observable autistic traits, and risk missing the reasons *why* certain behaviors are occurring (Williams, 1996). These approaches also ignore autistic individuals' internal (often overwhelmed) experiences of their environments (Pellicano & Burr, 2013), and thereby fail to understand what drives their actions/behaviors.

ABA as Abusive and Traumatic

Moving on to the second major critique of ABA, its origins in normative thought and resulting oppressive and abusive techniques can traumatize its participants. For context, autism researchers and providers have an abysmal track record of taking autistic personhood seriously, because they ascribe personhood to one's displays of intentionality and agency; both viewed as lacking in autistic people (Botha & Cage, 2022; Yergeau, 2018; Yergeau & Huebner, 2017). As a result, the communicated inner experiences of autistics are also called into question and invalidated. This is especially evident in the concerning history of explicitly documented abuses by ABA researchers/providers (Silberman, 2015). The punishments its first autistic child participants were forced to endure in the 1960s included loud noises, hitting, withholding of food and water, and even electrocution until the desired behaviors were performed (pp. 306; 309; 312). Contemporary proponents of ABA will often insist that such aversives are no longer used, but they do still exist in some iterations of ABA (Sandoval-Norton et al., 2021, p. 129). In truth, whether relying more greatly on rewards or punishments, ABA/behaviorism is *inherently coercive*; grooming autistic children for compliance and abuse through manipulative bribing at best and physical harm at worst (Walker, 2021; Yergeau, 2018). This assertion is best supported by a recent ABA literature review, which found that behavioral interventions tend to result in autistic client "compliance, learned helplessness, food/reward obsess[ion], magnified vulnerabilities to sexual and physical abuse, low self-esteem, decreased intrinsic motivation, robbed confidence, inhibited interpersonal skills, isolation, anxiety, suppressed autonomy, prompt dependency, adult reliance, etc." (Sandoval-Norton & Shkedy, 2019, p. 6). In light of such evidence, it is hard to fathom the mental gymnastics ABA proponents must undergo to believe and pitch it as a harmless form of care for autistic people.

In response to the above points and resulting concerns that ABA is harmful, some autism researchers have begun seeking the perspectives of those who survived it. In this process, many adults have revealed that they experienced childhood ABA as traumatic (McGill & Robinson, 2020). Recent research by Kupferstein (2018) found that, amongst a large sample autistic adults and children (*N*=460), those exposed to ABA were 86% more likely to meet the diagnostic criteria for PTSD than those who were not, with 46% of those exposed meeting PTSD criteria (p. 23). Yergeau (2018) succinctly summarizes this situation with the following quote: “In the autistic community, there has emerged a distinctive ex-ABA movement, one led by traumatized autistics and parents alike. Survivors of ABA speak of hours-long sessions spent on inculcating compliance, assessment, and normalized gender roles, hours spent on social stories that reinforce stereotypical and cis/heteronormative behaviors.” (p. 29). Indeed, ABA’s practices towards autistic clients have been described by those reviewing its empirical support as “tantamount to torture” (Sandoval-Norton et al., 2021, p. 126). To summarize, an “intervention” designed to systematically “train” (or put another way, coerce) a person to act in “normal” ways that are inauthentic to them – whether their authentic, non-normative ways of being are currently understood to be socially oppressed or not – is experienced by many as harmful and traumatic.

Gaps in ABA’s Demonstrated Efficacy

Even if one does support ABA’s oppressive aims, the large amount of existing research on ABA’s unique efficacy for ‘treating’ autism still has significant gaps to fill in demonstrating said efficacy. A recent meta-analysis investigated the clinical efficacy of ABA-based modalities in ‘intervening on’ autistic children, examining 14 randomized control trials conducted between 2000 and 2018, with the majority having been conducted after 2010 (Yu et al., 2020). This publication is well-cited, and attempts to serve as one of the more robust contemporary empirical supports for the efficacy of ABA-based intervention in “treating” autistic clients. In combination, these trials included 555 participants (278 in experimental groups; 277 in control groups) who were between 6 months to 8.5 years of age. The length of ABA use varied from 8 weeks to 2-3 years across all studies. The authors also conducted sensitivity and subgroup analyses to compare the effectiveness of traditional ABA (5 trials) to that of several other ABA-based treatments: the Early Start Denver Model (ESDM; 5 trials), Picture Exchange Communication Systems (PECS; 3 trials), and Discrete Trial Training (DTT; 1 trial). The authors explain that EDSM, PECS, and DTT approaches are all “consistent with the principles of ABA,” and specifically: 1) the EDSM uses “teaching strategies” for social and affective participation for both autistic children and their respective adults, 2) the PECS uses a manualized program which is said to “guide” (often, what they called “non-verbal”) autistic kids on how to communicate, and 3) the DTT uses repetitive “instruction methods” for training autistic children to break down and develop target skills (p. 433). The following outcomes were examined across the studies in the meta-analysis (in the authors’ language): “general symptoms” of autism, socialization, communication, expressive language, receptive language, adaptive behavior, daily living skills, intelligence quotient (IQ), verbal IQ, nonverbal IQ, restricted and repetitive behavior, and motor and cognition (pp. 437-440). While the scales used to operationalize these outcomes were disclosed, these latent constructs behind these outcomes were not clearly explained in the meta-analysis.

According to Yu et al. (2020), no significant differences were observed in ABA participant outcomes (socialization, daily living skills, communication, and adaptive behavior) for which there were enough data to be compared to the same outcomes for ESDM and PECS participants (there were not enough participants to compare DTT). Therefore, the ABA-based models studied were fairly consistent in their various measured outcomes. Additionally, results for the ABA-based models were compared with “conventional intervention” control groups (p. 433); these were “eclectic” and unclearly defined treatment-as-usual controls (pp. 440-441), making them difficult to properly compare across the studies analyzed. Results for the combined ABA-based models showed significant effects for the outcomes of *socialization* (the Autism Diagnostic Interview-Revised (ADI-R; Rutter et al., 2013) used in 3 studies, and the Vineland Adaptive Behavior Scales (VABS; Sparrow & Cicchetti, 1989) used in 6 studies), *communication* (VABS and the Chinese Psychoeducational Profile (C-PEP; Fu et al., 2010) used in 3 studies), and *expressive language* (Mullen Scales of Early Learning (MSEL; Dumont et al., 2000) used in 2 studies, Autism Diagnostic Observation Schedule (ADOS; Gotham et al., 2007) used in 4 studies, and Reynell Developmental Language Scales (RDLS; Reynell & Gruber, 1990) used in 1 study) (Yu et al., 2020).

These significant effects found by Yu et al. (2020) can be translated to mean that participants evidenced more neuronormative – and therefore, normatively desirable – patterns of socialization, communication, and expressive language after ABA-based intervention. In other words, ABA-based interventions taught these participants to look and act less visibly autistic in how they socialized, communicated, and expressed language. However, when compared to controls, the researchers found no evidence supporting ABA’s efficacy in producing desired changes for the remaining, majority of outcomes measured: autism “general symptoms,” receptive language, adaptive behavior, daily living skills, IQ, verbal IQ, nonverbal IQ, restricted and repetitive behavior, and motor and cognition. Based on the lack of change in autism “general symptoms,” the researchers themselves concluded that “there was not enough evidence to support the effectiveness of ABA-based interventions for treating ASD” (p. 440). It is unsurprising that autism was not effectively “treated” by this intervention, because – as mentioned earlier – *is* an innate way of neurocognitive functioning, and *is not* a disease/disorder that can be removed from the person without fundamentally changing them (Walker, 2021).

Furthermore, Sandoval-Norton et al. (2021) observed that other research conducted by proponents of ABA in the last several decades failed to find substantial evidence of ABA’s effectiveness in its specific goal of changing so-called “low-functioning” behaviors (typically defined as those specific to non-speaking and/or intellectually disabled autistics). They explain further explain that “any study that uses IQ as a measure of improvement…has excluded nonverbal children with autism since they notoriously do not have any measurable IQ. In clinical experience with hundreds of nonverbal children with autism, not one had a reported measurable IQ on any previous psychological evaluation” (p. 129). Given that many of the common arguments justifying the use of ABA – or any efforts to treat the state being autistic itself – focus on the need for an intervention that goes ‘far enough’ to ‘treat’ autistic individuals with the most complex support needs, this fact runs counter to those justifications. Again, in their earlier ABA literature review, Sandoval-Norton & Shkedy (2019) found that most autistic clients evidenced further compliance, dependence on authority figure prompting/instruction, and ultimately, learned helplessness after ABA (p. 6). Behaviorist intervention outcomes are also operationalized by observable signs of compliance, such as client directive-following, use of language as taught, attention to and participation in pre-selected tasks, etc. (Sandoval-Norton et al., 2021). Such findings and operationalizations seemingly run counter to ABA’s aforementioned treatment goal of developing greater autonomous functioning in autistic clients. In summary, while some evidence suggests that ABA may be effective in achieving its goals in select areas (teaching *neuronormative-passing* socialization, communication, and expressive language use), there is substantially less evidence to suggest that it decreases autistic “general symptoms” (Yu et al., 2020), that it develops “autonomous functioning” in autistic clients (Sandoval-Norton & Shkedy, 2019), nor that it should be held up as a “gold standard” for therapy, *particularly with* non-speaking and/or intellectually disabled autistic people (Sandoval-Norton et al., 2021).

ABA’s Problem with Conflicts of Interest

A fourth and final major concern with ABA is the lack of independent evaluation (i.e., third-party research) supporting the idea that it “successfully” normalizes autistic individuals. The ABA therapy model is an expensive product (Choi et al., 2022, p. 2) – as it is offered up to 40 hours a week per client – and ABA affiliates have a great stake in demonstrating their work’s efficacy with autistic clients regardless of whether it achieves its stated aims. As such, even if ABA is – for *at least* all of the reasons articulated above – unethical due to its philosophy and delivery, those who have built careers in it want to be able to keep practicing and profiting. A recent analysis of a year’s worth of studies on ABA efficacy (*N*=180) found that at least 84% of the studies included an author with a conflict of interest (either as an ABA provider or training consultant), but they were only disclosed in 2% of those studies (Bottema-Beutel & Crowley, 2021, p. 4). Eisner et al. (2015) discuss how this is a larger problem in the medical system, which has become more dependent on psychosocial interventions developed, researched, and distributed by privately profiting parties. They conducted a study that looked at other popular childhood psychosocial interventions (i.e., Triple P, Nurse-Family Partnership, Incredible Years, and Multisystemic Therapy) and found that amongst their published research from 2008 to mid-2014 (N=136), 71% had an undisclosed conflict of interest, with the most egregiously low disclosure rate (11%) represented by the Triple P program (p. 7). This demonstrates that the problem is not unique to ABA, but endemic to the landscape of childhood psychosocial intervention as a whole.

That the vast majority of newly published research on ABA comes from those whose income is derived from its success shows the high potential for bias in what appears to be most of its current clinical studies. ABA's often-touted empirical support may be largely based on studies that are conducted by investigators with undisclosed and, perhaps, unrecognized conflicts of interest. Here, it is also worth sharing that the U.S. Department of Defense's (DOD; 2020) massive (*N*=1,252) longitudinal study on ABA's efficacy for producing its intended outcomes in autistic clients is being conducted by a third party (the U.S. government), which serves as an ideal counterexample of what ABA research results might look like if conducted by unbiased researchers. That DOD study found that with most participants, predominantly minors, there was a reduction of visible autistic traits 12 and 18 months into ABA services, as measured by the Pervasive Developmental Disabilities Behavior Inventory Parent Form (PDDBI; Cohen & Sudhalter, 2005), but that the changes were small and "may not be clinically significant" (DOD, 2020, p. 23). Again, when ABA practitioners control and produce most research on ABA, they get to decide what it communicates to audiences. Therefore, the existing empirical support for ABA's efficacy with autistic clients was very possibly built upon corrupt research. Despite all of the formerly mentioned concerns about the history, conceptualization, ethics, internally-defined efficacy, and empirical integrity of the intervention and its practitioners, ABA remains a widely favored approach for working with autistic clients in U.S. mental health systems (Choi et al., 2022; Leaf et al., 2021; Gorycki et al., 2020; Politte et al., 2015).

Filling the Autism Care Gap

For the reasons above, a question of future psychotherapists to autistic clients is not one of *if* to replace ABA, but rather, *what* should fill the massive institutional gap it will leave behind where it has been the dominant form of autism "care." Additionally, those who were already understandably uncomfortable with ABA as a practice have been left without care regardless, and need accessible and ethical therapy options. Care gaps will and already do exist (Strömberg et al., 2022; Lipinski et al., 2021; Adams & Young, 2020). For example, Adams & Young (2020) recently conducted a systematic review of 12 studies on the barriers and facilitators of mental healthcare access for autistic people, which included research from the U.S., U.K., Canada, Germany, and Australia. They concluded that "the most commonly reported barrier was a lack of therapist knowledge or expertise in autism or an inability or unwillingness to tailor approaches to support the needs of those on the autism spectrum" (p. 446). In more a recent large-scale study, Lipinski et al. (2021) collected data from therapists in Germany (*N*=498) who use approaches paid for by government insurance (cognitive-behavioral therapy, psychodynamic therapy, and analytical psychotherapy). They found that participants felt least comfortable diagnosing and providing therapy for autistic clients compared to clients labeled with other mental diagnoses (i.e., depression, anxiety, bipolar, schizophrenia, etc.). Many reported lacking training for working with autistic clients. Finally, a study by Strömberg et al. (2022) in Sweden compared the experiences of autistic (*N*=62) and non-autistic (*N*=36) adults in healthcare settings, and autistic participants reported feeling more misunderstood by their healthcare providers on average, and complained of sensory overload caused by the clinical setting (i.e., crowds, loud sounds, bright lights, etc.). These findings suggest that many therapists and other healthcare providers are not well-prepared to work with autistic clients; a consequence likely related to the history of autism care being siloed into behaviorist institutions (Silberman, 2015).

Fortunately, autistic adult clients and their parents are reporting higher-quality, more individualized care when working with therapists at agencies where the staff have received training on working with autistic people (Hand et al., 2021). Several macro-level solutions to addressing this autism care gap in provider competency are already in development. For instance, initial professional training efforts are being made to improve the autism-related knowledge of both community mental health and independently-practicing therapists in the U.S. and many European countries, particularly in more isolated rural areas (Dreiling et al., 2022; Maddox & Gaus, 2019). These trainings generally focus on tailoring therapeutic practices to autistic clients who have also been labeled with other mental diagnoses (i.e., depression, anxiety, etc.) for which they would like help. Those offering the trainings report great interest and high numbers of requests from providers, particularly to learn how to work with autistic adults competently. They also report that as autism gains further representation in the media and increased mainstream familiarity, more undiagnosed clients are beginning to be recognized, and their providers are becoming more familiar and comfortable with serving them. Such findings are reflective of a recent shift in therapists towards wanting to better understand and work with autistic clients in their practices.

In addition to shifting therapist demands for training to work with autistic clients, a broader paradigm shift is in motion which has profound implications for how therapy is conducted with autistic clients in the future. Autistic academics have already written extensively about how therapeutic “treatment” with autistic clients is usually problematic (i.e., Yergeau, 2018; Walker, 2021), and advocate for a change in perspective on what “problems” autistic people need help with, let alone how to “treat” or “solve” them. Walker (2021) details how mainstream and contemporary conceptions of autism view it as a medical disorder and deficit to be “treated” or “cured” by therapists and other “experts;” called the “pathology paradigm” (pp. 18-19). She champions a cultural paradigm shift away from viewing autism (and other forms of neurodivergence) as pathologies which are inherently bad and in need of cure and treatment, towards viewing them as neutral and valid ways of being alongside those previously taken-for-granted as normal or default. Walker calls this the “neurodiversity paradigm” shift, along with embracing the core concept of “neurodiversity:” the idea that different people have naturally diverse ways of neurocognitive functioning, and that this variation is beneficial and should be honored because it results in more creative possibilities for the world (as does any form of diversity; pp. 19-20). Later in her book, she ultimately argues for allistic (non-autistic) professionals to seek out training from autistic people well-versed in the neurodiversity paradigm and critical theories (e.g., queer studies), who can guide them towards these anti-oppressive and liberatory ways of thinking (p. 138). In tandem with these ideas, a recent paper by Turncock et al. (2022) recommended exploring the use of *autistic-informed* online training tools for the public and professionals – including therapists. Specifically, to combat social stigma and misinformation associated with autism, they proposed the development and dissemination of educational trainings about autism which enable cultural/systemic shifts in their audiences towards the neurodiversity paradigm shift.

However, there remains the current issue that most therapists have not accessed autism-specific trainings, especially those that are autistic- and/or neurodiversity paradigm-informed (and thereby depathologizing of autistic clients). As the neurodiversity paradigm and its associated social movements continue to gain popularity, this too will hopefully shift with time. Beyond the initial interest and efforts to train more open-minded and willing therapists to work with autistic clients, these providers must determine which goals would be ethical to pursue –

and thereby, which approaches would be ethical to use – when working with their autistic clients. To accomplish this, the usual therapeutic problem must be reconsidered, and go beyond the basic blaming of autistic neurology for the many problems that currently plague autistic existence. Therapists must ask the following questions: 1) What problems do autistic clients themselves want addressed? 2) What problems do autistic clients face which cause them actual distress and harm? and 3) What specific psychotherapeutic approaches, techniques, and/or frameworks are well-suited to help with the above problems?

The Reconceptualized Problem – Autistic Minority Stress

The Case for Autistic Minority Stress

Population-level data for autistic adults is scant (Lipinski et al., 2019), and to date, there are no clear estimates of how often autistic people choose to seek psychotherapy and why. As a result, the problems that autistic therapy clients want addressed cannot be generalized. In lieu of such research (and unethical attempts to "treat" autism itself), existing literature on provider competence typically focuses on therapists' abilities to "treat" other forms of neurodivergence aside from autism in their autistic clients (i.e., Strömberg et al., 2022; Lipinski et al., 2021; Adams & Young, 2020). Obviously, other innate forms of neurocognitive functioning aside from autism (i.e., ADHD, dyslexia, etc.) cannot be removed from the person without fundamentally changing them, and efforts to remove them are also neuronormatively oppressive. Therefore, problems that therapists could ethically help autistic clients with include acquired psychological distress and trauma. Autistic people consistently report higher rates of anxiety, depression, PTSD, and other distressing experiences when compared to their allistic counterparts (Lai et al., 2019; Gillberg et al., 2016; Kerns et al., 2015). Additional evidence suggests autistics experience higher mortality rates associated with a wide array of physical and mental experiences, especially from suicide (Hirvikoski et al., 2016). New efforts to apply Minority Stress Theory (MST) to autistics may help explain where this greater risk comes from (Botha & Frost, 2018) and inform therapeutic work with autistic people.

The concept of minority stress originates from Meyer's (2003) theoretical efforts to explain the disproportionate instance of mental health diagnoses (i.e., depression, anxiety, PTSD, etc.) in lesbian, gay, and bisexual (LGB) individuals. In this seminal work, Meyer defines minority stress as, "the excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position" (p. 3). With the pervasive pathologization of autistic traits in mainstream discourse (Walker, 2021; Yergeau, 2018), as well as evidence of implicit prejudice towards autistic children and adults (Dickter et al., 2020; Wood & Freeth, 2016), autism is certainly stigmatized. Moreover, autistic people are socially oppressed for being non-normative "neurominorities" (Walker, 2021), as societal notions of "normal" are often based on majority presentations. In fact, Walker has already dubbed prejudiced attitudes towards autism as "autistiphobic" (p. 92), further cementing the recognition of autistic people as a socially minoritized and oppressed group. Therefore, MST might be a useful framework for helping researchers and therapists better understand how to improve and support the well-being of autistic individuals.

For those who experience minority stress, MST delineates two types of stressors: distal and proximal (Meyer, 2007, p. 245). Meyer describes distal stressors as those stressors acting upon the individual – typically social prejudice towards their perceived difference – regardless of their awareness or feelings about said stressors. In the case of someone autistic, this may be others' prejudice towards their stimming (self-stimulatory motions such as rocking, hand flapping, and spinning) and echolalia (repeating words or phrases out loud), resulting in them being treated as “strange” or “suspicious” in public spaces (and either reacted to with avoidance or aggression). Other autistic traits which may be perceived negatively in allistic-dominated social spaces are: a general predisposition towards specialized attention/focus and interests (Murray et al., 2005), a preference for “deep” or specialized topic-focused conversation over “small talk” or gossip, greater gravitation towards solitude or an “aloof” appearance to allistic people (Williams, 1996), non-normative amounts of eye contact, non-normatively timed facial expressions (i.e., smiling when stressed; frowning when content), stress responses resulting from heightened sensory sensitivities (i.e., sights, sounds, textures, etc.), non-normative executive functioning (i.e., time management, working memory, etc.), and the partial or absent use of speech to communicate. These traits are salient across a wide array of social experiences, and are prone to receiving ample negative attention from allistics.

In contrast, proximal stressors would be related to an individual’s own social perceptions and group identity (Meyer, 2007). For instance, an autistic individual who knows from repeated past experiences that others view their stimming and echolalia negatively may feel a deep internalized shame for being autistic, or even for simply being “weird” if they are not aware of being autistic. This may result in self-policing neurodivergent movements whenever possible to gain social acceptance or safety, usually referred to as “masking” (Hull et al., 2017). One specific framework from MST relevant to autistics is the choice to conceal one’s minoritized and stigmatized traits, which may help with avoiding discrimination (Meyer, 2007). Meyer explains, “paradoxically, concealing one’s stigma is often used as a coping strategy, aimed at avoiding negative consequences of stigma, but it is a coping strategy that can backfire and become stressful” (p. 252). In the instance of queer individuals, this often takes the form of being “in the closet;” while with autistic individuals it takes the form of autistic “camouflage” (Hull et al., 2017). Camouflage not only includes the previously mentioned mechanism of masking one’s autistic traits and replacing them with neurotypical-passing behaviors, but also additional compensatory and assimilating strategies (Hull et al., 2019). Compensatory strategies are those that are focused on the acquisition of social techniques/mannerisms (i.e., impersonating popular T.V. characters, scripting conversations in advance, using timer apps for reminders, etc.) that result in being well-received by allistic people, while assimilating strategies are those compelling the autistic individual to ‘fit in’ allistic social spaces (i.e., forcing oneself to sit still or make more eye contact).

For the autistic individuals who use them, these camouflaging techniques converge to form a long-term, elaborate, and systematic practice of acculturating into neuronormative/allistic social worlds. However, the neurocognitive functioning of allism cannot be truly “acquired” with practice, nor will it ever be natural to the autistic-proclivitied individual. Rather, allistic behavior can only be studied, copied, and successfully imitated with increasing effort and strain. When that effort must be sustained both too long and in an overwhelming amount, and in combination with inadequate social support, the autistic individual will experience what has been termed “autistic burnout” (Raymaker et al., 2020). Autistic burnout is defined as a several month or longer period wherein an autistic individual experiences “exhaustion, loss of function, and reduced tolerance to stimulus” (p. 140). During this period, they may struggle to perform daily tasks, withdraw from relationships, experience serious bouts of depression and suicidal ideation, and even enact self-harm. Unfortunately, most of those interviewed by Raymaker et al. (2020) reported a lack of empathy and patience from allistic individuals during their own periods of autistic burnout. Recent findings also support the idea that autistic camouflaging leads to burnout, but may help with avoiding social discrimination and harm (Bradley et al., 2021). These accounts provide additional evidence that many of the struggles seen as endemic to autistic being are better attributed to the distal stressors (prejudice towards and discrimination against autistic traits) and proximal stressors (internalized ableism and camouflage/masking). Indeed, a study by Cage et al. (2018; *n*=84) found that a greater acceptance of one's autistic traits from others (distal) as well as oneself (proximal) predicted decreased depression. However, increased stress was only predicted by decreased acceptance from others. Such findings support the idea that the depression and anxiety disproportionately experienced by autistics may indeed be caused by societal autistiphobia and residual minority stress.

Formally Applying MST with Autistic People

Botha and Frost (2018) conducted the first study deliberately applying MST to autistic adults (*N*=111) by gathering survey data for the following variables: stressful life events, within-year victimization and discrimination, everyday discrimination, expectation of social rejection, degree of autism disclosure in one's environment ("outness"), degree of physical concealment of autistic traits, internalized stigma, psychological distress, and social, emotional, and psychological well-being. They found that decreases in the social well-being of autistic individuals were significantly predicted by increased physical concealment of their autistic traits and an increased expectation of social rejection from others in their environment (p. 16). Decreased psychological well-being was significantly predicted by increased: expectations of social rejection, autistic "outness," degree of reported stressful life events, and everyday discrimination. Decreased emotional well-being was also significantly predicted by increased internalized stigma about being autistic. Lastly, increased psychological distress was significantly predicted by increased everyday discrimination, expectation of social rejection, autistic "outness," internalized stigma, and having a formal diagnosis of autism (p. 17). As expected by MST, these results suggest that both the visibility of one's autistic traits *and* the degree of autistic masking they must enact to avoid discrimination and rejection may lead to worsened social, emotional, and psychological well-being for autistic individuals.

These empirical findings support the idea that higher rates of psychological distress found in autistic people are attributable to their experiences of minority stress in society. Expanding on this idea, one would presumably conclude that the societal solution would be a combination of reducing distal and proximal stressors for autistic people. In fact, a study investigating the relationship between one's autistic identification and psychological well-being found that, amongst its autistic subsample (*n*=272), having a more positive sense of one's identity as an autistic individual was positively related to self-esteem and negatively related to depression and anxiety, with self-esteem serving as a mediator between autistic identification and psychological well-being (Cooper et al., 2017, p. 18). This provides initial support to the idea that depathologizing autism – and replacing it with the development of autistic self-esteem – is a key element of cultivating autistic psychological well-being.

However, transforming an autistic individual's negative self-image and internalized stigma into a more positive self-image can only serve as part of this solution. While *greater acceptance* of one's own autistic traits (proximal) as well as that from others (distal) was found to predict *decreased depression*, only *decreased acceptance* of one's autistic traits by others (distal) was found to predict *increased stress* (Cage et al., 2018). In other words, depression is probably an internalized form of autistic minority stress, while *the fundamental minority stressor is most likely a lack of autism acceptance from the greater social world*. Therefore, a more foundational step must be included in solving the societal pathologization and oppression of autism: transforming autistiphobic prejudice and discrimination into another way of relating to autism. A way of relating which – instead of casting autism as an inferior or deficient way of being – simply understands autism as *another* (sometimes positive) way of being alongside what is broadly neuronormative or specifically allistic. In other words, society must undergo the neurodiversity paradigm shift.

Transforming Society's Relationship to Autism

The Double Empathy Problem and Allistic Privilege

Relational implications of the neurodiversity paradigm shift – especially the idea that autistic people and other neurominorities are socially oppressed and minoritized – can be further explained with autistic researcher Damian Milton's concept called the "double empathy problem" (DEP), also known as the theory of double empathy (Milton et al., 2018; Milton, 2012). The DEP explains that allistic people struggle to understand the communication of autistic people when compared to that of other allistic people, and vice versa. However, the "problem" of this communication mismatch and delayed capacity for understanding the other person's experience tends to be blamed entirely on autistic people, as society is usually biased in favor of allistic ways of communicating. For autistic individuals who cannot communicate using oral speech, this bias tends to be further amplified (Wolf-Meyer, 2020). This is best evidenced in the fact that the authenticity of their communication is called into question, even when they communicate in ways considered legitimate for speaking allistic people, such as writing (Yergeau, 2018). Put another way, autism is socially oppressed, which also means that *allism is* *socially privileged* (Walker, 2021). There is a growing body of research that supports the existence of the DEP – and by extension, allistic privilege – as a framework.

First, Crompton et al. (2020b) conducted a diffusion chain experiment (*n* = 72) with three groups (autistic only, allistic only, and a mixed autistic-allistic group). Information was passed along a chain of individuals, and then evaluated for its accuracy to the original message at the end. The researchers found that information retention was only significantly worse in the mixed group compared with autistic only and allistic only groups. In other words, the group of autistic participants were able to transfer information between each other as successfully as the group of allistic participants were, but autistic and allistic participants struggled to do so between each other. Next, Crompton et al. (2020a) conducted a follow-up study with new autistic and allistic participants (*n* = 80), who were asked to observe video recordings of pairs from the previous experiment interacting. They were then asked to rate the rapport of the different pair interactions. The researchers found that the mixed autistic-allistic pairs were rated significantly lower for interpersonal rapport than the two neurocognitively similar pairs, and that the autistic pairs were, in fact, rated with higher overall rapport than the allistic pairs.

Next, Heasman & Gillespie (2019a) explored the unique characteristics of interaction between multiple autistic participants in a study on autistic intersubjectivity. Compared with the social practices of their allistic counterparts, the autistic participants tended to assume a broader range of shared interests amongst themselves, thereby building rapport more quickly amongst one another. That is to say, autistics more readily threw out potential topics of shared interest (i.e., specific video games, comic book series, etc.) as bids for connection, assuming they would have more in common with those around them. Interestingly, the autistic participants were also more forgiving to each other when interest-based bids for connection did not readily land with one another; they moved on to new subjects without making these moments a big deal. Such findings offer a possible explanation for why the aforementioned diffusion chain experiment follow-up by Crompton et al. (2020a) found that both autistic and allistic observers rated rapport between the autistic-only group slightly higher than rapport observed between the allistic-only group. Perhaps a unique strength of autistic-on-autistic relationality is faster rapport-building accessed through faster processes of social trial-and-error. Finally, another follow-up on the original Crompton et al. (2020b) study observed that less “backchanneling” (saying “mhm” or some other verbal indication of listening) between autistic participants was associated with higher rapport ratings between them (Rifai, 2022). This indicates that there are social cues assumed to be universally beneficial by allistics, which might not be needed by autistics. In other words, allistic people also need accommodations when communicating, but because their ways of communicating are privileged as ‘normal,’ these accommodations are taken-for-granted as standard communication.

In summary, initial research on autistic-allistic-paired interaction does not suggest that autistic neurocognitive functioning is evidence of a social-communication deficit, but rather, a stylistic difference in interaction of no greater or lesser value. In response, it is more ethical for therapists to view mixed autistic-allistic relationships like multicultural relationships (Walker, 2021), in which members with vastly different neurocognitive leanings must ‘stretch’ themselves to understand one another. This is a much less reductionist and blaming perspective than characterizing autism as a “condition” or “disorder,” and locating it as a “deficit” in only one of the relational parties present. Unfortunately, until recent large-scale challenges from autistic people, the belief that autism is a pathology has been our contemporary social world’s primary way of relating to autism as a phenomenon. The core tension in our societal relationship to autism is therefore derived from defining and responding to it as a “problem” with an *individual* (Yergeau, 2018; Walker, 2021), when in fact, “the problem” in question is a *relational* one. As Pellicano & Heyworth (2023) aptly explain: “It is the contextual response to the [autistic] individual that we need to address” (p. 5).

If our society continues to explain the greater discomfort allistic individuals feel in their interactions with autistic individuals (relative to that felt with other allistics) by mischaracterizing autistics as pathological, we will automatically attempt to “cure,” “treat,” or “fix” autism as a means to resolve that discomfort. This means that, by *centering* the allistic experience of such interactions, then *normalizing* the allistic discomfort felt in autistic company, autistiphobia and its resulting ideology of treating/curing autism is unleashed into our world (Walker, 2021). We as a social world will also need to abandon the idea that allism is *normal* and autism is *abnormal*; they are simply different ways of being. Again, this ideological shift is predicated on the neurodiversity paradigm shift. Finally, we must begin to *decenter* the allistic (and otherwise neuronormative) perspective, by making more room for exploring *first-person* autistic (and otherwise neurodivergent) perspectives. In other words, we must ask autistic people about their own perceptions and experiences, and not rely on others’ perspectives of them. This decentering must occur in all forms of social exchange – especially in psychotherapies and research – if the goal is liberating autistics from neuronormative oppression rather than obstructing such liberation. One could reasonably conclude that, amongst the therapeutic frameworks helpful in championing such a decentering and relational shift, systemic therapy (or, marriage and family therapy) frameworks would be ideal. As a result of their focus on relational problems, systemic therapy frameworks may offer helpful insights into transforming our society's current relationality towards autistic people and their ways of being, especially in the therapeutic context.

Systemic Frameworks for Liberating Autistic People

In drawing from family systems and cybernetic theories, systemic therapies use some theoretical frameworks necessary to challenge the idea that relational problems are caused by autism and located within autistic clients (Wolf-Meyer, 2020; Tilsen et al., 2005), instead, framing those problems as groups of clients with different neurocognitive functioning proclivities struggling to understand each other (Simon et al., 2020; Gratton, 2019; Milton, 2012). Perhaps most importantly, systemic therapists are trained to guard against aligning heavily with one client in the therapy room. Instead, they are encouraged to consider the well-being of an entire relational "system" (i.e., partners, family, etc.; Carr, 2015) by making equitable space for the perspectives of everyone in the room, and directly challenging perspectives which enact systemic and ongoing harm to others; a key technique in contextual family therapy called "multidirected partiality" (Hargrave & Pfitzer, 2003, p. 100). Many relational systems present to therapy with an "identified person" or "identified patient" (IP), named as such because other members of the relational system deem them responsible for their collective problems (Bateson, 1978; Ferenchick & Rosenthal, 2019). When a neurodiverse family presents to therapy framing one member's recognized autistic traits as the source of their relational distress, this autistic member has been declared the IP. As a result, their traits which are constructed as autistic are conventionally labeled as 'the problem' that requires "fixing."

However, systemic therapy frameworks advise against blaming systemic problems on one family member's participation, electing to view their causes as circular rather than linear (Carr, 2015, p. 19). In other words, they explore and identify the greater cyclical patterns of family interactions (e.g., what one family member #1 does, which precipitates the actions of family member #2, which catalyzes family member #1's initial actions again, and so on). This focus on circular causality helps systemic therapists creatively work with every family member to change what they *can* control (what they themselves are doing), rather than focusing so much energy on what they *cannot* (what the other family members are doing). No matter the specific systemic therapy approach, the intended result of systemic frameworks is relational system-wide transformation; usually called a "second-order change" (p. 24). In the instance of neurodiverse families with autistic and allistic-identified members, this transformation may become possible by shifting the relational dynamic away from attempting to blame and "treat" the autistic client's neurocognitive functioning proclivities, and towards family-wide accountability for meeting each other's relational needs; put another way, "syncing" their communication styles (Gratton, 2019). Then the case's presenting "problem" would evolve away from the blaming clients' autistic-labeled traits, and towards challenging the neuronormative, autistiphobic beliefs and expectations creating distal and proximal stressors for each client (Botha & Frost, 2018; Meyer, 2007). Such an evolution would, theoretically, result in universal client liberation from neuronormative constraints. This liberation would be universal because neuronormativity – in prescribing and mandating certain ways of embodiment, expression, and relationality as "normal" – oppresses everyone (Walker, 2021). For instance, although stimming movements are most often recognized in autistic people, everyone tends to tap their feet, pace, or move their bodies from time to time. The expectation that everyone remains still in public social settings is thereby neuronormative and oppressive to everyone, and ending this unrealistic expectation would benefit all clients.

In this endeavor to end neuronormative oppression via systemic framework-informed therapy practices, it is important for therapists to remember that “less powerful persons can be pathologized and/or made to carry the greater burden for change when well-meaning therapists center their attention on simply removing symptoms of oppression” (McDowell et al., 2018, p. 21). Therapists must avoid both 1) overtly oppressing and traumatizing autistic clients by misguidedly attempting to remove “symptoms” of their neurocognitive functioning through ABA/behaviorist approaches (Sandoval-Norton et al., 2021; McGill & Robinson, 2020; Kupferstein, 2018), and 2) covertly harming autistic clients by focusing on removing the symptoms of minority stress, residual trauma, and autistic burnout that result from systemic autistiphobia without attending to their many underlying systemic causes (Walker, 2021; Raymaker et al., 2020; Yergeau, 2018; Botha & Frost, 2018; Cage et al., 2018; Cooper et al., 2017). Therapeutic solutions for autistic clients and their close relationships lie in depathologizing a relational system’s beliefs about oppressed individuals (such as autistics) and redirecting problem-solving towards mechanisms of social oppression. Yet, client beliefs about autism and other oppressed ways of being are constantly informed and reinforced by pathologizing language about autism (Walker, 2021). Thus, social constructivist-influenced systemic therapy approaches, like narrative and collaborative (language systems) therapies are especially ideal for such work, as they focus on replacing pathologizing language about people and their relationships (White & Epston, 1990; Anderson & Gehart, 2007).

Importantly, autistic individuals do have innate neurobiological proclivities which cannot be ignored (Walker, 2021), such as feeling uncomfortable with prolonged eye contact, needing to stim with their bodies, etc. As a result, systemic frameworks of working with autistic clients must also facilitate the liberation of autistic embodiment. For this aspect of therapy, experiential systemic therapy concepts may be especially helpful. As those who explicitly “walk the walk,” experiential therapists are trained to put their whole selves into therapy, using their own authentic expression and role-modeling of that authenticity as the core therapeutic technique (Satir, 1988; Whitaker & Bumberry, 1988). A liberatory experiential therapist for autistic clients might challenge colonizing notions of what forms of expression should be honored (McDowell et al., 2018), and role-model an authentic “*neuroqueering*” – a disorienting or unorienting – of their neurocognitive expression alongside their clients (Yergeau, 2018, p. 182; Walker, 2021). Both Satir and Whitaker experiential uses of authentic and spontaneous being with therapy clients harmonize with this endeavor to dis- and unorient; to disrupt relational systems’ efforts to crystalizing into rigid homeostases, reminding them of their ever-fluid potentials. Such efforts could relax the expectations of the relational system to make more space for authentic autistic embodiment. There are many more considerations for conducting therapy with autistic clients and those close to them. The above therapeutic approach-based explorations merely offer some possible paths to take with these cases while using systemic frameworks. Indeed, systemic therapy approaches have already been considered for their efficacy in working with autistic clients and their families; this body of recent autism-focused systemic therapy literature is summarized at the end of the following chapter.

Introducing the Dissertation Project

The current chapter served as an introduction to contemporary problems with autism care (particularly in the psychotherapeutic professions), offered alternative conceptualizations of the problems autistic clients experience, and explored how systemic therapy frameworks may align with these new conceptualizations. The next chapter will delve into the following: the history of how autism came to be pathologized and how this history is rooted in deeper problems of socially oppressive Western cultural and scientific traditions; how phenomenological and critical theory-driven concepts challenge the taken-for-granted assumptions of these traditions and enable an alternative relationality towards autism reflective of the neurodiversity paradigm; and finally, how there are continued systemic therapy literature gaps in understanding and studying this neurodiversity paradigm-based relationality. The interpretative phenomenological analysis (IPA) study presented in the remaining chapters offers possible ways for therapists (and clients) to transform their relationships to autism in their therapeutic work and beyond. The experiences of ten neurodiversity paradigm-embracing therapists who work with autistic clients are explored to better understand what their journeys of becoming neurodiversity paradigm-embracing have meant for their therapeutic philosophies, practices, relationships, and senses of self.

Chapter 2 - Literature Review

The introduction chapter explored how behaviorism and the broader psychotherapeutic professions are currently failing to meet the needs of autistic people, often harming them instead. It also explained how the neurodiversity paradigm shift aligns with the relational shift needed to conduct more ethical work with autistic clients, addressing the stressors they face as a neurominority experiencing autistiphobia. Finally, the previous chapter gave examples of systemic therapy frameworks which might help create such shifts in therapy with autistic clients and those close to them. The following chapter sections will: 1) provide a more detailed history and theoretical background for how our world has come to relate to autism as an individual pathology such that the double empathy problem (DEP), autistiphobia, and residual autistic minority stress now exist; 2) explain how this history is intertwined with deeper problems in Western cultural and scientific paradigms that are inherently oppressive, exploring how insights from phenomenology and critical theories challenge these paradigms; and 3) advocate a systemic/cybernetic therapy-based framework which enables the desired neurodiversity paradigm-based relational shift towards autism, finishing with a summary of strengths and gaps in how systemic therapy literature has approached this relational shift towards autism thus far.

History and Theoretical Background

Naming, Defining, and Classifying Autism as a Pathology

Over the last several decades, individuals who identify as autistic have increasingly asked the question: is it fair to characterize autism as merely a pathology? An important critique of the medical, pathologizing model of autism – or, the understanding of autism as a disease, disorder, or condition to be medically intervened on, treated, or cured (Walker, 2021) – is that the initial concepts of diagnosis now appear riddled with the beliefs and values of the settings in which the condition was first medicalized. Given that autism was first distinguished from other psychiatric diagnostic categories/labels in both the eugenicist and fascist context of Nazi Vienna (Sheffer, 2018), and in the pathologizing, modernist context of the most "severe" childhood cases in the United States (Silberman, 2015), autistics and autism historians alike have increasingly condemned how broader society has evolved to understand and interact with autism through a deficit-based lens.

In 1944, Hans Asperger expanded on his previous papers and published a postdoctoral thesis (Asperger, 1991). It provided years' worth of evidence for a condition dubbed "autistic psychopathy," which was conceptually derived from clinical observations made at the pediatric hospital unit he directed during Nazi occupation of Vienna, Austria. Sheffer (2018) and Czech (2018) recently revisited documentation related to Asperger and his close Nazi party-member affiliates, and uncovered disturbing evidence about how he treated disabled children under his charge. Asperger evidenced a strong prejudice against intellectually disabled autistics – calling their behavior "automaton-like" and their special interests "crackpot interests" – and refused to acknowledge that assigned female at birth individuals could be autistic; even the mothers of the boys he worked with who presented classic signs recognized at the time (Sheffer, 2018; Asperger, 1991, p. 75). Asperger went so far as to say, "unfortunately, in the majority of cases the positive aspects of autism do not outweigh the negative ones" (p. 74), and described autism as a deficit in "gemut" – a German word for "social spirit" – often used to describe the ability to conform to the Nazi state (Sheffer, 2018). Asperger has since been connected with the assignment and transferal of disabled children to Spiegelgrund, the infamous child "euthanasia" center responsible for the abuse and killing of hundreds of children deemed by eugenicists as "life unworthy of life" (Czech, 2018; Sheffer, 2018, p. 20). In light of these horrifying actions, it is essential to reexamine and deconstruct Asperger's influence on autism research from the 1980s onward.

Before addressing Asperger's legacy, one would be remiss not to examine the legacy of Leo Kanner in autism research as well. In 1943, Kanner also presented his ideas for a new condition he described as "inborn autistic disturbances of affective contact" (Kanner, 1943, p. 250). This paper laid out a very similar presentation to the one described by Asperger, with the notable exceptions that Kanner included girls in his research, and would filter which children entered his practice by only taking cases labeled too challenging for other practitioners to figure out (Silberman, 2015). As a result, Kanner – and American child psychiatrists and psychologists by extension – developed a very narrow idea of autism focusing on combinations of traits (i.e., non-speaking, intellectual disability, etc.) which might have been labeled by the pathology paradigm as "severe" autistic presentation a few decades ago. In this way, Kanner carries much of the responsibility for proliferating the idea that autism is an extremely rare, monolithic way of being, and that only those viewed as dependent on others for most of their activities of daily living should meet autism's diagnostic criteria. This understanding of autism lasted until the diagnostic label gained public prominence by the end of the 1980s. It is now understood that two colleagues – Georg Frankl and Anni Weiss – who originally worked with Asperger later worked with Kanner and likely played major roles in their almost simultaneous "discoveries" and pronouncements of autism's existence (Sheffer, 2018; Silberman, 2015). In other words, these were not incidental, independent encounters with an objectively observable phenomenon to be discovered in the world (autism); they were connected, opportunistic, and pathologizing hypotheses about a way of being.

In 1981, Lorna Wing first defined Asperger's Syndrome upon discovering Hans Asperger's postdoctoral thesis, and noticing that it described what is today thought of as "high-functioning" autism (Wing, 1981). This change in framing autism from Kanner's "lowered" the diagnostic criteria and expanded the possibility for autism diagnosis, thereby making it accessible to more individuals (Silberman, 2015). However, it also popularized Asperger's own eugenicist dichotomization of autism between those subjectively deemed hopeless, useless, and "a drain on the state," versus those deemed genetically gifted, genius, and capable of participating in a fascist state (Sheffer, 2018, pp. 96, 100). In this case, those who are devalued and underestimated – usually for being considered individually unemployable, incapable of meeting most of their own care needs, and/or being noticeably non-speaking – are labeled "low-functioning." Such individuals were previously considered worthy of a blanket autism diagnosis as opposed to the "milder" label of Asperger's Syndrome. Meanwhile, "high-functioning autism" – and previously Asperger's Syndrome – is the label assigned those considered socially acceptable to the degree that they can obtain and keep a job at least part-time, "function" more independently, and use speech to communicate more often; all of this determined by the standards and expectations of the current (capitalist) cultural world/moment (Chapman, 2020). Given that this distinction between autistic people as more or less "useful" workers continues to be emphasized today, Asperger's eugenicist influence still dominates public understandings of autism.

The Rise and Fall of Theory of Mind: From Pathology to Autistic Identity

Wing's work of defining Asperger's Syndrome also catalyzed a new era of autism research and diagnosis, starting with the first study applying theory of mind (ToM) to autism. In this study, Baron-Cohen et al. (1985) defined having a theory of mind as, "knowing that other people know, want, feel, or believe things" (p. 38). They investigated whether or not "high-functioning" autistic children were able to pass a false-belief puppet paradigm test when compared to neurotypical and Down's Syndrome controls, in order to prove that autism is a unique type of developmental disability wherein one lacks a ToM. In essence, this test is designed to capture whether a child responds based on what they themselves saw happen while a puppet was not in the room (or only based on what the puppet would have seen happen before leaving the room) to assess perspective-taking towards the puppet. Based on their conceptualizations and measures, these researchers found that the autistic children passed the false-belief puppet paradigm test at significantly lower rates (20%) than the Down's syndrome and neurotypical controls (85% and 85% respectively) (p. 42). While the findings of this study provide evidence that autistic children are less likely to *default* to responses which first consider others' situational information gaps (i.e., considering whether a puppet knew an object was moved while they left a room), the authors inappropriately extrapolated the false-belief test's results to mean that autistic children are *incapable* of noticing others' feelings, desires, or beliefs. Such a finding was then interpreted to mean that autistic children do not fully recognize that other individuals have minds separate from their own, and that they don't experience others as people. This conclusion has since served as justification for discounting autistic persons' humanity, and also resembles how Asperger (1991) characterized autistics as souls alone, and not active participants in social systems (p. 38).

Gernsbacher and Yergeau (2019) offer a more thorough and deep critique of the original conclusions drawn from ToM research – based on numerous empirical ToM study findings from the last several decades – with the following counterarguments. First, broad swaths of disabled children and more socially isolated (i.e., fewer siblings or relatives nearby) children disproportionately fail false-belief tests, not just autistic children (p. 103). Second, many autistic people *do* pass false-belief tests. Third, false-belief tests strongly rely on use of spoken language and vocabulary, which may better explain who tends to fail them and who does not (p. 104). Fourth, four groups of researchers have attempted to replicate Baron-Cohen and colleagues' original false-belief test findings, and none could (p. 106). Fifth, recent ToM research with large samples failed to find convergent validity between various contemporary false-belief tests (p. 107). Finally, performance on false-belief tests fails to significantly predict autistic traits, empathy, social skills, social engagement (i.e., attention, cooperation, avoidance, etc.), and peer relations as measured in ToM studies (p. 108). Gernsbacher and Yergeau conclude that "the claim that autistic people lack a theory of mind is empirically questionable and societally harmful" (p. 102).

In review of the problems with ToM research, it may be fruitful to explore existing alternative perspectives of autistic being that are already being considered within contemporary medical research landscapes. Koldewyn et al. (2013) suggest that ToM experimental results may be better explained by recent findings that autistic individuals demonstrate a preference for processing information locally rather than globally. In the authors' words, "[autistic children] may report the aspect of the stimulus they focused on first, without trying to determine the "correct" answer," while neurotypical controls are more apt to match their responses to what they think the experimenters expect (p. 10). In other words, this research suggests autistics *can* notice the expectations of others; they are simply less prone to default to *prioritizing* them in their responses. Put another way, autistics are less likely to default to people-pleasing or task obedience. These findings also align with the results of a social conformity study conducted by

Yafai et al. (2014), which found that autistic children were much less likely to socially conform than neurotypical controls, and autistic traits were negatively correlated with social conformity. Most interestingly, the experiment authors reported that the only predictor they found for lack of conformity was “attention to detail” (p. 14). Such a result provides further evidence that defaulting to processing information on a local (detail-based) level makes one less likely to succumb or conform to socially normed expectations. Perhaps whatever autistics notice at the level of detail that allistic others do not leads them to question the taken-for-granted, traditional assumptions and procedures they are being asked to ascribe and adhere to by default. In other words, autistic thinking may be a matter of quality (catching small details/errors that others miss) over quantity (quickness of processing by conforming to the expected parameters of the given task). It would naturally follow that this way of being may lead to new social possibilities and potentials – i.e., relaxing rigid social traditions over time, leading the challenging of social normativities, preventing systemic collapse due to early problem-catching, etc. – if left to its authentic process. These systemic benefits of having autistic people in the world deeply contrast with conclusions drawn by eugenicist valuations of autistic life. As such, whether this autistic characteristic is framed as a strength or deficit is *heavily* a matter of interpretation and framing.

In addition to the to these aforementioned critiques, articles focused on the philosophy of social cognition have already argued against interpreting the results of past false-belief test studies as evidence that autistic people lack ToM. For instance, Froese & Gallagher (2012) assert that the ToM empirical findings that their article revisits support a very different interpretation: allistic infants are innately equipped to read (presumably allistic) intentions through “automatic sensory-motor processes” that occur during in-person interactions with their caregivers (p. 448). In contrast, autistic infants have been shown to evidence non-neuronormative sensory-motor processes before age of diagnosis, suggesting this ability to "tune in" to (presumably allistic) intentions through physiological cues is not innately present for autistic infants (Gallagher & Varga, 2015). These interpretations support that autistic communication differences are more attributable to differences in one's innate sensorimotor processes than in one's theory of others' minds. Indeed, Gallagher & Varga (2015) suggest that some autistics may actively develop and employ ToM strategies (e.g., perspective-taking) in order to compensate for their non-neuronormative intention-reading proclivities within allistic-privileging social contexts. In other words, autistics may already compensate for their current social disablement by practicing perspective-taking towards allistics, while allistics are not required to stretch this "muscle" so much in their daily interactions (and as a result, might not be as practiced in this skill as autistics). Hence, and as the DEP indicates, perspective-taking is only a "one-way street" expectation – from autistics to allistics (Milton 2012). Ironically, when autistic people fail to perspective-take enough for both groups, they are cast as the unempathetic group.

Despite the empirical shift in support of sensorimotor-processing frameworks for explaining autistic neurocognitive functioning over the last decade (Yergeau, 2018), ToM still serves as a powerful theoretical support for much of the dominant deficit-based and normativity-laden discourses about autism mainstreamed today (Yergeau & Huebner, 2017; Wood & Freeth, 2016). Recent calls to understand autistics as an oppressed social group that experiences autistiphobia and residual (neuro)minority stress have served as necessary responses *to* these tenacious pathologizing/phobic views of autism and their continued impacts on autistic being (Walker, 2021; Yergeau, 2018; Botha & Frost, 2018). In the meantime, it is no wonder that studies consistently find a correlation between measures of psychological distress (e.g. depression and anxiety) – or, proximal stressors – and being autistic (Cooper et al., 2017;

Hofvander et al., 2009). As a reminder, Cooper et al. (2017) observed that *positive* self-identification with autism was a protective factor against stress, anxiety, and depression. When the world pathologizes autistic being, it creates the very outcomes for autistic individuals used to justify that they are pathological. In fact, many diagnosed autistic clients do not identify with the diagnostic label because they do not feel that the criteria accurately reflect who they are (MacLeod et al., 2013). Even if autism were framed more neutrally or positively, many individuals might not recognize their autistic traits *as* autistic. This is because neuronormativity pressures everyone to socially assimilate and gain acceptance into neuronormative society by learning "social camouflaging" as a way of hiding their autistic (and other neurodivergent) traits (Hull et al., 2017; Tubío-Fungueiriño et al., 2020).

Knowing about one's own autistic traits in the context of the current world *might protect individuals* from internalizing some of the autistiphobia they experience. However, if the belief that autistic being is pathological remains culturally dominant, individuals who are "getting by" in the world (but still struggling) are less likely to choose resonating with autistiphobically conceived notions autism. Perhaps if the label of autism were based in a more value-neutral, experientially-informed characterization of autistic being – as opposed to a pathological diagnosis with degrees of relative social visibility and acceptability – more individuals might come to authentically "be" autistic and/or recognize themselves in its current meaning.

The Impact of Western Paradigms

'Normal' People Determine Reality

In attempting to establish a new way of understanding and relating to autism devoid of pathology, one must also learn to recognize and eschew the tools of the pathology paradigm, and those of the Western cultural and scientific paradigms from which the pathology paradigm was conceived (Walker, 2021). One such tool is fixed, or static, definition. We must therefore ask the following question with genuine curiosity: what is autism's current meaning, and is it even static or definable? Decades before the more commonly known works of Leo Kanner and Hans Asperger, another figure influenced the trajectory of autism's conception and understanding today. In 1911, Swiss psychiatrist Eugen Bleuler originally named and identified the term autism as a key characteristic of lifelong schizophrenia, and defined it with the following:

> "The most severe schizophrenics, who have no more contact with the outside world, live in a world of their own. They have encased themselves with their desires and wishes (which they consider fulfilled) or occupy themselves with the trials and tribulations of their persecutory ideas; they have cut themselves off as much as possible from any contact with the external world. This detachment from reality, together with the relative and absolute predominance of the inner life, we term autism." (Bleuler, 1950, p. 63)

This definition of autism is very interesting. The term, characteristic, and 'clinical presentation' upon which current notions of autism were originally based and built was first defined as *a detachment from reality*. More specifically, Bleuler's statement reveals that both schizophrenia and autism were conceived of as detachments from a *collectively shared and intelligible (and therefore, normative)* social reality with other human beings, in favor of a more internally determined and often solitarily understood reality. Given the pervasive pathologizing frameworks of psychological experience in the medical field at the time, this definition of autistic being was predictably framed as "severe" mental illness. As Bleuler explains, "The *sick* person deals with the *real* world as little as the *normal* person deals with his *dreams*" (p. 66). The implication of this statement is clear: normal people live in the *real* world, schizophrenic/autistic people are *not* normal, and therefore, schizophrenic/autistic people's perceived (and experienced) worlds are *not real*.

This raises an important question: what exactly makes the "real world" *real* except that "normal people" agree upon what it is? Such notions of a real world are founded on positivist, post-enlightenment, Eurocentric belief in a discoverable 'objective' reality (world) outside of the self (Heidegger, 1962; Guignon, 1983). After the inner self (subject) was conceptually split from the outer world (objects), so too did our notions of an objective reality become severed from individual meaning-making (i.e., perception and thoughts). This objective reality was then distinguished as concretely observable and measurable, and therefore, capable of being verified and agreed upon by multiple individuals, as opposed to subjective realities. In his famous work *We Have Never Been Modern*, Latour (1993) explains how the invention of modernity itself depends on the bifurcation of nature and culture, or, of the natural (objective) and sociocultural (subjective) worlds. Through the creation of this binary, countless other binaries cascade into being. Among the more insidious and consequential resulting binaries, *the worlds of science, empiricism, and technology are marked as objective* because they study measurable objects 'out there' in the world, meanwhile, *the worlds of culture, relationships, and language are marked as subjective* because they consist of immaterial constructs located 'in us' as living (usually, human) beings. However, Latour explains that one cannot be separated from the other; there are only "nature-cultures" (p. 104). Similarly, empirical sciences – and the agreed-upon "objective" realities that come from them – are social products, and vice versa. Yet, as any social scientist would know, there is often the assumption that "hard sciences" are more real or objective because their objects of study are ascribed full objecthood.

Phenomenological Critiques of Objective Reality

The Western philosophical discipline of phenomenology emerged in the early 1900s as a study of human experience, although each of its core philosophers took it in very different directions (Smith et al., 2022, p. 7). This section focuses on the phenomenology of German philosopher Martin Heidegger. What Heideggerian phenomenology came to take issue with in modern Eurocentric thinking were the false dichotomies drawn between the scientific and the social, nature and culture, object and subject, and the world and self. In *Being and Time,* Heidegger (1962; Guignon, 1983) linguistically and conceptually collapses the individual human self and the observable world of objects into an entirety called "being-in-the-world," or put shortly, "existence" (Dasein). His primary methodology for enacting this paradigm shift was playing with and changing language such that subjects and objects (signified in the subject-predicate structure of most language) began to collapse in on each other; hence, the neologism "being-in-the-world," and others' contemporary creations of more object-subject dualism-challenging terms (i.e., "bodymind" in somatic psychology referring to the fact that one's body and mind are not separate; Dychtwald, 1986). Heidegger then reconceptualized human existence as "thrown" into active contextual participation from the moment of one's birth. Additionally, he thought that people learn to derive and shape social *(and also real, for which I will hereafter use the term "social-real" to emphasize this reconnection of what is objective and subjective)* meanings and possibilities *through* the actions of being, or, existing.

Heidegger also considers the role of language and meaning-making in existence, and as Guignon explains of *Being and Time*, "although the dominance of the public way in which things have been interpreted in idle talk opens the possibilities of Dasein's Being, it also "cuts off"

Dasein's "primary and primordially genuine relationships-of-being toward the world, toward Dasein-with, and toward its very Being-in."" (p. 130). This quote takes effort to break down clearly to lay audiences, but has profound and important implications when more clearly understood. To explain the first half, accessing a shared language (and thereby, cultural understanding) enables a human being to *efficiently and intricately articulate and understand* shared meaning-making, or social intelligibility, with many other individuals. Through this process, possibilities of social-real existence "open up" to human beings-in-the-world. For instance, if one has the language/culture to *both understand and convey* that they want to marry another, such an existential possibility opens up to them. Even so, the possible manifestations of marriage as an experience will vary greatly across the linguistic/cultural contexts they are embedded in. Regarding the second half of the previous quote, the more a specific language/culture becomes dominant and shared, the more it begins to mold and constrain social-real possibilities to fit its existing structure. As a result, genuine and authentic being-in-the-world is also *thwarted by* conformity to existing language/culture; this conformity serving as the price to continue accessing shared intelligibility with many other human beings. After all, it is the uniformity of shared meanings which allows them to be quickly intelligible on a large scale. Going back to the earlier example, if such a vast number of human beings weren't familiar with *the meaning of marriage* through language/culture, they would not authentically come to marriage as it is understood in the here-and-now of whatever context. Language quite literally makes marriage *possible*. It is hopefully obvious, then, that anyone who accesses or uses language non-normatively (i.e., someone autistic) is less likely to live in the same "reality" as more linguistically connected others. Ironically, because such a person does not strongly base their sense of reality on the relative norm, they might also be experiencing something closer to the Western sense of a totally objective reality (contrary to the assertions of Bleuler).

To more clearly imagine the powerful warping of social-real possibilities achieved through an increasingly dominant shared language/culture/reality, it may be helpful to think of shared language as a black hole. At a comfortable distance, black holes organize galaxies around themselves, *creating more possibilities* of proximity and interaction between the bodies they organize. However, they also warp space-time around themselves so powerfully that they simultaneously *limit possibilities* for their neighboring bodies; possibilities which might exist for bodies beyond their effective gravitational pull. Furthermore, any bodies *too close* to black holes experience a homogenous outcome, and the previous distinctions that made them unique are torn apart under the enormous pressure. Similarly, languages have the positive quality of facilitating social-real possibilities through collective coordination of beings-in-the-world; they also possess the negative quality of limiting social-real possibilities through collective homogenization – and thereby, normativization – of beings-in-the-world. Put simply, the more human beings spend time participating in a specific language/culture, the more they act like it, think like it, and reflect like it; it normalizes them. Again, it should be obvious here why people who use language non-normatively are less normalized to a given social-real context. Fortunately, human beings also have the capacity to encounter and generate non-normative ways of being, as well as the tendency to express or combine those with their prior ways of being, thereby reshaping the world of social-real possibilities in turn. Thus, human beings are *actively participating* and *co-creating* beings-in-the-world (Anderson & Gehart, 2023); they are *literally part of* the world and its movements, not just separately influenced and influencing selves/subjects.

Authenticity, Invention, and Possibilities: From Autistic Identity to Being

Heidegger implies that this phenomenon of self-reshaping-the-world-in-turn is most obvious when beings-in-the-world exist more authentically. According to Guignon (1983), Heidegger defines authenticity as the "“essential possibilities" of "silence" and "reticence," while, "[everyday language] is taken as characteristic of inauthenticity" (p. 130). In other words, he views not speaking or being socially reserved as more characteristically authentic ways of being-in-the-world than participating in the everyday "idle talk" of contemporary society. This maps very beautifully onto Yergeau's (2018) suggestion that authentically autistic (often non-speaking) ways of being serve as "invention sites" for social-real possibilities (p. 178). Perhaps a jovial hand-flapping motion in the middle of a social gathering catalyzes surprised, playful, embarrassed, judgmental, or otherwise random responses from others in the room. Maybe it goes unnoticed, is thoroughly ignored, doesn't stand out as unusual, or is even joined in on. Stims are entropy embodied in an otherwise uniform, organized (and boring) existence; these "echophenomena" are possibility-making machines and invention sites for ways of being-in-the-world (p. 193). They are *real* and *meaningful* forms of communication, even as they sometimes defy the collectively intelligible norms of symbolic language/culture. This idea resonates strongly with the work of Gregory Bateson, the prominent systems/cybernetics theorist, influential figure in the creation of the systemic therapy field, and original conceptualizer of the identified patient/person (IP) role (described in the previous chapter). Of Bateson's perspective, Wolf-Meyer (2020) says the following (italics added for emphasis):

> "Bateson… views communication as the conveyance of affect between environments and the bodies that inhabit them. Bateson *puts aside the symbolic as the primary repository of human meaning* to explore the variety of communications and interactions

> that actually occur, utilizing gestures and sound. Bateson's approach allows us to see how *dominant expectations about language determine what is accepted as a signal and what is discarded as noise*, both in face-to-face interactions and across institutions. *Communication* is about information and interaction; it *might also traffic in the symbolic, but it need not*. *Focusing on idiosyncratic forms of communication helps to dislodge the anthropocentric, ableist biases that privilege particular linguistic and gestural forms as the only valid form of communicative interaction*." (p. 8)

Therefore, whether a particular individual's stim has an intended symbolic purpose or not, it is a spontaneous offering to the present moment. It is a *neuroqueering of communication and interaction*; a signal proclaiming its own relevance within a social-real landscape often refusing to recognize it as anything other than meaningless noise. It is an opportunity to reshape what future is possible in such a normative-tending landscape. One wherein what is deemed normal versus abnormal is always fluid and elusive for autistics (Chapman, 2020), and non-disordered humanity constitutes who is considered sufficiently tethered to the "reality" of the normative world. A world wherein autistic being – much like other marginalized ways of being – *literally occupies and demarcates* the cliffsides of normal humanity, and therefore, the cliffsides of normative and legitimized reality itself (Yergeau, 2018; Jackson, 2020; Malatino, 2019; Clare, 2017; Haraway, 2016; Chen & Luciano, 2015). In this way, autistic beings are not treated as fully human nor are they fully non-human; they are inhuman. As Yergeau (2018) explains, "To be autistic is to live and to lie in a between space" (p. 176); a space in which one simultaneously remains a human subject/self/person/individual/organic and becomes a non-human object/nonself/animal/relational-system-participant/inorganic (Wolf-Meyer, 2020). As a negative consequence, the autistic inhuman becomes marginalized on the edges of a hierarchically-valued humanity, and experiences myriad cascading harms. Yet, in a more generative view, the *reality* of autistic inhumanity serves as a call to reconfigure social systems so that they may facilitate more non-normative *possibilities* of being-in-the-world (*including* autistic being).

Going back to the beginning of this section – and importantly, the assertion that fixed definition is a tool of the pathology paradigm – there are several key takeaways. First, as beings-in-the-world, separating the ways in which we live 'out there' (acting/behaving) and 'in here' (thinking/feeling) is arbitrary and inaccurate, contrary to what Western cultural and scientific paradigms claim. This means that distinguishing between what is objective and what is subjective is impossible, attempting to do so destroys the complexity of the many interrelationships between our "inner" and "outer" worlds. In other words, what is scientific derives from what is subjective, and what is cultural derives from what is objective. In this way, science is an empirical endeavor *as well as* a contextually-embedded paradigm and culture, with its own merits and limits. Crucially, the scientific paradigm of today (including the pathology paradigm), relies heavily on static notions of what is "objectively" real, which it often seals within formal definitions of categorized constructs such as gravity, humanity, and even autism. The more one interfaces with others through normative symbolic language, the more one receives and internalizes the fixedness of such definitions and their parameters on what is possible. The less one interfaces with others through normative symbolic language, the more one encounters complexities and counterevidence to such fixed definitions, expanding what is possible. Non-normative engagement with language/culture is quite literally a powerful means to transform reality, and autistic ways of being – along with all other non-normative ways of being – are intrinsically valuable for their contributions to what is possible in the world. It should then be our task as a social-real world to adopt a relationality towards autistic being that recognizes its intrinsic value, makes space for those who ‘do’ it, and embraces its creation of possibilities for us all.

The Need for Improved Systemic Frameworks of Autism

Embracing Client Cybernetic Subjectivity

In review of all prior sections, it should now be clear that diagnosis, ABA, self-regulation trainings, executive functioning trainings, social skills classes, and the search for genetic cures are all neuronormalizing projects. Any proposed solutions to perceived autistic disconnection-from-the-world must instead address the *systemic* problem that is the social-real *disablement of autistic connectedness*. In a complex tapestry of writing which goes into much greater depth on these subjects of non-neuronormative being-in-the-world, *Unraveling: Remaking Personhood in a Neurodiverse Age* by Wolf-Meyer (2020) draws significant inspiration from family systems theory/therapies and cybernetics, arguing that medicalized societies should change how they facilitate connection with autistic and other non-normatively communicating individuals to be more generative of possibilities. In providing context for the book’s argument, the author explains how older “sociopsychological models” of schizophrenia and autism tended to blame bad mothering or social relations (nurture) as their causes, and were later replaced – within increasingly individualized and medicalized neoliberal contexts – by “neurological models;” these hypothesized that individual biological/genetic pathologies (nature) caused schizophrenia and autism instead (pp. 214-215). However, Wolf-Meyer explains that both models are limited by their separation of the person’s bodymind from their context/world-relations, thus destroying the complex interconnections driving these ways of being. Inspired by the work of both Gregory Bateson and another family systems/cybernetic theorist named Mony Elkaïm, Wolf-Meyer asserts that “cybernetic models” have the capacity challenge these self-world and natural-social dualisms by considering both the neurological and symbolic elements of schizophrenic and autistic being as *inherently interconnected*.

As cybernetics is a core theory behind systemic therapy itself, cybernetic models already correspond to a loosely theorized systems therapy approach from the work of Elkaïm. According to Wolf-Meyer (2020), “The purpose of a cybernetically informed psychotherapy is to make more possibilities possible, and Elkaïm sees the ethical role of the therapist as being the facilitator of these possibilities, which can occur through the therapist’s “chance” interventions” (p. 216). In other words, the goal of systemic therapy not only disrupting the homeostasis of a static relational system in a way that produces a satisfactory total systemic change, but also to *enable more possibilities of being-in-the-world to emerge* from said systemic change. For families of autistics and other non-normatively communicating individuals, this homeostatic disruption might look like the neuroqueering their entire family system; everyone must shift their previous expectations so as to facilitate their connection with the less normative being of the autistic family member. Perhaps a family’s growing child is diagnostically labeled as autistic and non-speaking, and they all learn to adapt their functioning/homeostasis to the child’s emergent needs in various ways. Maybe the family hires a facilitated communicator (FC) who “joins” the family system to support the child’s communication, or the family works with their child to use an augmentative and alternative communication (AAC) device, which later becomes a regular part of the child’s being. Potentially, the other family members make the necessary living arrangements to caregive for and connect with their autistic family member *across* that member’s adulthood. These disruptions of and resulting transformations in the pre-diagnostic family’s expectations/homeostasis – being both non-normative and in opposition to the demands of a productivity-driven capitalist world – make *the entire family system* an invention site and continuous nervous system.

Therefore, through their uniquely facilitated ways of being-in-the-world, which extend non-normatively into the lives of their loved ones, autistic and otherwise disabled beings clearly exemplify how our existences are *never* fully independent nor solitarily subjective (Wolf-Meyer, 2020). Instead, being-in-the-world is *always* interdependent and "cybernetically subjective," with *cybernetic subjectivity* meaning that subjectivity/selfhood cannot be fully isolated into individual bodyminds, but rather, is always intertwined with that of other people. In this way, the individual is merely a socially constructed unit that butchers the complex "nervous system" of our relationships and connectedness in the world. Wolf-Meyer exemplifies this by sharing the following quote from Gregory Bateson (1978):

> "Consider a blind man with a stick. Where does the blind man's self begin? At the tip of the stick? At the handle of the stick? Or at some point halfway up the stick? These questions are nonsense, because the stick is a pathway along which differences are transmitted under transformation, so that to draw a delimiting line *across* this pathway is to cut off a part of the systemic circuit which determines the blind man's locomotion." (p. 318)

In responding to this quote, Wolf-Meyer (2020) asserts that it is no accident a disabled person was chosen by Bateson to make this point. Disabled "individual"-including relational systems provide more overt examples of just how interdependent and cybernetically-extended all people are. Yet, because symbolic language is currently the normative means to connect people in the world, it is treated as an implicit "technology;" as opposed to FC, AACs, or white canes. In a hypothetical world in which symbolic language was suddenly impossible to use, people who use it normatively would certainly *become* disabled (and might no longer take for granted that their connection with others *is* technologically facilitated). Rather than continuing the development of therapeutic approaches that pathologize autistic being for connecting through non-normative means, one must realize that these *autistic client systems* (meaning autistic individuals and/or their relational systems who present to therapy), give therapists the *opportunity* to facilitate non-normative, liberatory possibilities. Furthermore, opening the possibilities for change in the structure of micro-level relational systems (such as families) also opens the possibilities for transformation in the structure of the wider world and all its ways of being. In other words, smaller systemic shifts tend to echo across the larger systems they are embedded in (Hardy, 2007). Systemic therapists can either project echoes that reinforce the normativities demanding their autistic clients live as individually pathologized bodyminds – rather antithetically to the conception of the systemic therapy field itself as a psychotherapeutic movement to depathologize the individual client – or they can project echoes that catalyze authentic autistic inventions across micro-systems, expanding macro-systemic non-normative possibilities. Put succinctly, when being-in-the-world is recognized as a totality, locating both "problems" and "solutions" in a small part of that totality (such as the autistic bodymind's neurobiology) is senseless. To fully depathologize the autistic bodymind and embrace the neurodiversity paradigm of autistic being, the cybernetic subjectivity of *all* clients must be recognized and embraced.

Summarizing Previous Systemic Therapy Literature

This subsection serves as a literature review of strengths and gaps in the previous two decades of autism-focused systemic therapy publications, which included theoretical and/or case example-driven literature advocating and outlining systemic frameworks/approaches to working with autistic client systems (i.e., Sickels, 2021; Simon et al., 2020; Gratton, 2019; Brockman et al., 2016; Helps, 2016; Monteiro, 2016; Smock Jordan & Turns, 2016; Neely et al., 2012; Solomon & Chung, 2012; Bradford, 2010; Simon, 2004;), as well as exploratory empirical research on the efficacy of systemic approaches (i.e., Parker & Mosley, 2021; Wagner et al., 2014; Cashin et al., 2013; Tilsen et al., 2005). Of the four empirical studies, two were individual case studies (Parker & Mosley, 2021; Tilsen et al., 2005), and two used small pilot samples (Wagner et al., 2014; *N*=3; Cashin et al., 2013; *N*=9). Finally, both Spain et al. (2017) attempted a systematic review of all randomized controlled trials (RCTs) and quasi-RCTs testing the efficacy of systemic therapies with autistic client families, only to find that none had ever been published. In conclusion, there is a dearth of empirical research on systemic therapy approaches to working with autistic client systems, and more studies are sorely needed in this area.

Based on the findings of the four existing empirical studies on systemic approaches to therapy with autistic client systems, a therapist's pathologization of autism (or inadequate depathologization of autism) may impact client outcomes. For instance, Parker and Mosley (2021) tracked therapeutic outcomes for an allistic-autistic paired adult couple (*N*=1) using solution-focused brief therapy (12 sessions), which was chosen with the intention to focus on both clients' strengths and not make autism the presenting problem. Yet, they observed declines in the allistic partner's relationship satisfaction (16% decrease) and the autistic partner's alliance with the therapist (14% decrease) by the final session, despite the couple self-reporting that the distress they experienced because of their partner's communication and emotional awareness was relieved across therapy (although these declines were much greater for the allistic partner). The excerpts from this case study reveal that the therapist still pathologized autism in therapy (i.e., talking about the need to develop autistic people's "ability to have relationships," regularly referring to autism as a disorder, etc.), which may explain why the autistic client changed his patterns of communication and emotional engagement substantially more than his partner across therapy, while his alliance with the therapist declined. Indeed, despite attempting to avoid making the autistic client the IP, this therapist still seemed to put inordinate burden to create relational change on him. Fortunately, as solution-focused brief therapy allows clients to determine their therapy goals, a neurodiversity paradigm-embracing iteration of this approach may still be possible with a therapist well-versed in the paradigm.

In another case study, Tilsen et al. (2005) conducted a qualitative, phenomenological exploration of therapy with a 9-year-old autistic boy and his mother. The therapist started therapy by challenging how traditional approaches to 'treating' autism tend to start with formalized assessment, electing to get to know the autistic client instead. Then, using narrative therapy and influenced by collaborative therapy, the therapist emphasized the importance of asking clients not-knowing questions that show them the answers to their own problems (Anderson & Goolishian, 1992). She also avoided clinical diagnostic labels of her autistic client's qualities, and instead, relied on the child's language about his struggles with "unnimbleness" (Tilsen et al., 2005). To explain the therapist's shift in approach, the article explains how, "Standard clinical and educational intervention…focus mainly on the individual, ignoring those who fall outside the prescribed dominant representations of relational behaviors," which seems to harmonize with the notion that autism is a marginalized, non-normative way of being (p. 34). The authors add, "although these concerns are described as "social" and "relational" implying an interactive context, the problem is firmly located in the individual and [their] deviation from dominant ways of being" (p. 34). Such conclusions are consistent with those outlined by the DEP and writings on autistiphobia. The article then follows up with the autistic client as a 13-year-old, interviewing him about the experience of therapy. He reported that therapy with his “old friend” (the therapist) was helpful in identifying and winning his battles with unnimbleness. The client said, “Before [therapy], I felt alone, and disregarded, helpless,” then added, “after, I was more social. I like being alone but not cut-off. When I feel helpless now, either I’m not being helped or no one wants to help me” (p. 39). Such statements indicate that, after therapy, the client felt he had more agency over being alone and was not blaming himself for feeling helpless. Finally, when asked what advice he would give to other therapists working with autistic youth, he gave the following advice (which seems to caution against using the pathology paradigm): “Make sure to tell the kid that they’re a friend, not a doctor; use your own way to let them know you can be trusted; tell the kid they can figure out what they need to do themselves; make the kid feel safe and secure and not in trouble – it’s help not punishment” (p. 39). In summary, this study provided a hopeful roadmap to more depathologized work with autistic clients using narrative and collaborative therapy approaches.

Wagner et al. (2014) conducted a pilot study (*N*=3) of the use of multisystemic therapy for an average of six months to address “disruptive behavior problems” observed in autistic youth (p. 319). The study’s focus on behavior already indicates a pathologizing perspective of its autistic youth clients, who were specifically targeted for therapy due to histories of “frequent interpersonal aggression and/or property destruction” (p. 325), despite such histories not being universal nor exclusive to autistic people. Post-therapy assessments indicated declines in the clients’ “behavior problems,” including both those labeled externalizing (i.e., aggression and rule-breaking) and internalizing (i.e., depression and anxiety). The researchers also observed decreased “psychiatric symptoms” and parenting stress in clients’ mothers, increased perceived peer support in clients' fathers, and increased family-wide adaptability and cohesion. In general, these results indicate that multisystemic therapy may help reduce the "interpersonal aggression" in those who come to display it "frequently," and that autistic people may be amongst the clients to experience such outcomes. In interpreting these results, it is important to understand that multisystemic therapy was specifically designed to target "complex clinical problems in children and adolescents" (p. 322), such receiving criminal charges, getting expelled from school, etc. As a result, its practitioners typically only work with 3-4 family cases at a time, often multiple times a week in the setting of concern (i.e., school, home, etc.; p. 323). These results are evidence that multisystemic therapy succeeds at doing exactly what it is designed to with its clients, including autistic ones. However, it is unclear how this study addressed the youths' personal goals beyond instrumentally rewarding them for 'improved behavior.' Ultimately, this study's application of multisystemic therapy is not neurodiversity paradigm compatible.

The last empirical study by Cashin et al., (2013) did not provide any excerpts of therapy nor client interactions, making it hard to evaluate the paradigm these therapists used to interact with their clients during sessions, and residually, how client outcomes may have been influenced. This study examined the effectiveness of brief, individual narrative therapy (5 sessions) with autistic teenagers (N=9). One concerning element of this study was that it targeted "the change over time in behavioral and emotional problems," as measured by the autistic clients' parents, as its primary outcome. Forfeiting measurement of the primary outcome to the individual clients' parents indicates that the autistic teens' perspectives of their own change were not actually the therapeutic priority, despite the use of narrative therapy (which it designed to let clients define and prioritize their therapeutic problems; White & Epston, 1990). However, the researchers did measure the teen clients' self-reported hopelessness and psychological distress outcomes. They found non-significant reductions in parent-rated behavioral problems and client-rated hopelessness, and significant reductions in parent-rated emotional problems and client-rated psychological distress after therapy concluded. These results indicate that narrative therapy may indeed be helpful for decreasing the psychological distress of autistic clients, without targeting their behaviors unduly. This approach may also be compatible with the neurodiversity paradigm, depending on those researching and practicing it.

In general, the remaining theoretical autism-focused systemic therapy publications made widely varied efforts towards a neurodiversity paradigm-compatible relational shift in theorizing therapy with autistic client systems. Most usually pathologized autistic being. For example, most of these publications consistently referred to autism as “autism spectrum disorder,” “Asperger’s syndrome,” “autism spectrum conditions,” and/or used functioning labels such as “severe autism” or “high-functioning autism,” directly perpetuating the idea that autism is a medically pathological way of being. The pathologization of autism was also explicit in pieces that talked about “living with autism” (i.e., Brockman et al., 2016; Smock Jordan & Turns, 2016; Neely et al., 2012), as if the state of being autistic is something one must endure or survive. Egregiously, some pieces were sympathetic with or even encouraging of allistic family members grieving that their loved one was autistic (i.e., Neely et al, 2012; Solomon & Chung, 2012), as if having an autistic family member was as terrible as having a dead one. Following this trend of over-sympathizing with autistiphobic family members of autistic people, many of the authors focused on family stress in response to having an autistic family member, making being autistic seem like ‘the problem’ that hurts the whole family (i.e., Brockman et al., 2016; Smock Jordan & Turns, 2016; Bradford, 2010). Additionally, autistic behavioral management and intervention was a major focus of some articles (i.e., Brockman et al., 2016; Bradford, 2010), and many even endorsed the use of ABA (i.e., Neely et al., 2012; Solomon & Chung, 2012; Bradford, 2010). Finally, most of the publication authors/researchers continued to hold allistic-privileging perspectives of relational responsibility. One common example of this was viewing only the autistic partner in a couple as lacking empathy for their allistic partner, rather than both equally struggling to comprehend one another's perspective (i.e., Sickels, 2021; Parker and Mosley, 2021). In such instances, the autistic person tended to be accused of – and pathologized for – 'worse' perspective-taking.

There have also been several exceptional theoretical and case example-based writings by systemic therapists which may provide some valuable guidance for how to depathologize autism with relational cases. In a family therapy handbook chapter, Simon et al. (2020) encouraged therapists to avoid getting caught up in medicalized notions of autism, and to search for evidence that, "autistic people have unique and useful expertise which plays a part in resolving social difficulties and improving communication between those in their networks" (p. 424). In other words, this approach goes beyond mere depathologizing of autistic traits, and actively recognizes the possibility of *autistic relational strengths*. The authors also recommended challenging ToM perspectives of autism, which locate the problem within the mind of the autistic individual (Baron-Cohen et al., 1985), and elected to view the mind as a relational construct that should be situated within the relational system instead (Simon et al., 2020). Most importantly, this chapter advocated for resisting and deconstructing pathologized notions of autism altogether, and replacing these notions with more thoughtful conversations about the family's experiences. In an earlier example of this, lead author Simon (2004) specifically recommended that therapists immerse themselves in young autistic clients' special interests by treating them as meaningful (rather than pathological).

Finally, Gratton (2019) is an openly autistic systemic therapist who wrote a book on working with transgender autistic clients from a strongly depathologized lens. They advocated against treating autistic clients as ‘the problem’ in relational cases, and encouraged focusing on improving each client’s understanding of the other in non-neuronormative relationships. Gratton also provides significant background on how to recognize autistic traits (that is not steeped in pathologized notions of autism), and explains why facilitating autistic-allistic relational attachment systems can be complex. They also discuss autistic camouflage, minority stress, how to develop plans and procedures for emergencies, and other difficulties experienced when navigating the world as a neurominority. Perhaps most importantly, Gratton (2019) is explicit about refraining from ‘treating’ concerns unique to autistic disablement in the social world (i.e., teaching allistic social skills) without the request and informed consent of the autistic individual.

Beyond these initial efforts, the systemic family therapy field has largely avoided the topic of working with autistic clients. This is despite being uniquely positioned to champion improving the lives of autistic clients by using depathologizing, systemic, and *truly* relational approaches when working with autistic client systems. To move clients through this normativity-challenging work, systemic therapists must also commit to moving through the same work themselves. Only in openness to deconstructing commonly taken-for-granted assumptions of what constitutes a “normal,” “healthy,” or “human” existence will they learn how to facilitate such a shift for their own clients. Yet, in alignment with the phenomenological shift presented earlier in this chapter, relational experiencing and transformation is not individual, linear, nor one-at-a-time; therapists and clients constantly co-create and transform in their understandings and possibilities *together* (Anderson & Gehart, 2007; 2023). However, qualitative research is needed to explore what such processes might look like. In fact, in another systematic review of systemic therapy literature with autistic client systems, Helps (2016) also advocated for the pursuit of more small-scale, qualitative research that provides “descriptions of process and practice, which can guide and inform contemporary systemic practice” (p. 228). In response to this need, the following chapter will propose a fitting exploratory qualitative study.

Present Study

Across the introduction chapter, the problems with therapists treating autism as a pathology were presented, and arguments were made for shifts to the neurodiversity paradigm. Among these arguments were: 1) the long and harmful histories of socially oppressing autistic people as a consequence of using behaviorist ‘interventions,’ 2) the remaining, pervasive autistiphobia against autistic people and residual minority stress, and 3) the less visible problems of allistic privilege and the double empathy problem, which must be addressed to thoroughly combat the oppression of autistic people. Lastly, systemic frameworks of therapy were presented as a possible method for addressing these deeply systemic/relational problems in therapy, without putting repeated undue burden for change on the autistic person. This chapter builds on the introduction chapter by providing historical context for the creation and transformation of autism as a social construct. This journey observed the following phenomena: 1) eugenicist and medicalized contexts first naming and pathologizing autism as a disorder, 2) the conception and proliferation of researcher rhetoric about autistic incapacities for empathy requiring the reclamation of autism as an identity, and 3) the greater historical backdrop of Western scientific and cultural paradigms that contributed to our current fixed and binarized notions of being such that autism (or any other way of being) was named and pathologized relative to the constructed norm. Afterward, it was argued that autistic being brings more possibilities of connectedness in the world, and that a neurodiversity paradigm-embracing systemic and cybernetic therapy framework might view the facilitation of these possibilities as an important task of therapy. Finally, recent autism-focused systemic therapy literature was reviewed, and it was determined that there is a major gap in empirical research, let alone that which provides insights into a neurodiversity paradigm-embracing therapy practice.

In the next chapter, this research project's methodology will be presented. Specifically, this project retroactively explored how therapeutic encounters with autistic client systems *mutually transform* systemic therapists' and clients' being towards social normativities and connectedness (with special attention given to neuronormativity and autistic connectedness). In so doing, the greater goal is offering possible paths for future therapists aiming to depathologize and liberate autistic (and otherwise non-normative) being, for both clients and themselves.

Chapter 3 – Methodology

The prior chapter was a structured literature review explaining the history of how autism was conceptualized within the pathology paradigm. It also described how this history was influenced by the limits of Western scientific and cultural paradigms across the last century. Next, the literature review reviewed phenomenological and critical theory-driven critiques to Western (and pathology) paradigms, and their implications for preferred ways of relating to autistic being. The prior chapter also advocated for a systemic/cybernetic framework of autistic subjectivity, viewing autistic personhood as being deeply interconnected and interdependent with that of other beings. This framework enables a neurodiversity paradigm-embracing relationship to autistic being. Finally, the former introduction chapter explained how the vast majority of systemic/cybernetic therapy literature has not conceptualized autistic being in a neurodiversity paradigm-embracing way.

As the previous chapters explained, a focus on autistic client systems – or, autistic clients as systemically embedded "cybernetic subjects" (Wolf-Meyer, 2020) – is warranted because autistic client's therapeutic problems need to be reconceptualized systemically/relationally to avoid pathologizing autistic people simply for being autistic (Milton, 2012; Walker, 2021; Simon et a., 2020). In other words, the constellations of the cases discussed with study participants (i.e., individual versus partner/family cases) did not matter, so long as they included at least one "individual" autistic client. Additionally, while the traditional pathology paradigm of autism posits that autistic neurocognitive functioning is the location of individual pathology and must be "cured" or "treated," the neurodiversity paradigm asserts that the diversity of bodymind neurocognitive functioning is both expected for and beneficial to the world, and should be accepted (Walker, 2021, p. 36). Therefore, the therapists who have made substantial efforts to embrace the neurodiversity paradigm were assumed to have the most experience unraveling neuronormative assumptions that hinder authentic autistic client being and connectedness. It was expected that a vast majority of therapists who underwent this paradigm shift did so on their journeys to explicitly recognizing and embracing their own forms of neurodivergence. As such, all study participants were expected to identify themselves as autistic and/or otherwise neurodivergent, and all did.

The current chapter builds on the literature review by justifying and outlining a study that does conceptualize autistic being in a neurodiversity paradigm-embracing and systemic/cybernetic way. The first chapter sections will: 1) outline this study's purpose and research question; 2) provide an overview of interpretive phenomenological analysis (IPA) as a qualitative research approach; and 3) justify the study's IPA design. The specific methods used in this study will then be outlined, including the study's conceptualization and procedures. Lastly, this chapter will conclude with a summary of IPA approaches to quality and rigor, and my (the researcher's) reflexivity statement.

Purpose and Research Question

This study aimed to answer the following question: how do therapists embracing the neurodiversity paradigm retroactively make sense of their co-transformations – particularly their reinterpretations of social normativities and connectedness – with autistic client systems? The phenomenon of interest was the *co-transformations* of therapists and clients through their therapeutic encounters. To fully grasp this phenomenon, one must expand their understanding of the role of language and other forms of communication as transformation mediums in social-real encounters; in this case, therapy sessions including autistic clients. In acknowledging symbolic language/culture as the normed and privileged means of connecting with other cybernetic subjects in the contemporary world (Wolf-Meyer, 2020), symbolic language may be understood as the primary communication medium through which clients are socialized to exchange their experiences of emotions and meanings (Anderson & Gehart, 2007). Non-speaking, partially-speaking, or otherwise non-normatively-speaking autistic clients' uses and internal understandings of symbolic language are often inaccurately discounted as "non-verbal" or pointless echolalia. Yet, any orientation towards symbolic language's use or understanding – even if externally unobserved and/or misunderstood – counts as meaningful participation in the social-real encounter. Put another way, to receive symbolic language (whether receiving it as intended or not) and to respond to it (whether responding in a way others expect or not) *is participating in it*; connection still occurs in this exchange whether it is externally measured and observed or not. Thus, even though autistic people's contributions and connectedness to linguistic/cultural contexts are more likely to be discounted from a normative lens, *all autistic people are participants in the symbolic languages/cultures they exist within.*

This assumption of autistic linguistic/cultural participation has important implications for this study's notion of co-transformation, specifically in the area of hermeneutics. Hermeneutics serves as a pivotal bridge between this study's IPA methodology and an innovative, often underestimated and misunderstood systemic therapy 'approach' called collaborative therapy (previously/broadly known as "collaborative language systems" and now transitioning towards an extra-psychotherapeutic implementation called "collaborative-dialogic practice;" Anderson & Gehart, 2023). Part of why collaborative therapy is so innovative is that it recognizes language as a relational medium through which people share meanings, and thereby treats here-and-now dialogue – or, the ongoing interactive encounter – as the medium *and* mechanism of therapist *and* client transformation (Anderson & Gehart, 2007). Harkening back to the previous chapter, because the self/subject and the world/objects are not separate (Heidegger, 1962; Guignon, 1983), all beings-in-the-world exist together as *part of* nature-cultures (Latour, 1991). Similarly, collaborative therapy considers clients "persons-in-relationship," and conversations as here-and-now opportunities to co-transform being (Anderson & Gehart, 2007, pp. 16-17). Thus, collaborative therapists believe that in the context of therapy (italics added for emphasis):

> "We meet people whose problems can be thought of as emanating from social narratives and self-definitions or self-stories that *do not yield choices* or that *blind a person to choices…* The therapist's role is to invite and foster a dialogical space and process, remaining open to the unexpected newness that will emerge. In this process, self-identities (meanings) transform to ones that permit self-agency (*action or a sense that action is possible*), *varied ways of being*, and *multiple possibilities* regarding the life circumstances we sometimes think of as problems. *Meanings and actions cannot be separated*." (pp. 17-18)

Again, therapeutic "problems" to be "solved" for (autistic) clients can be thought of as *limits to their possibilities of being* (Wolf-Meyer, 2020). As the above quote indicates, limiting meanings cannot be separated from limiting actions; for therapists and clients alike, they are intertwined. To invoke the philosopher Ludwig Wittgenstein (1981), "The limits of my language mean the limits of my world" (p. 74). In this way, the therapeutic encounter is not a *passive* moment wherein a therapist might then choose to *actively* inject an intervention leading to an *abrupt, singular* systemic change. Relational/conversational encounters *constantly co-transform* their participants, whether precipitating the maintenance of social norms or the disruption of them. As Anderson & Gehart (2007) further explain, the concept of "transformation" goes a step further than that of “change” by acknowledging that “there is always a sense of continuity in it; we do not change, for instance, from one person to another, but as new and different identities come forward, we remain who we have been and who we are, while at the same time we are becoming” (p. 11).

The focus on co-transformation in this study allows me (the researcher) to understand how therapists make sense of *constantly becoming* with their clients. The intention behind understanding this co-transformation phenomenon is illuminating how therapists can facilitate the ‘loosening’ of fixed (neuro)normative relational processes. This facilitation is assumed to be effective because a given client’s (and therapist’s) relationships to and understandings of social normativities and connectedness influence *their sense of* what is possible – and therefore, what *is* possible – for autistic people. In other words, the limits of the therapist’s co-created language, conversations, and encounters with clients *are* the limits of possible worlds beyond said encounters. When a therapist embraces a stance of constant becoming and co-transformation with their clients, they are truly making more possibilities possible (Wolf-Meyer, 2020, p. 216).

IPA as Contextual, Transformative, and Non-Normalizing Research:

Interpretative phenomenological analysis (IPA) is a phenomenological qualitative research approach developed specifically for the purpose of examining “how people make sense of their major life experiences” (Smith et al., 2022, p. 1). As the purpose of this study was understanding how therapists retroactively *make sense of* their co-transformations and reinterpretations of social normativities and connectedness undergone with autistic clients, this variation of phenomenology is most appropriate for the current study. As a form of phenomenological inquiry, IPA is interested in Edmund Husserl’s notion of “going back to the things themselves," with "the things" being experiential phenomena (p. 8). What distinguishes IPA from other forms of phenomenological inquiry is a specific focus on *interpretation and meaning making* as ways of accessing participant understanding and experiencing. Additionally, like any form of phenomenology, IPA is context driven; it should capture how "the things themselves" felt, looked, and interacted within a particular setting and time.

The IPA research strategy is informed by three theoretical foundations: phenomenology, hermeneutics, and idiography (Smith et al., 2022, p. 7). First, IPA draws its primary inspiration from phenomenological philosophers Husserl, Heidegger, Merleau-Ponty, and Sartre by seeking to understand the experiences of human beings (Smith et al., 2022). In addition to attending to Husserl's original idea to 'go back to the things themselves,' IPA also draws from his method of "bracketing" the researcher's prior knowledge and experiences off as much as possible by reflecting on one's biases when going into a research study/interview (pp. 10-11). Furthermore, IPA relies on Husserl's foundational belief in "science as a second-order knowledge system, which depends ultimately upon first-order personal experience" (p. 11). To paraphrase, IPA incorporates in its design the understanding that science is always embedded in everyday cultural/linguistic existences, and thereby, aims to capture such everyday existences it its studies so as not to miss important experiential influences and information in its analysis. In drawing from Heidegger, IPA's design also incorporates the understanding that the self and world are also inseparable, and aims to study the meaning-making of human beings-in-the-world as perspectival, relationally-driven, and contextually-embedded (p. 13). Furthering this incorporation with the work of Maurice Merleau-Ponty, IPA takes a particular interest in being a "body-in-the-world," and considers attendance to embodiment (i.e., felt emotions, sensations, etc.) as a crucial means of capturing participant experiences (p. 15). Finally, IPA references Jean-

Paul Sartre for emphasizing how the presence and absence of others impacts human experiencing (i.e., self-consciousness), and thereby incorporates these ideas into interview questions and data analysis (p. 16).

The second theoretical foundation of IPA is hermeneutics, and Smith et al. (2022) cite philosophers Schleiermacher, Heidegger, and Gadamer as their key influences in this area. As discussed in the previous section, collaborative therapists Anderson & Gehart (2007) distinguished between notions of 'clipped off' change versus ongoing transformation, preferring the latter. This concept of ongoing transformation strongly resonates with the IPA-influencing insights of Friedrich Schleiermacher. Smith et al. (2022) describe Schleiermacher's contributions to hermeneutics and impact on IPA with the following (italics added for emphasis):

> "A text is not only shaped by the conventions and expectations of a writer's own linguistic community, but also by *the individual work that [they do] with that language*. Thus, Schleiermacher bridges the essentialist and discursive divide: he suggests that *there is something unique about the techniques and intentions of a given writer*, which will impress *a very particular form of meaning* upon the text which they produce…Part of the aim of the interpretative process is to understand the writer, *as well as* the text." (p. 18)

By bridging the essentialist (objective) and discursive (subjective) divides, Schleiermacher highlights *continuous* audience connections to the written object of study, *as well as* its author as a meaning-making participant within the same temporal existence. In this way, the time of the author's writing does not reduce the co-transformational nature of their interaction with future audiences through the text. Schleiermacher (1998) himself said that interpretation is an ongoing consequence of being *receptive* to others, as "everyone carries a minimum of everyone else within themself," motivating them to compare the perspectives of others with their own (pp. 92-93). Heidegger's contributions to hermeneutics take these ideas a bit further by explicitly breaking down the self and world divide (Heidegger, 1962), and making it clear that interpretation is a means of participating in the world with others (Smith et. al, 2022). Therefore, IPA methodology is literally *embedded in* and *doing* this interpretative experiential process along with its participants, called a "double hermeneutic" (sense making of their sense making; p. 29). Adding to this, because one is *always* bringing their preconceptions into the interpretation process and changing through newly incorporated insights, pure bracketing is never possible; one must also be prepared to engage in reflexivity across the research process with the understanding that full self-awareness can never be achieved (p. 20).

Building on these understandings of hermeneutics with the work of Gadamer, Smith et al. (2022) explain that "sometimes [our preconceptions] will emerge during the process of engaging with the new…this requires a spirit of openness" (p. 22). For instance, IPA originator Smith (2007) explains that when he returns home after a researcher interview, "I am also irretrievably changed because of the encounter with the new, my participant and [their] account" (p. 6). In a very isomorphic or "meta" endeavor, the present study aims to explore this exact co-transformational phenomenon between therapist and client(s) by conducting *the same co-transformation* between researcher and participant in its proposed methodology. This ever-cyclical and embedded nature of the interpretative process (even in the researcher's process) is precisely what IPA methodologists are referencing when they describe the "hermeneutic circle" (Smith et al., 2022, p. 23). Put succinctly, IPA views the research process as iterative and – in using the hermeneutic circle – requires a researcher who is takes upon an *open, receptive* stance and *transforms* their interpretations through their encounters with participants (p. 29), much like the co-transformative way of being this study examines as a therapist experience. As such, the IPA methodology is capable of attending to the complexity of this phenomenological research question and resulting responses.

The third and final theoretical foundation of IPA is idiography, which is "concerned with the particular" (Smith et al., 2022, p. 24). As explained in later sections of this chapter, IPA's sampling and data analysis procedures are meant to preserve the specific nuances and complexities of its participant "case studies," which are only compared to one another for corresponding themes in the later stages of data analysis. The latest IPA guide asserts that its case studies are inherently valuable and rigorous beyond the traditional notion of exploratory justifications for qualitative research, as the case study "provides a means of troubling our assumptions, preconceptions and theories" (p. 25). It goes on to explain IPA's intrinsic value as a non-normalizing methodology (italics added for emphasis):

> "IPA is concerned with the *detailed* examination of human lived experience. And it aims to conduct this examination in a way which as far as possible enables that experience to be expressed *in its own terms*, rather than according to *predefined* category systems" (p. 26).

To summarize, if traditional positivist research concerns itself with the generalizable, the universal, and the certain, then IPA (and other idiographic research) concerns itself with the local, the unique, and the wonderfully uncertain. The following section will justify why each of these theoretical foundations to IPA are important for this particular study.

Justification of Methodology and Approach

The importance of using a qualitative methodology must be explained before justifying an IPA approach to the study's design. The primary reason for using a qualitative approach is that the majority of existing quantitative measures that could be applied with autistic individuals are either 1) designed under the scientific-cultural paradigm that autistic people are abnormally deficient (and intended to capture such constructed deficiencies), or 2) are normed on allistic people, and consequently, treat autistic people as deficiently abnormal by default and result in equivalent interpretations (Tillett et al., 2023). Consequently, while quantitative measures which are not inherently pathologizing of autistic being are in increasing development and demand (i.e., Nicolaidis et al., 2020; Hull et al., 2019), qualitative research with autistic people is also needed to learn from autistic perspectives and experiences, and thereby, limit the (often ungenerous) interpretations of autistic participant data typically gathered in quantitative research.

Two additional qualitative methodologies were originally considered when designing this study: constructivist grounded theory and narrative analysis. Grounded theory is a qualitative research methodology designed to investigate and understand processes that underlie specific social phenomena (Daly, 2007). Building on general grounded theory, constructivist grounded theory maintains that researchers socially construct reality alongside participants through the use of language and the sharing of meaning. In this way, constructivist grounded theorists believe researchers cannot avoid influencing the research process at all levels (sampling, data collection, data analysis, and data interpretation) and must approach their work with that understanding (Charmaz, 2014). Narrative analysis seeks to understand how people make meaning of their lives, and to maintain the integrity of this meaning-making by collecting their stories (Daly, 2007). If a researcher using narrative analysis wanted to understand how autistic individuals make meaning of first realizing their neurocognitive ‘style,’ they would interview small sample and ask participants story-prompting questions/statements such as, “When did you first learn you were autistic?” or “Tell me about the time when you first realized you were autistic” (Earthy & Cronin, 2008, p. 11). Both constructivist grounded theory and narrative analysis have valuable methodological strengths that could have been harmonious with the aims of this study in many respects. However, their primary focuses are on understanding social processes and personal narratives, respectively, and not on understanding the *first-person experiencing and sense-making* of a given phenomenon (Daly, 2007). As a result, they were not as ideal as IPA for addressing the research question, which aimed to capture therapists’ first-person experiencing and sense-making of the phenomenon of interest: the co-transformations they undergo with their autistic clients.

Each of the three theoretical foundations to IPA (phenomenology, hermeneutics, and idiography) were crucial for this study’s design. Starting with phenomenology, there is a dire need for phenomenological, contextually driven research with autistic people, including autistic therapy clients. Pellicano & Heyworth (2023) assert that autistic lives need to be studied in-context rather than in contrived experimental settings, otherwise researchers will continue to miss important information about autistic being and perpetuate autistiphobic research results. Evidence of the unique benefits of conducting phenomenological, contextually driven research with autistic people can be found in the only previously existing phenomenological study about systemic therapy with autistic clients. In the publication of this research by Tilsen et al. (2005), a peer therapist reflecting on the therapy process laments, “Everything that has been written about [autism] is so clinically distant, heady, and bleak … I end up feeling depressed reading such expert material; it's so disconnected from real people's lived experience" (p. 40). Indeed, phenomenological research aligns well with the endeavor to reconnect with contextualized autistic experience, and it is clear why those authors chose this methodology.

The hermeneutic elements of IPA are also important for this study's design because they attend to the interpretive role of the researcher. Considering the long, tumultuous history of autism research delineated in the previous chapter, it is important that this study have a way to transparently engage with my personhood as a researcher, and how my interpretations will impact every level of the study (e.g., background offered, study design, results gathered, and conclusions reported). Additionally, hermeneutics address the iterative processes of interpretation that occur throughout this research, as participants, audience, and I all participate in this shared meaning-making process that co-transforms one another. This co-transformation process is not only important between therapist and client – it extends to researcher-participant, researcher-audience, and participant-audience relationships as well.

Idiography might be the most important element of IPA for this particular study. The initial reason for conceiving this research was a concern about researcher, therapist, and public gaps in understanding autistic being as it authentically exists in the world. Any empirical efforts to bridge these gaps by collecting "generalizable data" run the risk of shaping participant experiences into greater patterns, losing the details that make each case example unique. In the long-term, this might only exacerbate the trend of understanding autism as a homogenous experience, divorced from the heterogeneous ways it shows up across varied contexts and lives. In focusing on the particular, idiography is more likely to honor the full complexity and divergence between participant experiences, in addition to highlighting the connections between them. This study's purpose is therefore aligned with all three theoretical foundations of IPA.

Methods

The previous two sections explained the theoretical background and justification of this study's IPA methodology. The following sections offer a detailed breakdown of the specific IPA methods used, including the conceptualizations behind data collection, important sensitizing concepts, screening and sampling procedures, interviewing procedures, and data analysis procedures.

Unit of Analysis and Collected Data

The decision to treat therapists as the "unit of analysis" (the participants) in this study (Daly, 2007, p. 179), rather than their clients or both, was made for several reasons. The first reason was conceptual in nature. As discussed in the previous chapters, there is a need for society to remove conceptualized "problems" from individual autistic biology/neurology and relocate them into relational processes undergone *with* autistic people (Milton, 2012; Milton, 2018; Walker, 2021). The intention behind interviewing neurodiversity paradigm-embracing therapists who work *with* autistic clients was to better understand what undergoing relational/therapeutic processes *with* autistic people looks like in an ideal scenario (within the neurodiversity paradigm). Furthermore, it was helpful to understand *first-person perspectives* of this way of being in relationship with autistic clients/people. The second reason for only interviewing therapists was ethical. In order to give therapist and client participants privacy from one another in their informed consent processes and responses (Dolbin-MacNab & Gale, 2014), and to prevent therapists from having to over-disclose to their clients about their therapeutic work, interviews needed to be conducted separately. Thus, it was most appropriate for the purpose of this study to conduct retroactive phenomenological interviews with only therapists who had experience working with autistic client systems, rather than with therapist and client pairs/groups.

Use of Sensitizing Concepts

Based on the work of symbolic interactionist Herbert Blumer (1969), sensitizing concepts are defined as, "theoretical ideas that come from existing theory" which can help refine what one is looking for in qualitative data (Daly, 2007, p. 104). They tend to be represented as brief words or terms, and can be found in past theoretical and empirical literature on a given topic. In IPA, the purpose of reviewing prior literature and theory is to 1) identify a gap in research to address and 2) learn about one's participants; it is not to drive the study's outcomes with theory (Smith et al., 2022, p. 37). Therefore, sensitizing concepts were useful in determining the subject matter and scope of the introduction and literature review chapters.

Several sensitizing concepts were referenced from relevant theoretical literature when conceptualizing this study. First, and most importantly, the concept of "neuronormativity" – and the concept of "neuroqueer" as a disorienting challenge to it – was central to this study's (neuro)normativity-critical phenomenon of interest (Walker, 2021; Yergeau, 2018). Neuronormativity was also foundational in conceptualizing the topic of this project, presented in the introduction chapter. Second, as this was a phenomenology study, "being-in-the-world" (Heidegger, 1962) served as a key term and concept for understanding autistic people as *active participants within and parts of* their experiential contexts, as well as divesting from the hierarchical valuing of them as "humans" over other beings-in-the-world (Yergeau, 2018; Jackson, 2020; Malatino, 2019; Clare, 2017; Haraway, 2016; Chen & Luciano, 2015. Another sensitizing concept from Wolf-Meyer's (2020) work on neurodiversity and personhood was "cybernetic subjectivity;" the understanding that subjects/people are not really "individuals" separately encased in their bodyminds, but dynamically embedded relationship "system" participants who are inherently interdependent. Being-in-the-world and cybernetic subjectivity offered important theoretical contributions to crafting the literature review. Finally, the process of "co-transformation" as a dynamic way of being-in-relationship (Anderson & Gehart, 2007) was at the core of understanding this study's participants, and crucial in conceptualizing the phenomenon of interest within this chapter. Indeed, neuronormativity, cybernetic subjectivity, being-in-the-world, and co-transformation all helped with conceptualizing the research question by grasping the dynamic, relational opportunity of therapeutic encounters with autistic clients.

Procedures

Screening and Sampling for Perspective

A total of ten participants were included in the study sample. The recommended number of participants for IPA studies is approximately ten to twelve because 1) the sample is still small enough for one analyst to feasibly analyze the data in enough data and 2) the sample is large enough to be seen as credible in its claims by an academic journal (Smith et al., 2022, p. 105). Generally, IPA participants are selected "on the basis that they can grant us access to a particular perspective on the phenomena under study" (p. 43). In this study, the desired participant is a neurodiversity paradigm-embracing therapist who works with autistic client systems, and the perspective of interest is how such therapists make sense of their co-transformations with autistic clients in relation to normativity and connectedness. Eligible prospective participants were referred by study informants and asked to provide their demographic information. Participants must have had an associate or full license (i.e., Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, Licensed Professional Counselors, etc.) in a U.S. jurisdiction, and substantial experience practicing psychotherapy with autistic client systems.

Moreover, prospective participating therapists were screened for resonance with Walker's (2021) "fundamental principles" of the neurodiversity paradigm (p. 36). Walker specifically warns against several signs that a person's current understanding of neurodiversity is not compatible with the neurodiversity paradigm shift: 1) thinking that neurodiversity is compatible with pathologizing notions of neurodivergence (i.e., using functioning labels in their language, framing autistic relationality as a social deficit, etc.); 2) using the word "neurodiverse" inappropriately to mean "neurodivergent," thereby wrongly casting non-neuronormative individuals as "diverse" when diversity is meant to be a concept about *groups of people* (p. 43); 3) attempting to "treat" or "cure" the qualities of a person's being that are considered autistic (i.e., encouraging neuronormative eye contact, externalizing "the autism" as an intervention, etc.); and 4) encouraging autistic clients to perform allistic displays of empathy and experiencing emotions (AKA autistic camouflaging). All of these signs indicate that someone has not yet embraced a neurodiversity paradigm shift, but rather, engages with the concept of neurodiversity in a superficial way. Thus far, a fuller embracing of the neurodiversity paradigm shift *is* the shared language developed within the autistic community for grasping an alternative, more relational way of looking at and engaging with autism. Therefore, it is the clearest way that currently exists to conceptualize another possible being-towards-autism, which this study aims to understand as co-transformed within therapist-client relationships.

The simplest, most precise way to sample for neurodiversity paradigm-embracing therapists was to use an informant and subsequent snowball sampling strategy initially gatekept by people that this study's researcher knew already understood these criteria. Locating neurodiversity paradigm-informed therapists – as opposed to pathology paradigm-dedicated therapists – required building relationships with the autistic psychotherapists developing and championing these neuroqueer concepts and missions on the western coast of the United States (i.e., Walker, 2021). Beginning with the opportunities and referrals described below, I used an informant-based and subsequent snowball sampling strategy to gather eligible participants. This began by clearly communicating the participant eligibility criteria to informants/gatekeepers, then sharing a recruitment flyer with them to share with prospective participants. Sampling continued until ten interviews were conducted in total.

The first proposed informant was Nick Walker herself, along with any snowballs that result from participants she would recommend. Second, I was introduced to the neurodiversity paradigm by another autistic psychotherapist, Angie Sylas, who served as an informant for other neurodiversity paradigm-embracing therapists across the United States. Next, I reached out to another neurodiversity paradigm-embracing psychotherapist I was connected with who agreed to serve as participant. For each informant, I clearly communicated the study's inclusion criteria before requesting participant referrals. In total, seven participants were referred by Nick Walker, two were referred by Angie Sylas, and one was a direct professional connection of mine. The sampling strategy described here was compatible with IPA as a methodology, which – as a result of sampling for perspective – typically relies on purposive sampling strategies (Smith et al., 2022). These may include finding participants through 1) "referral" from gatekeepers, 2) "opportunities" from one's own network connections, and/or 3) "snowballing" of prior participant referrals to new participants (p. 43).

Interviewing Procedures

All therapist participants were individually interviewed by me, the sole researcher. Interviews ranged in length from 90 to 120 minutes, and were conducted and recorded via HIPAA-compliant Zoom. I initially saved the recordings on an encrypted computer, and then stored them on a secure drive until transcription was complete. Online interviews were ideal for this study, as finding the desired amount of qualified participants required interviewing individuals located across the United States (Smith et al., 2022, p. 126). Interview audio transcriptions were conducted by Transcribe*Me!*, paid for with a dissertation grant from Virginia Tech, and then de-identified by myself and stored on a secure drive. At the start of interviews, I: 1) checked in and expressed flexibility about the participants' needs during the interview process (i.e., breaks, eating, typing in screenshared word document instead of talking, walking around, stopping the interview if distressed, etc.); 2) reviewed the study overview and aims with participants and answered their corresponding questions; 3) gained the participants' informed consent; 4) reminded participants not to share any identifying information about their clients during their interviews; and 5) asked the participants for permission to start Zoom or audio recording before beginning the interview. The initial interview protocol appended at the end of this chapter served as a pliable set of semi-structured, open-ended interview questions, and the interviewer also shifted the direction of the interview with probing questions to follow the experiences participants were describing (as specified in the interview protocol).

Over the course of the interviews, I was prepared to go along with and probe what the participants choose to talk about, and operated with the understanding that participants are the experts on talking about "the thing itself" (Smith et al., 2022, p. 55). For instance, to address participant embodiment in interviews, Smith et al. (2022) suggest that "this might be evoked when people describe feelings or sensations, or when they use emotion words or embodied language to indicate what they care about, or – particularly – what is changed or threatened” (p. 15). As such, I was looking out for spontaneous use of embodied (i.e., emotional, sensed, etc.) language and following up on its connections to participant meaning-making. In general, pre-planned and improvised interview questions were open-ended, non-leading, and as devoid of assumptions as possible while also not being too vague (pp. 56-58). Finally, I strived to uphold a “centre-ground position” that “combines a hermeneutics of empathy with a hermeneutics of ‘questioning’” (p. 30). That is, I aimed to strike an effective balance between empathizing with the interpreted perspectives of the participants, while also using curiosity to question participant perspectives from the interpreter role. In this way, I attended to both the participant’s hermeneutic and their own within the course of the interview. Across each interview, I took extensive notes documenting reflective thoughts, tracking potential follow-up questions, and highlighting salient participant quotes.

Data Analysis Procedures

Smith et al. (2022) have outlined seven specific steps for conducting IPA data analysis, particularly for those newer to this methodological approach. Yet, they maintain that “within this repertoire of strategies, there is considerable room for manoeuvre,” because IPA is an iterative, circular process (p. 76). The first step they outline for a less experienced IPA analyst is the “reading and re-reading” of the first transcript to be analyzed (p. 78), which I did following the interviews. This was important because it forced a “slowing down” of my process, and helped me develop a clearer picture of each interview’s structure. For the second step, called “exploratory noting,” it is recommended that the IPA analyst “maintains an open mind and notes anything of interest within the transcript" (p. 79). Specifically, my exploratory noting consisted of writing down the participants' language (i.e., metaphors they used, emotion words, etc.), and even conceptual noting that "asks questions of the data" and becomes more abstract (p. 83). Smith et al. explain that making such abstractions in step two is still acceptable, "as long as the interpretation is stimulated by, and tied to, the text" (p. 84). Furthermore, both steps one and two tend to be merged, as the analyst usually wants to write down and preserve their initial thoughts while reading and re-reading. I found that this was the case for myself and merged them.

At the third step, Smith et al. (2022) say that the IPA analyst will take the exploratory notes that correspond to specific lines of participant text and turn those into a smaller group of "experiential statements" (p. 86). In this way, the third step begins formally incorporating the data analyst's interpretations into the qualitative coding process. Experiential statements should produce "phrases which speak to the experiential core of the piece and contain enough particularity to be grounded and enough abstraction to be conceptual" (p. 87). Step four in IPA analysis is the "charting" or "mapping" of how experiential statements fit together, also known as "searching for connections" amongst them (p. 90). For this step, Smith et al. invite the data analyst to print out a copy of the experiential statements from the transcript and cut them up. From there, the analyst can mix around the cut-up experiential statements, and then try to keep an open mind while manually building a "conceptual ordering" of them into overarching "clusters" of their connections (p. 91). Step five proceeds by naming and organizing the step four experiential statement clusters and orderings into the "personal experiential themes" – or, PETs – of that particular participant (p. 94). This can be done by assigning a PET to each cluster, and subthemes to further organize specific experiential statements. These are then ordered with PETs on top, subthemes underneath, and experiential statements underneath (p. 95). Importantly, experiential statements that don’t feel as important at this stage can be discarded from the analysis. Step six is rather simple: the IPA analyst should repeat steps one through five for each of the remaining transcripts, one at a time (p. 100). Again, IPA is fundamentally a case study-derived, idiographic methodology that aims to preserve the contextual integrity of each participants’ experiences. As such, the goal is to enforce rigor through a slow, detailed, systematic examination of each participant case.

For the first transcript, I tried starting with step three in the way Smith et al. described, separating out experiential statements by writing directly on the transcript copies. However, I found that this approach allowed me to hold onto too much information beyond experiential statements (i.e., interview text that felt meaningful to me as an analyst, but was not focused on the experience of participants) and decided to adjust my approach. I began a new process of filtering down interview content into experiential statements in a separate word document, then re-organizing them into greater bulleted groups of themes within that document. This process essentially combined steps three, four, and five. I then conducted this process for all of the interviews, completing step 6. Given that Smith et al. (2022) recommend allowing oneself flexibility in the IPA data analysis process (thereby enabling the whole process to truly be iterative as needed), this adjustment in my own research process felt appropriate and permitted by the methodology.

Finally, Smith et al. (2022) say that step seven takes all of the participants’ PETs and their subthemes, and – much like step four –rearranging them into a conceptual ordering of similarities and stand-out differences (p. 101). In this process, they indicate that some subthemes do not make sense where they are anymore, and need to be moved into their own new clustered orderings to account for their complexity. As the last part of this step, similar PETs and subthemes are then collapsed into "group experiential themes," or GETs (p. 100). It is recommended that themes designated as GETs apply to at least half of a study's participants when the sample is larger (p. 105), which I made sure was the case for this IPA study. To approach this final step of the analysis, I pulled out the experiential statement/quote clusters most reflective of each participant's PETs and put them in one document for comparison. Then I reorganized those clusters repeatedly until they were grouped and connected across participants. These themes (and their respective clusters) were then ordered and re-ordered into larger GETs and group subthemes.

Upon beginning the results chapter writing process, I took the group subthemes and what I originally selected as their most representative quotes, and organized them within the chapter outline. Originally, I used italics to track experiential statements within the selected participant quotes, keeping myself grounded in exactly what participants were saying when I discussed the meanings they made. Later, this use of italics was removed for quote readability and clarity. As I wrote these quotes into the chapter – making sense of how they were connected through experiential statements in a new way – I also began to alter and adjust which reflected which group subtheme. This essentially resulted in a second round of group-level coding, ensuring that the themes were coherent and reflective of the sample. The outcome of completing this coding within the writing process is what remains as the final version of the results chapter.

Quality, Rigor, and Hermeneutic Reflexivity

Attending to IPA Quality & Rigor

Smith et al. (2022) also share some key markers of high-quality research in their IPA guidebook. First, they re-emphasize that a high-quality IPA study must *be* IPA;

phenomenologically focused on participant experiences, incorporating the interpretive processes of both participants and researchers, and committed to the level of detailed analysis needed to be idiographic (p. 151). The way that interviews were conducted to primarily follow participant experiences and language were phenomenologically focused, in addition to the careful crafting of pre-scripted interview questions which brought participants close to the phenomenon of study in their interviews. Interviews were approached in a researched, intentional, and responsive manner, allowing for deeply meaningful participant statements to be gathered. My interpretations were present for the entire research process, but given focus within the discussion chapter. Meanwhile, participant interpretations were given focus in the results chapter, which broke down their quotes into groups of contextualized experiential statements, and engaged with them in a way as grounded in their language and meaning as possible. Additionally, the level of detail and time spent on immersing myself within and coding each of the individual interviews was extensive (it took about 6-10 hours per interview) and indicative of an idiographic process.

Second, Smith et al. (2022) emphasize that an academic paper about IPA should focus on depth over breadth of analysis (i.e., possibly taking more time to highlight the experientials of a specific GET in further detail so as to generate a detailed narrative of study findings). Furthermore, they insist that high quality IPA clearly attends to both “convergence and divergence” in reported participant themes (p. 152). In general, they explain that evidence of analytic depth is most important for an IPA paper, which means showcasing group-level, individual participant-level, and experiential commentary-level data and themes. Also, Smith et al. consider a strongly organized and written narrative of the data vital for high quality IPA, as the approach is best showcased when presented in an engaging, contextualized way. Thus, the results chapter of this project goes into extensive depth engaging with each participant’s contextualized quotes and experientials within group themes, and highlights areas of convergence and divergence between them. For the purposes of this study, an advising committee member and I met regularly in the data collection, analysis, and results writing processes, and continuously considering and discussing how to stay accountable to these measures of rigor. In particular, my advisor was instrumental during the analysis stage, notating and reflecting back summaries of what I would describe as I was conceptualizing the themes and quote content. I referred back to these summaries as I finished the analytic and writing processes, so as to track and remain connected across my ideas. Several peers and colleagues who have similar interests in neurodivergence and therapy also provided me with sounding boards as I underwent the analytic and writing processes, giving me direct feedback about my and conceptualization of participant quotes and my writing. Finally, my dissertation committee assessed the quality of this project in the defense process.

Researcher Reflexivity

<u>An Overview of My Reflexivity Process</u>

As the researcher, I spent time learning from others representing related “etic” roles (researchers and therapists) as well as “emic” roles (marginalized identity groups represented in therapist-participant and target client samples) to better understand how could unknowingly influencing the research process (Beals et al., 2020). Much of this work was done by consulting with other researchers and therapists (many autistic or otherwise neurodivergent themselves), and gleaning insights from literature written by those with lived experience. Trying to live the inherent contradiction of being a neuroqueer researcher-psychotherapist came with unique opportunities and challenges. By straddling the line between the world of the academy and the worlds of the neurodiversity and disability justice movements (p. 38), I was in near-constant inner dialogue about "walking on the boundary between self-realization" through therapeutic and research-based endeavors, and risking "a complete loss of self" (Beals et al., 2020, p. 598). In fact, I would argue that by interfacing with the worlds of psychotherapy and research – which are largely responsible for the creation of contemporary autistiphobia – I embraced my autistic cybernetic subjectivity as someone who cannot be separated from these worlds (a sentiment the therapist-participants echoed about their therapeutic practices). I strived for the co-transformation of how participants and I made meaning of autistic and/or neurodivergent being, and observed the participants opening themselves to this process during their interviews as well. Additionally, Smith et al. (2022) have the following to add about the IPA researcher's etic and emic roles:

> "IPA does not require that you have 'insider' status… IPA *will* require that you can imagine what that status might entail, however, and it *does* require you to negotiate access to insider accounts via suitable participants. It makes sense then to reflect upon your previous knowledge of, and experience with, your proposed participants." (p. 37)

In this way, the experience and exercise of reading for and writing this dissertation served as an invaluable part of this reflection process, particularly when thinking about interviewing participants who had different normative or non-normative lived experiences than myself. Spending time in active practice as a neurodiversity paradigm-embracing therapist was also helpful, and reflecting on those experiences played a pivotal role in the conceptualization of this study's research question and aims. Furthermore, spending the year prior to data collection interviewing and analyzing data for another qualitative study that centered a wide variety of non-normative ways of being shaped my understanding of how to approach this study in a profound way. Again, Smith et al. (2022) remind us that the IPA research is designed to be iterative in its use of hermeneutics, transforming the researcher's own being and sense-making through participant encounters (p. 29). Therefore, incorporating my own learning and transformation from relevant past experiences served as part of the iterative process. In general, this iterative process was upheld across this dissertation study by consistently updating and building this reflexivity statement at each stage (Goldberg & Allen, 2015). At the end of this project, I redrafted the following reflexivity statement to increase transparency about how I approached the study.

My Reflexivity Statement

In review of the interviewing process, it was vital I did not assume that being autistic – and thereby sharing a marginalized experience of interest with some of the participants and target clients – would make me immune to enacting autistiphobia or other forms of systemic, normative social oppression in this work (Walker, 2021; Cascio et al., 2020). I prepared myself to enter this study's interviews and analyses prioritizing receptivity to – as well as a thoughtful questioning of – participant experiences and interpretations. Such openness needed to be actively cultivated and maintained in instances of diverging perspectives from participants. In this study, such instances arose when participants' ways of being neurodivergent were rather different from mine, and/or if participants problematized a non-normative way of being that I no longer tended to (or vice versa). In these moments, I abided by the advice of Anderson & Gehart (2023) for employing a collaborative-dialogic practice; rather than offering my own perspectives, my first goal was exploring the participants' worlds from their perspectives.

For instance, I went into the study knowing very little about plurality – known as dissociative identity disorder (DID) under the pathology paradigm – which means having more than one person/self living in an individual body, often called a "system." Thus, when I interviewed a plural participant about offering neurodiversity paradigm informed-therapy with their plural clients, I focused on remaining curious about their lived experience-based knowledge and learning things I had never considered before (i.e., trying to force systems to reintegrate into "singlets" is harmful, and requires clients to mask their total selves). If I had not taken this curiosity-driven approach, I likely would have shaped the interview in a more normatively oppressive way, based on my prior understanding of plurality (or lack thereof). As a result, that interview experience co-transformed my perspective and our process as people in a research setting.

In fact, I noticed the overall interview process was co-transformative for myself and participants, and that we were "constantly becoming" together in several ways. Firstly, I observed that my participants and I usually became more candid across our interactions with one another, often led by one party unmasking or beginning fairly unmasked, and the other following suit. My second participant even commented that she noticed me unmasking my own autistic traits across the interview. This is ironic because, in the moment, I had been internally thinking that I was getting "worse" at interviewing across the interaction, even as I felt it was freeing me up to ask questions closer to what I meant and to create sincere dialogue. My original belief was likely a product of internalized ableism, and feeling the internal pressure to interview in a more scripted manner in order to seem put-together and "professional." Once I took in this participant's observation and noticed how it seemed to make her more comfortable with me as an interviewer, I decided to more intentionally unmask and show more of the messiness underneath my thought process for the remainder of the interviews. This was another example of the power of the co-transformative process and constantly becoming together.

When I became more transparent about my thought processes behind and challenges in forming probing questions, I noticed that it gave participants more of the information they needed to authentically steer how they answered. As a result, participants seemed to check in less about whether they were answering my exact questions as I intended, and instead, went on "tangents" that led to more earnest and fruitful examples of their experiences. Vulnerability was another important ingredient and dynamic in these interviews, as I noticed myself becoming more hesitant to ask intuitive questions when participants offered less vulnerability in their answers. Similarly, I noticed participants opening up more after I briefly expressed resonance with what they said or demonstrated an understanding of the philosophies they were discussing in my follow-up questions. In this way, participant offerings usually felt most authentic when the interview operated less like a prescriptive call-and-response exercise, and more like a fluid, interactive dance between both discussants.

The process of co-transforming and embracing my constant becoming with participants was both intrinsically fulfilling, and profoundly aligned with what they were saying about their experiences as therapists. Indeed, all participants eventually referred back to the group experiential theme of "being with another human," and the co-transformative power of doing so in the therapeutic relationship. By extension, participants tended to reject the premise of being in an "expert role" or enacting saviorism as therapists. As such, I felt it was only appropriate to melt into my own personhood with them as research participants, not taking on an "expert role" as the researcher. Instead, I strived to embrace my own vulnerability with them, showing my emotional responses, allowing myself to struggle to articulate my thoughts in front of them, and learning and growing in reflection upon what they shared. The resulting interactions were among the most thought-provoking and “human” I have ever experienced, connected me to the feeling of a wider neurodivergent therapist community, and still impact my present thinking and being.

Chapter 4 – Results

This chapter begins with a detailed description of the study's ten participant sample, including demographics as well as the therapeutic professions, licenses, and approaches to therapeutic practice with autistic clients represented. Next, super-ordinate, experiential themes and subthemes will elucidate the experiences of the ten cases as they relate to the phenomenon under study: therapist paradigmatic co-transformation with their autistic clients. From the analysis of the ten cases, two major group themes and six group subthemes emerged. The first major group theme is *Recognizing and Opposing Normative Oppression in Therapy*. This group theme captures participants' experiences of coming to see the idea of "normal" as a powerful and oppressive social force that can dictate the purpose and practice of therapy. This theme also explores participants' senses of opposing the oppressive forces of normal they described. The second major group theme is *Aligning with Neurodivergent Authenticity and Autonomy*. This theme addresses the ways in which participants came to pursue, protect, and uphold authentic neurodivergent expression, self-determination, and ways of connecting and relating, both for themselves and clients.

Three group subthemes emerged in association with the first major group theme, *Recognizing and Opposing Normative Oppression in Therapy*. Firstly, *Critiquing the Premise and Enforcement of Normal in Diagnosis and Treatment* illuminates the role of DSM diagnosis and corresponding clinical treatment in conceiving ideas of normal and then enforcing them with therapy clients. The second subtheme, *Encountering and Unraveling Intertwined Normative Oppressions as Therapists*, details how participants encountered and unraveled intertwined normative oppressions (i.e., ableism, racism, cisheterosexism, etc.) in their work as therapists. Within the third subtheme, *Rejecting the Expert Role and Saviorism as a Therapist*, participants came to recognize and reject how normatively oppressive hierarchies manifest in traditional therapist-client relationships. Next, three additional subthemes emerged for the second major group theme, *Aligning with Neurodivergent Authenticity and Autonomy.* The first, *Embracing Resonance and Belonging in Neurodivergent Communities and Cultures*, showcases various participant examples of relating to their clients' neurodivergent experiences (and vice versa), and embracing their belonging within greater neurodivergent communities and cultures. Second, *Facilitating Emergent Authenticity and Autonomy for Clients* discusses the therapeutic philosophies and approaches that participants developed in order to be responsive to and facilitate emergent authenticity and autonomy for their neurodivergent clients. The third and final subtheme, *Noticing and Honoring the Systemic Contributions of Neurodivergent Relationality*, highlights the uniquely systemic qualities of authentic neurodivergent relationality and connectedness, and demonstrates how participants appreciated and honored those. In the presentation of the data analysis results below, demonstrative quoted segments are provided to illustrate each theme and sub-theme. Points of convergence and divergence are also identified.

Participant Sample Overview

Ela is a 36-year-old, White American, cis woman. She is pansexual and ADHD, and practices as a music therapist (BC-MT) in the Midwest. She has 8 years of experience as a therapist, and estimates that she has worked with over one hundred, mostly autistic clients. She expressed a belief in client-led therapy, where clients are experts in themselves and are supported in creating their own goals and determining their own needs.

Elizabeth is a 38-year-old, Black/African American, cis woman. She is straight and autistic, and practices as a marriage and family therapist (LMFT) in the Southeast. She has 12 years of experience, and has worked with an estimated 25 autistic clients in her therapy career. She described her therapeutic philosophy as grounded in liberatory, decolonized, anti-oppressive approaches that serve Black and Brown families.

Hazel is a 47-year-old, White American, genderfluid person. They are pansexual, demisexual, autistic, ADHD, and plural. She practices as a marriage and family therapist (LMFT) in the Western United States. She has 21 years of experience practicing therapy, and has worked with over 50 autistic clients. Their training is rooted in relational psychodynamic therapy, but they described drawing on a wide variety of practices with the intent of collaborating with clients in whatever way best suits their emergent needs.

Indigo is a 28-year-old, Hispanic/Latine American, non-binary person. She is pansexual, autistic, and ADHD. She has practiced as a licensed professional counselor (LPC) in the Southwest, with four years of experience, and has worked with an estimated 50 autistic clients. Their practice is rooted in collaboration and self-determination, basing the goals of therapy on a client's personal definitions of well-being, and collaborating to uncover and affirm a more authentic self.

Jay is a 63-year-old, White American, agender person. They are queer, allosexual, and autistic. They practice as both a marriage and family therapist (LMFT) and a clinical counselor (LPCC) in the Western United States, with 17 years of experience, and have worked with an estimated 50 autistic clients. They are a somatic therapist who believes that therapy should be a grounded space of curiosity that holds the power to change both the client and the therapist through their interactions.

Maria is a 56-year-old, Chinese American, cis woman. She is straight, autistic, and ADHD. She practices as a licensed professional counselor (LPC) in Western United States, with

6 years of experience, and has worked with an estimated 25 autistic clients. She believes therapy is a space for autistic clients to feel that someone understands their experiences, incorporating Internal Family Systems (IFS), polyvagal theory, and neurodivergent-affirming practices.

Olga is a 41-year-old, mixed race Latino American, (Gender)queer person. She is queer and autistic. She practices as a music therapist (BC-MT) in the Southwest, with 10 years of experience, and has worked with over a hundred autistic clients. They believe in drawing from the strengths of a wide variety of therapeutic practices in order to best serve client needs. They also believe that the experiences of autistic clients are cultural, and should be approached with cultural humility, and that therapists don't need to be the experts in the room.

Ray is a 42-year-old, White American and Jewish, cis man. He is straight, ADHD, and aphantasic. He practices as a psychologist (PsyD) in the Western United States, with 17 years of experience, and has worked with an estimated two hundred autistic clients. He describes his practice as existential with a postmodern flare and neurodiversity-informed. He believes in taking what clients give you in the moment without pushing them, and in helping clients find their own definitions of success, happiness, and meaning.

Sydney is a 32-year-old, White American, genderqueer person. He is queer, demisexual, and autistic. He practices as an independent clinical social worker (LICSW) in the Western United States, with 7 years of experience, and has worked with an estimated 230 autistic clients. Their practice is client-centered, focusing on how to make a client's lifestyle more accommodating of who they are rather than the reverse.

Tiff is a 38-year-old, White American, trans non-binary therapist. They are queer, autistic, and ADHD. They practice as a clinical social worker (LCSW) in the Northeast, with 10 years of experience, and have worked with over one hundred autistic clients. Their therapeutic practice is decolonizing, anti-ableist, and affirming. They believe in letting clients drive the session, and in using whatever resources make sense emergently to meet clients where they are.

Data Analysis Results

The following results sections will give an in-depth analysis of the study's two major themes and their respective subthemes. The first major theme, *Recognizing and Opposing Normative Oppression in Therapy*, will explore ways in which participants came to recognize normative oppression in therapy, including the pathologization clients in the diagnosis process, how clients' normative oppressions compounded with those reinforced by pathologizing therapies, and the inherent hierarchy and oppression in the "expert" role of the therapist. This theme also explores how participants opposed normative oppressions in therapy, including expressing ethical malignment with therapies that enforce "normal" behaviors, explicitly opposing the normative oppressions that pathologizing therapies reproduce, and critiquing how creating a hierarchical relationship with clients hinders therapeutic work.

The second major theme, *Aligning with Neurodivergent Authenticity, Autonomy, and Connection*, will dive into participants' ways of aligning with neurodiversity authenticity and autonomy, including embracing neurodivergent communities in which neurodivergent authenticity and autonomy are enabled, creating a more emergent process in therapy that allows authenticity and autonomy to bloom, and honoring the ways that authentic and autonomous neurodivergent relationality offer new possibilities of being. It will also showcase how participants explore neurodivergent connectedness, including resonating with client experiences as neurodivergent people, facilitating new connections with them in the therapeutic encounter, and being curious and appreciative of unique ways that neurodivergent people engage in relationality and connect with others.

These two superordinate themes – *Recognizing and Opposing Normative Oppression in Therapy* and *Aligning with Neurodivergent Authenticity, Autonomy, and Connection* – connect intimately with each other in a circular fashion. In other words, participants described how each repeatedly served as the impetus for the other. Thus, the more that participants recognized and opposed normative oppression, the more they aligned with neurodivergent authenticity and autonomy, and vice versa. For instance, Tiff explained how *Recognizing and Opposing Normative Oppression in Therapy* (i.e., not listening to disabled clients) led them to *Aligning with Neurodivergent Authenticity, Autonomy, and Connection* more, as opposed to the traditional therapy approaches they were taught:

> "I feel graduate school did not prepare me for anything other than TF-CBT, CBT, DBT, like all the T's. I ended up falling into a job in grad school where I was a behavior and sexuality consultant for folks with disabilities…That was my biggest teacher because what was in the way was me. Until I was diagnosed [as ADHD], I walked up to the [therapist] role thinking, "Okay. I'm here to support. I'm here to help." But those folks really taught me that I can't do my job if I don't truly listen. And as silly as that sounds like, "Yeah, therapists listen." *They really don't, right?* There's so much that gets in the way because we have to do treatment plans. We have to do goals. We have to do this. And even more so in the disability world, I would sit at team meetings where the clients sat at the head of the table and not one person talked to them. I would be the person like, "Time out, time out. Joe Schmo, does this fit for you?" And they're like, "No." "Okay. Then, y'all need to redo this" …And so they were probably my biggest teachers to be like,

> "*Whoa, slow down.* This is not about you. You need to know what they need. And then, you need to advocate for what they need regardless of if that's your view, treatment plan, or goal setting.""

Thus, Tiff first noticed the normative oppression at play in their therapeutic work when therapists and other members of client's support teams did not truly listen to their disabled clients, too fixated on treatment planning to gather and work towards clients' perceptions of what they needed. This then led Tiff to realize that they needed to slow down the process of these meetings so that the disabled clients could be heard, and their expressed needs advocated for without regard to a therapeutic expectation or script. From here, an orientation towards aligning with client authenticity, autonomy, and connection evolved. Olga gave another demonstration of this circular process, with *Aligning with Neurodivergent Authenticity, Autonomy, and Connection* precipitating *Recognizing and Opposing Normative Oppression in Therapy* in turn:

> "I just jumped in [to advocacy]. It's like, "I'm going to disclose to people that I'm autistic. I'm just going to be myself. I'm gonna bring that who I am into this space in a way that I hadn't before"…Initially, [I received] bad ableist responses. By now, I look back and I see this is pretty much the standard autistic experience of trying to speak up. Nothing about it was unique or special. Just the same ableist nonsense that people just say, "Oh, but you know, I'm a parent of an autistic child." And like, "Well, I think it's fine," and "You're really high-functioning," or whatever…The more I would learn about neurodiversity and connect with autistic community, I'd realize this is the same script…And because it wasn't new, and there were all these people who came before me, I kind of realized "I don't have to reinvent the wheel when I'm doing this advocacy…I don't have to be the expert.""

Olga’s quote shows how cultivating emergent authenticity as an autistic therapist by starting to openly be themself precipitated encountering and challenging more normatively oppressive, “ableist” responses in others. These ableist responses also helped them notice “scripts” in what people said to them and other autistic advocates, reinforcing their deconstruction of the normatively oppressive “expert” role. Specifically, they realized that there was a lineage of “people who came before me,” which reduced the pressure they felt to “be the expert” by completely “reinventing the wheel” of neurodivergent advocacy.

Lastly, each theme and subtheme presented below encompass the co-transformation phenomenon under study. In particular, all focus on participant responses to the therapeutic encounter and relationship. Responses included how participants’ thinking, awareness, beliefs, practices, and self-understandings all changed with regard to their therapeutic careers and related personal journeys. In the following sections, all participants were given pseudonyms to represent them, except one participant who requested their real name be used. All therapeutic case examples discussed by participants were referred to in gender neutral language to protect their clients’ confidentiality.

Recognizing and Opposing Normative Oppression in Therapy

Within this major theme, three subthemes will be presented. First, *Critiquing the Premise and Enforcement of Normal in Diagnosis and Treatment* will delve into participants’ encounters with therapeutic diagnosis and treatment frameworks, forcing them to contend with the idea of pathologizing “abnormality” and “treating” it through coercive and normatively oppressive means. Second, *Encountering and Unraveling Intertwined Normative Oppressions as Therapists* explores how participants began to unravel interconnections between different kinds of normative oppressions (e.g., ableism, racism, cisheterosexism) in their therapeutic work, maligning with them all. Third, *Rejecting the Expert Role and Saviorism as a Therapist*, attends to the ways in which the traditionally constructed therapist role is inherently hierarchical, lends itself to the dismissal of client lived experiences, thereby reinforcing normative oppression in therapy. This final subtheme also explores how participants came to reject this version of the therapist's role in their work. Participants statements converged most strongly in their shared critiques of traditional therapeutic training settings, perceptions that they are expected to play "experts" as therapists, and observations that ableism and neuronormativity work in tandem with racism, xenophobia, queerphobia, and transphobia. Participants diverged most strongly in their timelines for questioning the premise of normal, the normative oppressions they came to recognize and oppose in their work first (based on their own lived experiences), and the degrees to which they explicitly identified and challenged saviorism and hierarchy within the traditional "expert" role of the therapist.

Critiquing the Premise and Enforcement of Normal in Diagnosis and Treatment

The first sub-thematic component of *Recognizing and Opposing Normative Oppression in Therapy* for participants is critiquing how "normal" is conceptualized in therapy – as compared to "abnormal" or "disordered" DSM diagnoses – and then enforced through therapeutic "treatments." For example, Jay shared an overview of how they encountered and contended with notion of abnormality in their clinical diagnosis and treatment training, and how it impacted them emotionally:

> "I started out [my therapy career] with some real questions about [the idea of being] normal, and yet had to make it through a holistic psych program that had some room; but

> still, child development was *standard* child development, and things outside of that were *abnormal*. So there continued to be wrestling in my internships and things like that. There were people I didn't recognize as neurodivergent, when later I went "Oh," right? But we didn't have that language then, and I was still like, "You're supposed to meet [DSM] criteria for something. If you don't, then we'll give you something else, and treat you as somebody who's struggling with what people think you should be." It was like, "What do you do with the people who don't fit the boxes that we made for them?" ...I had to just stay quiet through most of my internships. I was a bad supervisee except for the one good supervisor, because I didn't want to talk about my clients because they would be pathologized in a way that made me angry. And what I was doing with them would not meet what I was expected to do with them around those things."

Jay's narration shows how they came into the therapy field with some skepticism and dissonance about notions of "normal" vs. "abnormal" development, only exacerbated when many of their clients did not fit DSM criteria in the ways their professional training program taught them to expect and assess. Furthermore, Jay's experience indicates that the majority of their clinical supervisors were not open to thinking about and working with clients in ways that were less "pathologizing," which left them feeling like they would not receive ethical advice and instruction during their clinical internships, and that they would need to hide their true work to protect their clients. Sydney shared a similar example from his professional training:

> "I remember my first diagnostic class in the master's program. There was a case study and we had to watch a video; someone was clearly acting out psychosis, hallucinating delusions about a bird showing up every day at a certain time and spying. As I listened, I'm like, "Okay. Well, it actually sounds like maybe it's the UPS eagle they're

> describing.” I started to do a write-up around like, “Sure, it sounds like there’s some delusions, and also some of this is probably based in reality that someone really is showing up.” And I didn’t get a good grade on that. Instead, I got the comment, “You’re giving the client too much credit. This client just needs a referral for medication management for their psychosis, and they’re clearly schizophrenic.” … And a lot of the professors’ feedback was just rooted in fixing [clients] instead of figuring out what supports they needed. Sometimes, if it was very clearly a kid not showing up to school, always missed the bus, said they’re hungry all the time, maybe they’d be like, “Oh, let’s get some basic needs. Maybe they need a case manager and to know where the food bank is.” But outside of that, it was a lot of medication, CBT, DBT, and whatever else. When all of your professors, the people you’re meant to look up to and learn from, keep hammering it in that the solution is change [clients’] core beliefs through CBT or teach them skills through DBT (especially the social skills piece) – so that they can get along better, navigate the world better, and be less like themselves – it’s hard to go out into the world of private practice or community mental health, and feel like you can support the client in getting their needs met without essentially *undermining* them and being like, “Well, I think you need this.””

In this quote, Sydney described how – because his faculty did not take his clients’ senses of reality as seriously as he did, based on the phrase “you’re giving the client too much credit” – he perceived that they were asking him to undermine his clients’ senses of reality altogether and decide what was best on their behalves. Meanwhile, he was inclined to focus on understanding his clients’ senses of reality as a basis for therapeutic work, rather than jumping to trying to “fix” or “change” them simply for being schizophrenic. Sydney also explained his reluctance to use popular evidence-based and behaviorally-driven approaches, because he noticed that CBT and DBT seemed to be aimed at making his clients agreeable to the world, but less authentic to who they were. Thus, Jay and Sydney both noticed how their clients' experiences were being pathologized and their realities dismissed, and moreover, felt they had to hide these concerns based on their mentor's responses. Ray reported that he had a better experience in his therapeutic training program, but similar concerns about what he noticed in his clinical internships:

> "I have been profoundly lucky to have supervisors and teachers who were able to teach the medical model from a critical perspective, and who would be open to other perspectives as well. I have worked in institutions that were more medically model-based, and burnt out very quickly on them. It's been instrumental for me to be in private practice because I don't get along in those situations very well. My sense of justice and what I feel is right becomes just triggered all the time... I worked at a clinic that primarily saw foster children, and every single one of these kids was on antipsychotic medication. I think if it was more than a summer job, I would have exploded at some point, and maybe even reported the psychiatrist I felt was getting kickbacks from the industry for prescribing; it was so wrong. These kids were traumatized, and they were being told that they were behavioral cases and needed antipsychotic medication because of agitation, and they had all these incorrect diagnoses of mania and psychotic depression and all these things which were just *not* happening…I think the biggest difference with the medical model is how we [teach] it. "Here's how we do treatment planning. Here's how we focus on the symptoms. Here's how we do this and that," which I think is the basis of a lot of programs. Versus "Here's the DSM. Here's how you're supposed to diagnose on these reports, but here's a deeper way to look at it. Here's what's really going on. Here's how to

> sit with this kind of thing. Here's how to encounter this kind of thing. Here are the developmental things that happen to create this kind of thing. And here's how we might look at it." It's much more holistic."

Thus, Ray's professional training encouraged him to be more critical of the medical model of diagnosing and treating clients based on DSM criteria, *which supported rather than undermined his instincts* that the diagnostic and over-medication practices at his summer internship placement were unethical. His example also shows how the diagnosis of clients can be abused to justify profiting off of their maltreatment, and in general, how profit in mental healthcare can incentivize malpractice. Tiff shared a similar example of having to advocate for an autistic teen to stop being overmedicated for an inappropriate bipolar diagnosis, and receiving pushback from their psychiatrist about the idea of the client being autistic instead. Tiff also advocated for a style of clinical training comparable with what Ray described experiencing, and was similarly critical of applying the DSM criteria to clients without questioning them more deeply:

> "In our current society, you would be missing a step in being neuro-affirming if you didn't understand and know the DSM criteria. Even if it's not accurate, you need to know that foundation to be able to start seeing outside of the box. So looking at that criteria and then engaging with a client and recognizing, "Wow, this criteria is incredibly limiting, or it's incredibly stereotyped based on one type of person." Then from there, recognizing that *no criteria can match human experience* because every human being is different. Every depressed or schizophrenic person doesn't look the same."

Both Ray's and Tiff's statements suggest that the DSM diagnostic criteria are, at best, superficial descriptions of what is going on for clients, and indicate that these criteria must be viewed in-context and applied with great caution. Additionally, Tiff encouraged others to question that homogeneity of diagnosed psychological experiences (particularly, how they are detailed by DSM criteria), and to honor that depression, schizophrenia, etc. will experienced differently by different people. In fact, all participants in the study described autism in ways that contrasted greatly with the DSM-5-TR criteria; they did not characterize it as a disorder nor did they inherently frame autistic traits as negative. Maria spoke to this difference in conceptualizing and describing autism below, and the consequences this has on client self-esteem, particularly during the diagnostic process:

> "I've had so many autistic clients come to me and talk about how their other therapist didn't understand autism or wasn't trained sufficiently to really help them… I'd like to see therapists better trained to recognize autism and support autism. The first part of it is to not see it as a disorder. The neurodivergence-affirming philosophy is super important because autistic people don't need to feel like there's something wrong with them, that they're deficient or impaired in any way. Now, I use the standard gold standard measurements, the ADIR, ADOS 2, and IQ test; those are my three. And the ADOS and the ADIR are super, super entrenched in the deficit model. In the language, it's all about "failure to do this," "lack of that," "impairment in this." …When I first started, I used that same language. Then I realized, "It is not helpful for clients to read the report and see all their failures, deficits, impairments, and abnormalities." …So I've started to change. I use the same test, but instead of "qualitative *impairments* in social interaction," I say, "qualitative *differences*." [Instead of] "*Failure* to socially engage," I put, "*disinclination* to socially engage." Changing a few keywords into a difference model, and not using the deficit model…Affirming means really believing and helping clients realize that their

> brains are beautiful. In the right environment, it would thrive. They're not lazy, stupid, or defective in some way because, if they believe that, they can't love themselves."

Maria's example shows how contemporary diagnostic criteria and corresponding assessments for autism inherently characterize autistic ways being as problems, and how this harms autistic clients' relationships with themselves. Part of her therapeutic practice became changing the language of these assessment results so that they did not cause undue harm to autistic clients by characterizing their authentic ways of being negatively. Like Maria, Hazel discussed how language about neurodivergences can influence how people view them, however, she gave specific examples for plurality instead of autism. To provide important context from Hazel, "plural" people or "systems" are non-pathologizing terms that replace dissociative identity disorder (DID) to describe people who have multiple selves living in their individual bodyminds. When asked about her stated preference for the term "selves" instead of "alters" for plural people, Hazel explained:

> "A lot of the language [about plurality] is from the medical community, and it sort of puts forth that it's not supposed to be there. "Alter" is like it's an alternate or it's not the main one. There's a "main one" or there's an "internal self-helper." Then there's "the host" is the other term – "Alternate host." "Host" is creepy. *Who is the host?* Is it a parasite or is it [laughter] a paranormal activity? It doesn't really lend itself to teamwork [between a system's selves], per se. And it posits that there's a "real one" and then the rest are delusional content. Rather than, it's an interconnected, interwoven system, like a living and breathing ecosystem in a mind or psyche, and that everything is important and valid. A lot of those terms really just seem strange and clinical, and not personable or human…I know the current medical model one is "self-states." They've shifted from "alters" and

> now “self-states.” But that’s still “states.” …I mean anybody could say, “I was in a state,” when they were upset, bewildered, or anxious. It doesn’t really acknowledge that [those self-states] might have their own thinking and that they’re valid enough to be there.”

Both Maria and Hazel’s statements provide evidence that clinical language developed *about* neurodivergent people is usually dehumanizing, because it describes them in negative and alienating ways. Additionally, Hazel’s quote highlights how language developed without the support of neurodivergent lived experience tends to produce inaccurate understandings of said neurodivergences. In addition to pathologizing neurodivergence, Elizabeth expressed another limitation of the DSM that was not explicitly brought up in other participant interviews:

> “If we look at mental health diagnoses from an individual or medical perspective, there’s so many things we don’t get to talk about that matter to Black and Brown people, like racism, for instance. Racism is out here taking Black people out. *People are ending their lives* because of the racism that they’re experiencing, right? We know this, but there’s no direct recourse for that in the DSM as it exists. So for me, if you don’t think about humans in a systemic perspective, you’re not going to address any of these things that, I would argue, can have an outsized impact on the Black community or the disabled community or what have you…Also, thinking from the fact that the DSM is constructed based on the medical model, one of the other challenges is a lot of Black and Brown communities rely heavily on their faiths. Whether they’re Christians, Muslims, or Catholic for my Latino families, they rely very heavily on their faith, and it plays a huge role in their mental health…Because the DSM is medically focused, when you start talking with folks that have strong religious alignment about mental health diagnoses, the disconnect of the two worlds can be so strong sometimes that they don’t even want to get

> involved with it. It makes my job harder as a therapist to help the family because there's not any consideration for those things with a document like the DSM."

In other words, Elizabeth critiqued how DSM diagnoses focus on pathologizing individuals, but do not pathologize larger-scale relational phenomena which harm clients, such as systemic racism or ableism. Furthermore, she named that clients whose religious and spiritual beliefs are not aligned with medicalized understandings of psychological experiences are alienated by DSM diagnostic frameworks. All of the aforementioned participant statements demonstrate how DSM-based "disorder" and "abnormality" constructs harm clients, undermine lived experience-based understandings of neurodivergence, and reinforce that neurodivergences are individual "problems" rather than shared experiences. Olga passionately broke down how a DSM-derived normal vs. abnormal dichotomy then steers the purpose and course of therapy:

> "We [therapists] are basically the *cops* who enforce the normal. We're the *authority*. That's why we have the degrees and go to the board certification – to prove that we gained that right to be the *cop*, to *police* other people, to *fix* them, to *intervene*. That's why we use the language of "intervention" and of "cure." We're the psychology cops. We're going to police somebody's mind and behavior. That's the expectation… "This is how we're going to make a better society: we're going to normalize everybody…Oh, we don't need to address the outrageous cost of housing. We just need to get therapists to fix somebody's way of thinking so they can adhere more to this capitalist system. So they can just show up to work and be the little cog in the machine." We're supposed to grease and make that machine of capitalism run more smoothly, *even if it's just grinding people up*."

Much like previously quoted participants, Olga is observing how the medicalization of psychotherapy results in harming clients (e.g., policing how their minds work and ignoring the real, contextual problems they experience), in this instance, through trying to "intervene" on and "cure" anything construed as abnormal. She also adds a missing piece to this conversation by naming how this all serves to keep contemporary capitalist systems functioning as intended, because "normal" people are those who keep said functioning "smooth." Olga is also identifying the coercive nature of the therapist role (being a "psychology cop") when it is focused on "enforcing normal" in clients. Ela spoke to this sort of coercion when asked for her thoughts on why therapist training programs and K-12 schools focus on changing client behaviors:

> "*Compliance and control.* I think it's all: how can we make our lives easier and not have to deal with somebody else's *"behaviors?"* …We used to institutionalize everyone who was different. I think it all stems from colonial patriarchy, White supremacy, and just filters down to everything. And because it's been this way, people don't know that there can be a different way, or they're resistant for other reasons. For me, I just didn't know I could think differently. Being neurodivergent, I'm also trying to fit in and be accepted in the community as a professional. Evidence-based practice is all behavioral and medical, even though I've always had more of a humanistic approach to people. Until I heard stories of autistic people saying their experiences in certain behavioral models – how much harm it caused and continues to cause them, even if they're not receiving that therapy directly anymore – the trauma of all of it; until I heard those things, I didn't know how I contributed. Even though I'm not directly trained in ABA, it was an approach that was presented to us in school, and I used some techniques that borrowed from ABA and other types of behavioral therapy – like reward systems. Some restrictive things…like

> following behavior plans that clients have, taking away the iPad, and stuff like that… I don't think it feels good to have to restrict anyone in any way…But also, I think a lot of it, I didn't even know, realize, or have the awareness. I was just following what I was told."

The "control" of client behaviors to create "compliance" that Ela described mirrors Olga's observation that therapists are meant to "police somebody's mind and behavior" so that capitalist systems can run more efficiently. She also names colonial patriarchy and White supremacy as forces behind this pattern, which will be explored more in the following subtheme. Additionally, Ela, Indigo, and Sydney all cited the belief that "people do the best they can with what they have" or "humans do well when they can," and warned against casting clients as having "problem behaviors" for communicating their needs in the only ways they have available. Ela's example also demonstrates that early career therapists are under their own social pressure from colleagues to "fit in" and "follow what I was told," like using techniques from evidence-based medical and behavioral therapy approaches. In this way, the therapeutic focus on "control" creates pressure for the "compliance" of therapists too. Sydney gave the following example of their experience being faced with this type of pressure in a clinical internship:

> "I had an internship at a Children's Day program, which was a program for kids who weren't doing very well in general public education… Looking back, I can almost guarantee you 100% of those kids were autistic, even though maybe only 20% of them had that diagnosis. And [DBT] just wasn't working. It was a program where you could put hands on the kids, take them to seclusion rooms, and close and lock the door. *It felt so gross.* But I quickly realized if you could de-escalate the kid before it got there, then that whole traumatic thing would not have to happen… Although I enjoyed my time at that

> program, seeing those few moments of the escalation, what would happen to those kids, and the way the kids talked about that afterwards, I was like, "I can't be a part of a system that's going to do that."

Thus, even though Sydney avoided participating in the seclusion process directly, they had little control to change this practice in that environment. Both Sydney's and Ela's explanations speak to the deep moral discomfort that they felt in these situations, and the sense that responding differently would not have been an option for them., Sydney's experience (much like Ray's summer internship experience) further shows how this deep moral incongruence can impact a therapist's willingness to participate in parts of mental healthcare systems. Overall, these are examples of how participants observed and critiqued the premise normal in DSM diagnosis, and the enforcement of normal in medical and behavioral therapy approaches. In challenging participants to face the systemic injustices they saw enacted against psychotherapeutic clients rather than turning away, these moments catalyzed the process of therapist-client co-transformation.

Encountering and Unraveling Intertwined Normative Oppressions as Therapists

The next subtheme of *Recognizing and Opposing Normative Oppression in Therapy* that participants described is the encountering and unraveling of intertwined normative oppressions (i.e., racism, ableism, cisheterosexism, xenophobia, etc.) in their therapeutic work. Jay explained how the idea of "normal" precipitates social discrimination, marginalization, and oppression (hence, the term "normative oppression" unifies their logic for this subtheme):

> "This normal thing is, at best, something that people hold to settle their fears. "There is a normal, there is." And at worst, [normal] is a way to maintain a hierarchy that keeps

> *certain* groups of people in positions of power and comfort. People are made very uncomfortable by behavior they can't read or understand right away. But if there's a large enough group of people who say, "This is weird," then we can say, "It's not *us* unable to flow with this different energy. It's *them* and *they're* doing something wrong… If we don't have norms created by those who have decided they're the majority (but more the ones in power), then what are the principles around which we can actually meet and hold society or community? …One of them, and I think why people struggle with it so much, is that we need to be *community-in-change*. The principles have to exist in the unknown, rather there be a structure that fights off the unknown… Many times in the history of this planet, [there's been] desperate holding to a structure that is familiar. I think that's why they're using the trans thing so much. It just hits a core thing: "Boys are boys and girls are girls." …Diversity is what helps people make it, helps species make it, helps anything. Having different ways to pivot and using the different strengths to have the best chances of thriving and surviving. Yet our society has really clamped down on diversity to hold on to some sense of safety. Trans autistic people, BIPOC trans autistic people blow that one up. They're also the ones who pay at the hugest price, because some folks make it and a lot don't…That's just– I have enormous grief about that."

What Jay posits here is that a fear of the unfamiliar, uncertain, and unknown drives so many of the normatively oppressive belief systems that exist today, as well as the desire for powerful social groups to "maintain a hierarchy" of power and comfort. The examples they gave also show how the pursuit of normal through normative oppression is harmful and lethal to social groups with the least power. Elizabeth built on the same theme of intertwining normative oppressions as Jay, but went into further depth on the overlap between racism and ableism:

> “A lot of people are not aware of how racism and ableism inform and reinforce one another. Racism could not have come about without ableism, because ableism is way older. But racism is only like 500 years old. Xenophobia is older, but specifically racism – it’s not that old. Racism was able to come about through very targeted, specific, well-thought-out plans to dehumanize Black people first, but also went on to impact others as well. And the heart of ableism is *dehumanization*. The thing about most oppression… Ableism (and racism) should cause a lot of cognitive dissonance for most humans that live in democracies; that live in the Global North. The only reason it doesn’t is because ableism fuels our ability to dehumanize folks enough where the rules that apply to humans – in our minds – don’t apply to these people, whether they’re Black or Brown, disabled, queer, or whatever it is. And because ableism is so ancient – it’s so “the way of being human,” it’s so built into ancient societies – most people don’t question it the way they question racism.”

Elizabeth went on to delineate how these ideas have informed her meaning-making of her own struggles (and those of her clients) when experiencing intersecting normative oppressions:

> “In other people’s eyes, I’m a successful human. Despite that, ableism keeps coming up as a problem. What’s challenging is – when you’re a Black or Brown disabled or autistic person – you don’t know why you’re experiencing the barrier, microaggression, or oppression. Sometimes it’s clear, but then other times I’m aware that I’m being discriminated against, but it could be for all kinds of reasons…So when the Black woman experiences microaggressions at work and her boss treats her that way specifically because she’s a Black woman – not because she’s black, not because she’s a woman, but because she’s *a Black woman* – but there’s no legal recourse for that, for specifically

> being that intersection, what do you do? This person can provide evidence that, "No, I treat Black men just fine," or, "No, I treat White women just fine." They have this problem with *Black women*. Intersectionality is not addressed in the ways that it should be because we're *obsessed* with categorization. People like me fall through the cracks continually. The families that I serve – they fall through the cracks."

Elizabeth's first statement provides a deeper historical context for understanding what Jay alluded to about people in power using ideas of normal to maintain their positions of power and comfort. Furthermore, she added how a societal lack of attendance to intersectionality exacerbates the struggles that both her and her multiply marginalized clients experience. Similar to what Jay said about people who "pay the hugest price" of society's "clamping down on diversity," Elizabeth described how her most marginalized client families "fall through the cracks continually." Ela offered a client example that demonstrates Elizabeth's points, delineating how intertwined racism, xenophobia, ableism, and autistiphobia harmed one of her client's relationships with the marginalized parts of themself:

> "I can think of an example of a Latino teenager. They didn't want to use Spanish with their family, even though that's what they primarily spoke at home. They also tried not to stim in front of people. It was because there were a lot of White kids where they lived. They said they wished they were White at one point. Also, being autistic and needing to stim for their emotional health – but being afraid of not fitting in. I think those are some barriers clients face. I don't think it matters what age they are; they want to fit in because everyone wants friends. With presuming competence, I think presuming people want connection is also really important… And it broke my heart that [the client] didn't want to speak Spanish with their family because that was a meaningful connection with their

> family. That they also saw something inherently wrong with themself, including being autistic. That they weren't allowed to express themself. They had to sit there in class, and they couldn't move or walk around…thinking there's something wrong with them because they don't fit in that way."

That Ela simultaneously spoke to each of her client's internalized oppressions and their resulting harms shows how hard it is isolate and identify which specific "abnormality" is being targeted and dehumanized, because the person's "abnormalities" are all wrapped up in each other for "not fitting in" with a given culture's "normal." Or, as Elizabeth had put another way, "When you're a Black or Brown disabled or autistic person, you don't know *why* you're experiencing the barrier, microaggression, or oppression." Both Ela's and Elizabeth's quotes demonstrate how *the mere idea that a "normal" person exists inherently dehumanizes and oppresses every single marginalized person and experience, all at once*. Sydney expanded on this idea, highlighting similar consequences he noticed for his autistic, queer, and/or trans clients who underwent ABA or other intensive behaviorist programs, and/or those who experienced religious trauma:

> "It might sound like an odd parallel, but most of my clients are also queer and/or trans. With my autistic clients who were enrolled in ABA or similar behavioral groups in school (like The Zones of Regulation), they tend to have the most internalized transphobia and ableism. It reminds me of folks with religious trauma. It's just so deeply ingrained, and there's so much shame and guilt. It seems like, when they were made to stuff down who they were in regards to their neurodivergence, they also stuffed down any other difference that they sensed. And now, for them to be authentic, *it's a process* to undo the guilt and shame they feel…They will frequent places online where they see strict rhetoric around what it means to exist and what you should be doing. Like they will listen to Ben

> Shapiro, go to Kiwi Farms, look at incel stuff, men's rights activist stuff, or TERF stuff. They will constantly be checking in, even though it is mentally damaging and they always leave feeling worse. Some of my clients will even say it feels like self-harm, but *mental* self-harm. It's similar to what a lot of my clients who are fresh leaving a religion do; they keep checking back in. Like if they're Mormon, they keep going back. "What are the elders saying now?" …It's like an insidious thing that just sticks."

Sydney brought something new to this discussion by explaining how the most intense enforcements normal (like ABA and conversion therapies) can precipitate powerful "mental self-harm" habits. Sydney's statement also reflects both Elizabeth's and Ela's commentary on the intertwined natures of normative oppressions, and directly suggests that – for multiply marginalized clients – *internalized oppression begets internalized oppression*. Put another way, their statement, "when they were made to stuff down who they were in regards to their neurodivergence, they also stuffed down any other difference that they sensed," indicates that the pursuit being normal in a particular way begets the pursuit of being normal in another way (because "normal" is a unifying construct). Thus, Indigo – like Jay, Elizabeth, Ela, and Sydney – observed how therapeutic work on internalized normative oppressions all seemed to connect to one another. To start, she described how working on internalized ableism became a core part of her work with neurodivergent clients, and naturally connected to her other areas of social justice work:

> "When I first started exploring more about neurodiversity and autism, some of the things that I came up against in my own personal work – and within clients' work, especially – was the giant mountain troll of internalized ableism. The giant mountain troll that lives in many neurodivergent or autistic people. And when I viewed my clients' mountain trolls

> and my own in context, we saw that they had to come from some mountain range. And that mountain range was some of the philosophies of our own society around value, expectations, and societal contribution. Exploring those has really tied in with the other work that I have done in social justice, in working with racial or ethnically marginalized groups or with the queer community. It just added so many layers of understanding to all of those other passion areas. Exploring internalized ableism within myself and supporting my clients in uprooting some of these concepts – that were planted for them, that weren't naturally occurring, that they initially suspected were evidence that they were deficient or not enough – has been some of the most profound and passionate work of my life."

When asked what were some of the basic tenets of those "mountain ranges" that internalized ableism came from, Indigo expounded:

> "Some of the basic tenets are very capitalistically oriented. We have value if we give quantifiable value to others. That is really, really pervasive, especially in millennial and older neurodivergent folks... If you can create value, then you should – you have an obligation to. There's a societal obligation to create a certain kind of value, defined by others with authority as being a productive pursuit that is worth engagement in. So that points to systems of societally recognized achievement like money or prestige. And if you can't or don't want to participate in the accumulation of these representations of value and power, then not only are you *not* contributing, but *you are actively costing society*. And money and prestige are just two of the most highly valued ones in a Western and capitalism-driven society. But there are also others like social likability or social giving that are also very present in Western society, and especially in other cultures."

Like the previously referenced participants within this subtheme, Indigo noticed how different normative oppressions (toward disabled people, queer people, racial and ethnically marginalized people, and anyone else struggling to adhere to the values of capitalism) are completely wrapped up in one another. Furthermore, in the second half of her statement, she described realizing how these oppressions worked in tandem with capitalism to pressure people into meeting these "societal obligations." Thus, Indigo reported that her autistic clients' struggles are largely due to internalized ableism, which starts with how clients do not feel "valuable" or like they are "contributing" enough to the world as they already are. Her quote also implies that clients develop internalized ableism under the pressure to earn or acquire money and other "representations of value and power." Adding to this idea, Maria explained, "*I have two groups of [autistic] clients: those who can't keep jobs and clients who do keep jobs but completely crash at the end of the workday*." She said that her clients typically resolve this issue by "moving in the direction of self-employment" or, if possible, "getting accommodations" at work. Thus, the pressure to earn money through work can become one of those "societal obligations" Indigo talked about, and autistic people's troubles doing so can precipitate internalized ableism (the sense of "actively costing society").

Coming back to the idea of internalized normative oppressions overall, Ela and Sydney had explained how normative oppressions encouraged their clients to hide their respective marginalized ways of being from the world. Meanwhile, Indigo described how helping her clients uproot ideas "that they initially suspected were evidence that they were deficient or not enough" constituted her work on internalized ableism (and other connected normative oppressions). Hazel added to this conversation in the following statement, by explaining how they have also observed "normal" being an oppressive force that shapes clients' lives for the worse, without them even noticing for long periods of time. The following was their response when asked how their ideas of what is normal have changed since working with autistic clients:

> "The concept of trying to fit into what's normal, how damaging that is, and how hard people try to fit into that. Even if they're allistic and successful, that also seems to be rather damaging for them too, fitting into social constructs and ways we relate to each other, and not even questioning them and just kind of going along with them. Sometimes it's led people to be very deeply unhappy [in ways] that they don't even think about until maybe years and years later."

Thus, a variety of participants noticed that fitting these normative metrics of "success" or meeting these "societal obligations" were not working for their neurodivergent and autistic clients. Hazel explicitly added that "fitting into social constructs" did not really seem to work for any of their clients, even those experiencing relatively less normative oppression. Reflecting Hazel's statement, Sydney also explained how upholding the pursuit of normality and "fitting in" to find social belonging fails in the long-term. They additionally suggested that normal plays into the creation of new in- and out-groups which people then use to discriminate against and police what is the new "cringe" social group:

> "When we are like, "Let's normalize this thing for you," it almost implies that there's an *abnormal*. Like, "Let's normalize being a furry, but not a scaly; the scaly is the cringe part of the furry community. Or you can be trans, but not non-binary." I see that happen all the time. In this community, you're seeing that [a given] interest or hobby is super normal and typical of this group. Yet we know in others it's *not*. All of it [connects with] the neuroqueer piece of moving away from the norms to be like, "You're okay. This is okay. Show up how you are." It would be nice if the world could continue to move in

> ways where that is accepted, nice, and affirmed, instead of seen as cringy by a majority or even a small vocal minority.

Sydney was explaining how “normalization” can be a slippery slope into continuously re-drawing the “line in the sand” to distinguish what is normal vs. abnormal, recreating the cycle of normative oppression repeatedly. Their words indicate that avoiding the recreation of normative oppression involves “continuing to move in ways” in which “showing up how you are” is “accepted, nice, and affirmed.” Also, their argument directly converges with what Jay said about the world needing to adjust to being a “community-in-change” and how our principles of community “have to exist in the unknown.” These ways of thinking likely took part in driving Sydney and Jay – and possibly other participants – towards facilitating emergence for clients in their therapeutic practices. To summarize the current subtheme, participant quotes showcased the direct interconnections and interplay between normative oppressions that they observed in their therapeutic work and personal lives. The encountering and unraveling these relationships between different normative oppressions served as another catalyst for the co-transformation process, as they guided participants (and through them, their clients) to embrace the neurodiversity movement and related social justice movements.

Rejecting the Expert Role and Saviorism as a Therapist

The third and final subtheme of *Recognizing and Opposing Normative Oppression in Therapy* is about recognizing and rejecting how the dichotomization of the self/subject (therapist) versus the other/object (client) creates a normative hierarchy of wellness vs. sickness, expert vs. inexpert, and savior vs. saved, and noticing how this exacerbates the normative oppression of clients. For instance, Hazel explained how the pressure to conform to therapist norms included hiding her plurality from clients, and thus, maintaining the appearance of a "well-sick" divide between them:

> "Initially, I would have clients clock me [as plural] and not directly ask, but then ask sideways or say, "I think this, but I'm not going to ask you." It felt like there was this weird hiding in the room like, "I'm supposed to be in a hierarchy above." …There's a lot of well-sick type things in the dissociative clinical world. I'm supposed to have it together and not be plural, and then help those poor dears who are. It doesn't feel good; there's a lot of inauthenticity in it…I am expected to perform my therapist duties as if I have everything together and my life is great. That I don't have any complications with my plurality, my autism, the larger community, power dynamics, or things like that. And that I can help clients fix their stuff because I have it absolutely together…I have literally been told, "It's unprofessional for clinicians who work in the dissociative world to come out with their own plurality. So hide those things." But that's not necessarily human."

In other words, Hazel experienced other therapists' pressuring to conform to their established norms as an expectation for her to be "inauthentic," more than human, and seem strifeless around her clients. She indicates that this normative performance from therapists reinforces that they "have it absolutely together," so that they can "help those poor dears" who do not (and that being plural/dissociative inherently means "not having it together"). Therefore, this performance not only distinguishes and divides the self-of-the-therapist from the other (their clients); it puts them on a "well" to "sick" hierarchy in which wellness is assumed to be the superior half of this binary opposition. Hazel's response suggests this performance also encourages the therapist to play the role of a "professional" – a trained expert on "help[ing] clients fix their stuff.” Tiff described a session which further exemplified the expectation that therapists assert their expertise with clients.

For context, Tiff had given an example of a second session in which they observed to a teen client that they could be autistic based on some of their traits, and then brought that client’s parent into the conversation. Tiff narrated how this conversation eventually led to a disagreement with the client’s original psychiatrist, and diverging from their opinion to help the client obtain an autism diagnosis. A year later, the client’s parent thanked Tiff for the major life improvements that resulted from correcting the course of their child’s psychiatric treatment. Indeed, this was an example of client satisfaction with therapy, and – from the parent’s, client’s, and Tiff’s perspectives – increased well-being. Yet, right before they shared this example, Tiff said, “I have an example that I think most therapists would yell at me for.” When they were directly asked why they thought other therapists would yell at them for what they did in that second session, Tiff said:

> “Because that’s not how we’re supposed to do it. We’re supposed to be the knower of all things. But *no*, my client is the boss of their story. My client is the expert of their story, *not me*. I’m here to facilitate. “Hey, I have a thought, and it’s around autism. What do you think?” “Nah, I don’t think I fit that.” “Okay, cool. If it comes up again, are you open for me to give you some examples of what I’m seeing?” “Absolutely.” “Fantastic. Let’s move on.” Or the example I gave you. “My God. Yes, I think I am.”

When Tiff said that “my client is the expert of their story, not me,” they asserted that therapists are not meant to force their own interpretations of clients’ experiences onto them. For example, even as Tiff displayed their desire to offer clients information which might help them make sense of their experiences (e.g., “I have a thought and it’s around autism,” and “Are you open for me to give you some examples of what I'm seeing?"), they did not force their own hunches on their clients, heeding and respecting their in-the-moment responses. Even so, Tiff said, "That's not how we're supposed to do it. We're supposed to be the knower of all things," suggesting that *therapists are expected to act like the experts on clients' stories* (or "be in a hierarchy above," as Hazel said), even when doing so might harm clients.

Ray offered a comparable statement to Hazel's and Tiff's quotes on the peer pressure that therapists are under to play the "professional" and "expert" role, but he recontextualized this dynamic within the history of psychotherapy. He explained the importance of learning about autistic phenomenology, how profoundly this impacts autistic lived experience, and why more therapists do not have nor seek this understanding:

> "[Autistic phenomenology] is misunderstood and fundamentally different than allistic phenomenology. It's about how they experience life differently from sensation and perception all the way up to meaning-making. For me, it's primarily phenomenological differences that create the more overt-looking, relational, and thinking differences…Why is this not more understood or known in [the psychotherapeutic] professions?…Because phenomenology is about subjectivity, and we've been bullshitting ourselves that we're objective scientists for the last 50 years and have *absolutely nothing* to show for it…We started out as a primarily subjective, phenomenological discipline. With insurance companies, capitalism, CBT, and all these other cultural forces – as well as our own sense of inferiority compared to the medical industry – we decided we wanted to be like medical people and hard scientists and prove our worth. And it created modern mental health, which is *completely broken* and separated from what *actually* makes us human. It's all about symptoms and disorders, and manualized treatments; they're of very limited

> utility when it comes to truly being human, how we connect in therapy, and how we connect as people outside of therapy."

To summarize, Ray asserted that therapists have historically tried to relieve "our own sense of *inferiority* compared to the *medical industry*" by "proving our *worth*" and embracing an "objective," scientific, and medical paradigm of therapy. He said this then "created *modern mental health*, which is completely *broken and separated from what actually makes us human*." Meanwhile, Hazel had stated that acting "well" is "not necessarily *human*" because it requires therapists to hide their authentic struggles from clients, thereby *pathologizing the visibility of human struggling*. Thus, Ray and Hazel implied that *client devaluation* is inherent to a well-sick (expert-inexpert) dichotomous hierarchy, requiring therapists and healthcare professionals to perform being *superhuman experts* who are then responsible for "helping" the *sickly, inexpert humans*. Furthermore, Hazel began to notice that the "well-sick" hierarchy between therapist and client was actually hindering their therapeutic work:

> "For one of my clients, a lot of clinicians really experienced with DID were working with them and got stuck. I got them because [the client] didn't want to work with different people. The traditional models of working with DID do not work with this particular person. The only thing that really has worked…is me divulging my plurality. Talking about how things sometimes do feel really depressing, and how I don't necessarily have suicidality anymore, but I have had that and self-injury in the past…Most of the experience that they have is shame about even [being plural] at all, and it drives a lot of their desire to not be here. To have a therapist who also has this thing that they're deeply shamed about – and who is connecting with them and can divulge some of that stuff – has popped them out of some really dangerous suicidal episodes…While we've done this

> work together, they have gone back into work that's meaningful to them; that has provided some more structure, which has made their life better."

When asked what they think makes this self-disclosure strategy so effective with their neurodivergent clients, Hazel elaborated:

> "…Having them talk about their [neurodivergent] experiences means that they're crazy, broken, and there's stuff that's wrong with them…[Instead, for me to say,] "This is something I experienced too, and it's a different way of being that isn't wrong, that other people and I live in"…makes them feel less alone with it, because otherwise, they're entirely by themselves with this particular experience. The less-aloneness is probably the biggest tool I have in my therapy kit for moving even awful suicidality and trauma, and that works with autism too…Being alone is kind of an essence of or the worst part of trauma. So autistic kids who are bullied – nobody's coming in and saying that they see them, see that they're different, and that [the bullying] isn't okay. They're just letting them be bullied, and that creates this shame like, "There is something broken, wrong, and different, and I should be like these other kids and I'm weird." Having somebody else go, "You *are* different. That doesn't make you wrong, and there's nothing to be ashamed of. It doesn't mean that you need to work harder to fit in with these kids." It lets you sit beside them and be different and weird *with* them."

To summarize, after disclosing their neurodivergence and related struggles, Hazel noticed their client with these shared experiences finally reporting less suicidality and being able to find more meaning and stability in their life. In other words, the "traditional model" of trying to "fix" the client's plurality was not helpful, but role-modeling unconditional self-acceptance (by being "different and weird with them") as an openly plural or autistic person with past suicidality *was* helpful. Adding to this idea, Maria explained of her approach, "*It's more important for me to have [clients] love parts of themselves rather than solve the [presenting] problem itself*. Because if they love that part, acknowledge the fear, and take care of it, *they find the solutions themselves. I don't have to help them."* Both Hazel and Maria realized that supporting clients in building new relationships with the parts of themselves that they were ashamed of (i.e., feeling "less alone" with them, or learning to "love" them) was most helpful in addressing the "symptoms" they originally presented to therapy with.

Also – harkening back to Ray's words – "subjective" and "phenomenological" knowledge (i.e., lived experience as a plural and once suicidal person) were the basis for helpful work in Hazel's therapeutic relationship, rather than imposing "objective scientists'" expertise from outside of lived experience communities as a medical professional or scientist might. Indigo corroborated that client (lived experience) devaluation is a common expectation for therapists, and – like Hazel – indicated that creating a well-sick and expert-inexpert dichotomy is not helpful in therapeutic relationships:

> "Another part that's really important to me in working collaboratively, taking a step out of the expert seat in client work, and working alongside and with clients, is the recognition that this is a two-way street… If I was in the, "I am the holder of the information, the well-being stuff, and you are the peasant who receives my wisdoms and applies them," then it wouldn't be so, right? I would be in the seat of, "I am fully actualized, and you learn from me." *That's not part of my client philosophy at all*. I feel that healthy, successful, and impactful therapeutic relationships should also feel impactful for clinicians who are meaningfully engaged in supporting other people in transforming

> their own lives. Doing that work should feel healing to be a part of – contributing to healing of a part of your community."

Again, by referencing the "I am the holder of the information, the well-being stuff, and you are the peasant who receives my wisdoms and applies them" mentality, Indigo challenged the well-sick and expert-inexpert hierarchy of some therapist-client relationships. Instead, they expressed the belief that "healthy, successful, and impactful therapeutic relationships *should also feel impactful for clinicians*," and that "doing that work should *feel healing to be a part of*." In this sense, facilitating the healing of one's community and world – of which one is a part – *should feel healing for the therapist too*. Olga offered a similar statement about "mutual healing" in therapy when sharing their experience demonstrating accountability to an autistic client:

> "I had to apologize to a client that I worked with for seven years because when I first started working with them, I was trying to do this, "Okay, I'm told I need to do ABA stuff, so I'm going to try ABA stuff," and not having any success. Then I was learning, changing, and growing, doing things differently, and seeing so much better results. At some point, I thought, "*Gosh*, this kid really hung out with me. They tolerated so much. They've been so patient with me for all these years, and look at this wonderful relationship that we have now. They didn't give up on me." So I had to acknowledge that with him, apologize, and say "*I'm sorry* for how I used to do things. *I was wrong*, and I'm going to try to do better," then also say, "Thank you for being patient, even though I was doing things wrong, and for sticking with me and giving me a chance to get better."…[The client was] non-speaking and used AAC, so their AAC didn't have anything that was sophisticated enough for them to just communicate with words. But they had a look – [laughter] had a "positive affect." It was a quiet moment, and they were

> stimming in a way that they enjoyed. They came and sat next to me. They were looking at me, and they put their hand on my hand. I don't want to speak too much on their behalf, but I felt like it was a moment of connection. Did they understand perfectly my intent or every word? I don't know. But it seemed positive and reciprocal, because they did have a choice where they could get up and walk away. They chose to sit with me, to touch my hand. Even if they didn't fully understand my intent – I know some people would say, "They didn't understand what you're talking about" – I *do* think they understood the positive regard and desire I had to connect with them…It's that mutual healing that Ralph Savarese talked about in regard to neurocosmopolitanism. This healing in the client-therapist relationship is *mutual*."

Olga's experience resonated with the noticeable improvements (i.e., "seeing so much better results") in therapy that Hazel experienced when moving away from traditional (and not lived experience-informed) models of working with neurodivergent clients. Additionally, by "sticking with me and giving me a chance to get better," Olga's client helped them grow and heal from past harm too. This also harmonizes with Indigo's assertion that the therapeutic relationship is "a two-way street," and that "information," "wisdom," and the resulting growth travel bidirectionally between therapists and clients. This particular example that Olga gave is also crucial because it shows how mutual healing does not require use of oral speech on the client's part, nor certainty of shared meaning between therapist and client. Mutual healing simply required vulnerability and growth during a shared "moment of connection." Like Olga, Elizabeth offered an example of how her clients have helped her learn and challenge herself to grow as a person and therapist:

“My favorite thing to ask my clients is “who said?” People just say things like they’re fact. “I can’t let my child act like that.” Well, “*Who said?* Where did we get these rules? Where did you get this rule from?” …But then there were other things where I didn’t ask myself “who said” in ways that I should have been asking myself; this is that juxtaposition between being a devout Christian and being a decolonized anti-oppressive human and therapist…I had these beliefs that were religiously entrenched that I didn’t realize until I started serving more queer clients…I’ve had a couple of clients who – they came to me for couples therapy, but they identified as bisexual and they just so happened to be married to what society deems as “this is what’s supposed to happen.” And I, until seven or eight years ago, wasn’t entering the conversation with that in mind. Again, “who said” that this woman is supposed to be married to a man? …So there’s always room for growth for everybody, right? I think I’ve seen more growth in that regard and areas of oppression that I don’t personally experience…One of the things I love about being a therapist is how much growth happens for you. Therapists are really cool humans because of all the opportunities for growth that we have, considering all the hundreds of humans that we get to connect with deeply. I think that growth happens mostly in the therapy room. Whenever those [“who said?”] questions do arise in the therapy room, I bring them out of it. I’m talking with my colleagues, my family even, about challenging things that I see them do and say – that I didn’t think anything of, before this experience with a client…Saviorism is not my thing. *I am in awe of my clients*…I look at it like I’m just a witness. Like, “I’m honored to be sitting here watching you crush it like this, to be sitting here crying with you when you don’t think you can crush it, but you can.” That’s the most

> rewarding part for me, is that folks would trust me enough to let me into their world and walk beside them while they're doing all this cool stuff. *Hard stuff*, but cool stuff."

Elizabeth articulated how her clients' experiences become her "opportunities for growth" and how she believes "*that growth happens mostly in the therapy room*." In this way, she speaks to the process of her clients mutually healing her as well. Elizabeth was the only participant to explicitly name "saviorism" in this discussion, putting it in opposition to a mutual healing framework for therapy. This understanding of a savior vs. saved hierarchy also adds to the previously named well vs. sick and expert vs. inexpert dichotomies in therapist-client relationships. In this way, a mutual healing/healed therapist was offered as an alternate approach to the therapist role, as opposed to performing the hierarchical and normatively oppressive "well" therapist, "expert," or "savior." In fact, Tiff, Sydney, Ray, and Elizabeth all explicitly referenced "decolonizing" therapy as something they were in active discussion about and working on, directly challenging (White colonial) saviorism. Jay concluded and added to this discussion of mutual healing in the following quote:

> "Philosophically, spiritually, I hope that we're in this together – that my clients are going to change me. We change each other…Every interaction has changed, and I will be changed. And I need to be both open and grounded so that, whatever change I can metabolize, I can choose what to do with it or whether to be changed in that way."

In addition to reinforcing the idea of mutual healing through the statement "we change each other," Jay introduced a new idea to this conversation: the therapist can still exercise agency in how they want to be changed, just like the client. They presented this idea when saying "Whatever change I can metabolize, *I can choose what to do with it* or *whether to be changed in that way*." Jay suggested that the way to make this choice possible is to be "both open and grounded" to metabolizing said change. During their interview, they described how clients can learn to metabolize difficult change in the same way. As such, Jay described how therapists and clients can learn and practice the same task of being-in-relationship during sessions: remaining open to one another's influence and deciding how to receive and respond to it with change.

Given that these participants presented the central task of anti-expert and anti-saviorist therapy to represent a more fluid, mutual healing and influencing between therapists and clients, this subtheme of *Rejecting the Expert Role and Saviorism in Therapy* most closely represents the phenomenon of study (co-transformation) itself. Furthermore, the rejection of the expert role and saviorism serves as one more rejection of a normative social hierarchy, deconstructing and eschewing the therapist-client hierarchy initially entrenched in the therapeutic relationship. By doing away with the arbitrary hierarchy that separates therapist and client, therapists allow themselves to engage with clients in ways that are mutually influential, dynamic, and therefore, profoundly co-transformative.

Aligning with Neurodivergent Authenticity, Autonomy, and Connection

This major theme also includes three subthemes, presented in the sections below. First, *Embracing Resonance and Belonging in Neurodivergent Communities and Cultures* examines how therapists found authentic resonance and belonging amongst other autistic or otherwise neurodivergent people, and then sought the connection and autonomy experienced within these communities and cultures. Second, *Facilitating Emergent Authenticity and Autonomy for Clients* discusses how participants used their roles as therapists to facilitate clients in becoming more authentic and autonomous in a spontaneous and unscripted manner. Third, *Noticing and Honoring the Systemic Contributions of Neurodivergent Relationality*, explores the unique, deep, systemically connected forms of relationality that autistic and otherwise neurodivergent people came to embody, and participants' appreciations of them. Participants statements converged most strongly around the degree of authentic belonging they reported feeling amongst alike neurodivergent people and cultures, the strong pull they felt to follow clients' authenticity as a compass in therapy, and the openness, interest, and appreciation expressed towards neurodivergent ways of being relational. Participants diverged most strongly in the timing and means by which they found belonging in neurodivergent communities, the approaches and modalities that they used to bring out the authentic emergence of clients or to facilitate their autonomies, and the forms of neurodivergent relationality they came to notice and honor.

Embracing Resonance and Belonging in Neurodivergent Communities and Cultures

The first sub-theme of *Aligning with Neurodivergent Authenticity and Autonomy* is about discovering an authentic resonance and sense of belonging with neurodivergent people, choosing to identify with and join neurodivergent communities and cultures, and inviting clients on the same journey. The timing of this journey over participants' careers and lives varied greatly, but each reported learning more about both their own neurodivergence and that of others through their therapeutic work. In fact, Maria, Elizabeth, and Sydney each shared how they realized that they were autistic partially *because of* their work with autistic clients. Maria said that two of her sons were recognized as autistic by their healthcare providers, and one of those sons said he thought she was autistic too. She then offered the following example of finally coming into her own autistic self-recognition, partly informed by her work with autistic clients:

> "I started noticing that a lot of my clients would meet me once or twice, and then they ran away. They'd say, "Oh, I'll schedule," and then never did. Then I had other clients who

> had been with me for five to six years, they loved me, and they'd tell me, "You're the best therapist that I've ever had because you're the *only* therapist who has ever understood me." Then I started noticing the threads of what they all have in common. I'm pretty sure they are [autistic]. They're not officially diagnosed, but they either self-identify or we suspect they're definitely neurodivergent. Then I thought, "Why is it that only autistic people like me and non-autistic people can't run away from me fast enough?" Because of my self-selected client population, I decided to go for training to be able to administer the ADOS-2 and officially diagnose these clients. As I was sitting at the training, I realized if I took that test, I would classify as autistic. *I do all those things* that they're looking for. I hide it really well, but if I didn't, it would definitely show up. That's when I decided, "Okay, I can officially diagnose autism now, and I can officially diagnose myself with autism." I say I self-identify, but if I took any of the gold-standard measures, I would come out as autistic."

Thus, even though Maria had initially filed away her son's idea that she was autistic, she began to notice how autistic clients felt more understood by her than their past therapists, while incoming allistic clients might have felt put off by their interactions and started avoiding her. This then came to a climax when Maria recognized herself in the diagnostic criteria taught in her specialized autism diagnosis training. Maria's narration beautifully demonstrates how – despite not fully realizing she was autistic until she saw diagnostic "proof" on paper – she was connecting more easily with autistic people long before then. Elizabeth gave a very similar story to Maria's, in which her son was diagnosed as autistic first, but she came to fully realize her own autism through therapy work with an autistic client:

> “Mind you, I had autistic clients too. Neurodivergent people tend to find each other somehow; it’s a very interesting thing. I had autistic clients, and had diagnosed autism before. So I wasn’t totally lost. But I had a client come in and they were Black... and I had all this fresh knowledge, like really understanding a lot more about what autism is, because I was in the throes of it as a parent. So [the client] sat down, and started talking about their life experiences, childhood, and the ways that they thought about things, and I thought I was looking in a mirror…I was sitting there listening to them like, *“Why do I understand this human so perfectly clear?”* I’m a good therapist because I’m autistic, and so I have to ask a lot of questions to understand what somebody who is not neurodivergent is saying; I know that now, but I didn’t know it at the time. But I just totally understood this person…They were talking and I was instantly like, “This person is autistic,” and then I was like, “Oh, my gosh, *I’m* autistic!” They were textbook autism, but the Black version of textbook autism. You’d have to be a Black person and understand autism to know, right? Then I gave them a preliminary diagnosis, and told them we would talk about it more later. We went through that whole journey together. But I left that session and went to my car, cried, called my mom, and was like, *“Mom, I’m autistic!”*”

Here, Elizabeth points out that *understanding her autistic client “so perfectly clear”* was a really novel experience for her, which was very similar to Maria’s clients’ saying, “*you’re the only therapist who has ever understood me.”* Both Elizabeth’s and Maria’s quotes show how their clients and they themselves encountered more resonance with the experiences of alike autistic others. Sydney gave a third, similar example in which he consulted with an autistic autism diagnostician to get a second opinion on some assessment results his clinical supervisor disagreed about, and how the diagnostician clocked him as autistic:

> "I was like, "You know what? His whole bread and butter is doing assessments, and he is autistic." So I redacted a bunch of client information, and showed him the scoring on some of these clients' tests. And I said, "I'm really certain that my clients are autistic, but I think my boss is missing it." And he went, "Well, yeah. Us autistic folks tend to be able to pick up on other autistic folks." And I was like, "Oh, no. No, *I'm not autistic*. My friend is autistic. I really enjoy working with him, but no, I'm not." And he was like, "Are you sure about that?" That was the first time I'd ever considered autism for myself."

Based on Sydney's recounting, this autistic autism assessor validated that his ability to recognize autism in others was sharper than it might be for (allistic) others. Additionally, the assessor's statement about autistic people's ability to "pick up on other autistic folks" implied that he had already picked up on some autistic traits and cultural affinities that Sydney had displayed during their interaction (*because the assessor was autistic himself*). Finally, the assessor assumed that Sydney already knew he was an autistic person because it was already so evident to him. The phrase that this experienced assessor used – "*Us autistic folks tend to be able to pick up on other autistic folks"* – spoke to an intimate social/cultural awareness and *authentic autistic resonance* that he felt between himself and Sydney (and presumed Sydney was feeling with his clients), connecting back to Elizabeth's observation that "*neurodivergent people tend to find each other somehow*." Hazel gave another clear example of how her plural and/or autistic clients have found this same type of authentic resonance with her as a therapist:

> "Sometimes, when I'm helping them navigate stuff inside [their system as plural people], I am doing a little bit of coaching from my personal experience, which they can feel.

> Then they want to know, "How do you know this stuff?" To have it not be something I got trained in or something from a book has been deeply meaningful – that I just know how to do it. With the autism, they wonder, "Why is it so easy to talk to you?" [Laughter] And then they're like, "Oh, yeah, because you're also autistic." The communication just flows better between each other. Some have remarked that they've seen other therapists, and they feel like the therapist wants to fight them all the time, and that hasn't worked. They don't feel that with me. Some of them have said that it's just easier to talk, they don't feel like they have to overexplain, and they can relax when I'm talking. And that's something they experience with other people who are more neurodivergent."

The observations that Maria, Elizabeth, and Sydney made about authentic autistic resonance were very similar to those Hazel shared from her clients in this quote, such as "*some of them have said that it's just easier to talk," "they feel like the therapist wants to fight them all the time…they don't feel that with me*," and "*they can relax when I'm talking*." These phrases demonstrate the sheer depth of *unique resonance* that Hazel's autistic clients have felt with a self-aware autistic therapist, as opposed to their previous allistic or neuro-conforming therapists. Moreover, Hazel showed how autistics are not the only neurodivergent group to feel the impact of these resonances, and that her plural clients could feel something different in how she worked with them – *that her coaching felt more connected to a lived experience of plurality*. Maria gave another example of authentic autistic resonance, explaining the huge difference and she felt when experiencing a primarily autistic social environment for the first time in her life:

> "I attended the World Autism Conference in person, and I had never met that many autistic people gathered in one place in my life…There, all of a sudden, I'm in the majority. It's an incredible feeling to be physically in a group of people where

> everybody's like me. Then I started watching the allistic people there and how awkward they felt. The double empathy problem is a real thing. They had that blank deer-in-the-headlights stare. You know, "I don't know how to respond to that;" it's this awkward silence. One thing that happened there was, if anybody was uncomfortable with anything, they would just stand up, raise their hand and say, "Well, I don't think that is fair." I was like, "*Oh, the honesty!* How refreshing to be in a group of people, and they just speak up." …Physically being there with a bunch of autistic people really helped me understand and feel in my body and heart the affirmation, the neurodivergence-affirming side of things…You feel like you've come home…All my life– you're in a culture where certain things are never done. You want to do them, but you hold back. And you finally go to a place where nobody holds back, and *it's amazing.* [Laughter] It really validates that there's nothing wrong with what you want to do – you just have to be in the right environment. And if you're in the right environment, you can be yourself. It's a feeling of home and freedom; you don't have to hold back."

What Maria presented in this quote went beyond mere resonance and spoke to *authentic autistic belongingness*. Her self-observations (e.g., "*physically being there with a bunch of autistic people really helped me understand and feel in my body and heart the affirmation," "you feel like you've come home,"* and "*it's a feeling of home and freedom"*) expressed a *deep, embodied sense that she belonged with autistic people*. Another personal reaction that Maria shared from this event was, "Oh, finally, *I'm with my peeps. I'm with my community*." She also *likened autism to a country* that she was from and could finally return to, meaning that this quote was about *belonging to an autistic community and culture*. Two allistic ADHD participants – Ray and Ela – also reported that participating in broader neurodivergent communities and cultures offered them more authentic belonging, and even altered their own senses of social belongingness. For instance, the following quote was Ray's response to being asked how his perspective changed as a result of his therapeutic work with autistic clients:

> "I can't socialize with neurotypical people anymore. They bore me to tears. The things they like to talk about and pay attention to in most conversations just do not spark joy, and it has become progressively harder having to censor and follow the rules…Now, if I'm at a supermarket and an autistic person starts info-dumping at me, I'm like, "Cool. Tell me more about all the different types of cans Hostess has been using." …I think partially it just had to do with my own masking; ADHD people mask as well…It was kind of an unmasking process, because I realized how much I was tolerating things that really bored me. Because you want to be this person's friend; you want to be part of the group. And the more that my community is neurodivergent, the less I'm feeling the need to do that."

Ray's descriptions of "having to censor and follow the rules" and "tolerating things that really bored me" indicate that neurotypical-leaning cultures and communities felt inauthentic to him, requiring him to "mask" his ADHD and boredom in order to belong. Meanwhile, he suggested that having an interaction with an unmasked autistic person felt more authentic to him, because those interactions allowed him to unmask as well. In other words, he experienced a broader iteration of neurodivergent culture and community as one in which people with any form of neurodivergence can unmask, be more authentic, and still find community and belonging. Ela responded with the following when asked what it was like coming into awareness of her own neurodivergence and neurodiversity in her professional work:

> "Just embracing and understanding more about the neurodiversity paradigm has been one of the most important things of my whole life, honestly. I mean, it's affected everything in my life, including my own self-awareness and self-confidence, and connection with my inner self. Yeah. It's meant *everything*, really. That's why I feel like it's really important that I talk about it with clients specifically, especially clients who might not have access to technology and helpful social media, because some clients don't have devices at all that they use. They still don't have access to that bigger community. As much as I can talk about it, I feel like it's really helpful. Because it's life-changing for me, so I'm sure that it's the same for a lot of other people."

Here, Ela not only credited the neurodiversity paradigm with changing her life, but also discussed how important it is to connect her clients with the same information from neurodivergent communities so that their lives can be changed too. Moreover, she suggested that clients without access to the internet count on the neurodivergent people in their personal lives to serve as their primary connections to these communities (and the resulting benefits of accessing said communities). Like Ray's appreciation to his neurodivergent community for enabling him to unmask, Ela's statement reveals a deep appreciation to neurodivergent communities and their development of the neurodiversity paradigm for changing "[my] connection with my inner self." Sydney gave a final example of how being in neurodivergent community – either with clients or in general – facilitates a new, more authentic relationship with neurodivergent self-expression:

> "I think the world socially from puberty on kind of ABA'd me into compliance and performance. And I think it made me not trust my gut as much and be embarrassed of those things that society deems embarrassing. As I've done this work and seen how helpful it is for others and myself, and I'm going to show up and ask others to do this, I

> should be able to do some of this stuff myself. I think it's made me more authentic, made me be able to trust myself more and trust my gut more, lean into my interests more. One of the things I love about working with autistic folks and their passions is that it is almost contagious to see that energy and to feel it."

Because autistic clients' authentic passions and energies were "contagious" to Sydney, they started unmasking to be more "authentic" and self- "trusting." For participants, this was the core journey of *Embracing Resonance and Belonging in Neurodivergent Communities and Cultures*; once they (or their clients) felt that neurodivergent resonance, and they embraced neurodivergent relationships in which they felt more authentic belonging, their relationships with themselves transformed for the better.

Facilitating Emergent Authenticity and Autonomy for Clients

The second subtheme of *Aligning with Neurodivergent Authenticity and Autonomy* centered on being neurodivergent person-centered, client-led, and ultimately, facilitating *emergent* authenticity and autonomy (eschewing structure and prescriptivism more often) within one's therapeutic approach. Ela, Indigo, and Sydney all named "*person-centeredness*" or being "*client-led*" as possible descriptions of their approaches, and Tiff said of their approach "*the clients drive the session*." As an initial example of this phenomenon, Indigo included the following in her therapeutic philosophy:

> "My general therapeutic philosophy is rooted in collaboration and in self-determination. I really value understanding my clients' definitions of a good life and well-being, collaborating with them to build a life that reflects those existing values, and uncovering

> where some of those values may have been obscured by societal or structural stressors and oppressive factors.”

Based on this description, Indigo conducts therapy in a *client-led* manner from the very beginning, by “*understanding my clients’ definitions of a good life and well-being*” and then collaborating with these in mind. Furthermore, she considered how normative oppressions may get in the way of her clients actualizing their values and personal definitions of well-being, and incorporates this understanding into her work with them. Thus, even when she is collaborating with her clients to deconstruct normative oppressions such as internalized ableism, it is in service of their personal goals. Much like following a client’s lead for their goals in therapy, Sydney explained how he learned to follow their interests and needs as an intern:

> “I would spend a lot of time as an intern one-on-one with the kids, and I would take a much different approach. Didn’t know what I was doing then, but now I realize I was engaging them in conversations about their special interests. So if they had a binder with Five Nights at Freddy’s or Pokémon on it, and that’s when they’re starting to get agitated by their classmate, I was like, “Hey, tell me about that art on there. What is that?” And let them essentially info dump and info swap about the games or books they were interested in…I think it was through my master’s program and learning more about play therapy there were a few modalities that are very hands-off, very client-led. Some of the tenets of child-centered therapy is that the kid knows what they need. It’s in there somewhere, and it’s just about you joining them on that journey to figure it out and to support them. That felt a lot better to me, and it seemed to work better for the youth that I was interacting with. Through a little trial and error, but mostly witnessing other folks’ trial and error, I

> was like, “I have to move away from that more structured stuff. It just doesn’t seem to work for myself or for the kids that I vibe the best with.”

Sydney noticed that “structured stuff” at this DBT-based program was not helpful in his work with neurodivergent child clients, and instead, he tried to engage them through their own interests and help them access their internal understandings of what they needed. Collaborating towards a client’s definition of a good life and well-being, as Indigo discussed, was rather similar to Sydney working with his clients by engaging their authentic interests and needs; both approaches worked with their clients’ authentic motivations (including deeply felt needs) rather than against them. Harmonizing with this idea, Ela shared that an important part of her therapeutic approach is *giving clients choices*:

> “I think it’s important to just assume that being given choices is beneficial for them. Also, trying to check in with them however you can to see how many choices are helpful…Just going about it with openness and presuming competence with everyone. That you might only give a couple of choices, and that’s enough to start until you can really see the evidence of what’s helpful for them. Even if anyone else who may be in the home, like a direct care staff member, their parents, or something thinks, “Why are you giving them a choice? They’re not going to tell you what they want.” Because I’ve heard that, of course. *I still do it.* Even if I don’t know, because you can look for really subtle cues sometimes, like eye movement or facial expressions or even slight hand movements, maybe you just look for any indicators of a choice. Even if you’re not sure, you just say, “Hi, I noticed that you had this reaction, or I noticed your eyes twitch this way, or something. It looks like you might be choosing this choice. So we’re going to go with this for now, and we’re going to see if this is helpful for you, or if you like this.””

Ela’s determination to offer her clients choices and look for signals of the choices they are making – including those who might not have the motor coordination necessary to reliably communicate a mutually intelligible answer to her – demonstrates the incredible depth of commitment that a therapist can make to work with their client’s intrinsic motivations. Her example also shows how the emergent autonomy of a client can be facilitated by enabling them to decide what happens in therapy, and how it is the therapist’s responsibility to make sure that, as much as possible, this facilitation meets the client where they are. Similar to Ela, Olga gave a detailed example of how she manages to extend her clients choices in the group therapy context:

> “I try to be really flexible…I usually have like four session plans so that I can come in and say like, “Okay, here’s a big overall topic like family dynamics, relaxation skills, or dealing with change.” One of the things that I like to do is make my own handouts…The main flow of when I’m going to ask the group a question, if I’m going to give them information: “Here’s a term, here’s a technique, and here’s a song.” That is all typed out. If there’s a question, there will be space on the paper where they can write their answer…Sometimes people will be totally silent the entire time, but then they will come up and show me their answers. So they can interact that way, or I tell them they can write their answers out, and they don’t have to tell me…It also allows people to read ahead so that they know what’s coming…So it can help people feel prepared. And it can help people with processing…Then they have something to take home if somebody has to step out of group because they become overwhelmed, or the nurse needs to give them their medication…I’ll have several different [music-related] things so that I’m not coming to them and saying, “We’re all going to play drums today. Even if you’re not comfortable doing that, just *deal* with it.” I will have some options and let the group choose how they

> want to go into further exploring that topic…The group rooms already have some sensory tools, but I have my own. I have my big cart… And that can be good for building rapport, too. Then we can spend a minute talking about the sponge or, "What's this thing in this Tupperware that you have here? This slime smells really bad." That can be a lot safer conversation to have."

Again, Olga is "flexible" and gives her clients "options" in a way very similar to how Ela gives her clients "choices." In both instances, the options serve as a way to facilitate client autonomy over what they do in therapy, and to emergently explore what works well for them. Olga also showcased the variety of options that can be explored – even in large group therapy – including different session plans, instruments, fidgets, ways to process information, ways to start conversations, and what to share with whom and when. Comparably to Olga, Elizabeth discussed exploring "doing what works" for herself and teaching this to her clients:

> "I'm very purposeful about moving through the world in the way that works for me. And I'm very purposeful in encouraging my clients, my families, to do the same. We have a whole training program for it. It's called home training. But at the end of the day, the world is not built for you. So then how are you going to build your world? People don't realize how much power and agency they have in their own homes. You're subjected to all the things everywhere else, and then you let it come in your house. *No, it's your house. It's your family, your spouse, your children,* or for business owners, *it's your business*…I take what works for me and I use it. And if it doesn't work, I come up with a way that does work for me because that's what disabled people do. It's what disability culture is, is that level of ingenuity that you've been doing your whole life because you had to in order to survive."

Paying homage to disability culture here, Elizabeth explained that part of her work with clients and families is helping them explore how to "build their worlds" at home or work in ways that work better for their unique households and relationships. Furthermore, she indicated that this strategy was based on her own experiences being "very purposeful about moving through the world in the way that works for me." Thus, whether exploring what works well for clients is done within the parameters of individual and group therapy, or within those of an entire household, this is a way that participants facilitated emergent client authenticity and autonomy. Another way that participants described facilitating client autonomy and exploration of what authentically works for them is by facilitating them exploring their bodies for emergent signals of what they need. Maria offered an example of her trauma-informed approach to doing this in the following quote:

> "No matter how your brain is different, everybody still has the basic same nervous system of being in flight, fight, or freeze mode, or feeling connected and at rest…So it's very important [for clients] to pay attention to their bodies and what nervous system states they're in. I like to use Bessel Van Der Kolk's analogy of a horse and a rider. Our cognitive brains are the riders, and we tell the horse where it wants to go. But sometimes the horse doesn't want to go there and you can't make it. You have to *understand* the horse; you have to really learn to intuit what the horse is feeling, listen to, honor, and take care of it. It has to be a very *close, intimate* relationship between the horse and the rider. You can't just whip it and tell it to go there. That doesn't work…I use IFS to actually talk to the horse: "Hey, body, what do you need now?" and learn to listen to their bodies with dialogue."

Maria's phrase, "you can't just whip [the horse/your body] and tell it to go there" offers a good metaphor for what each of these participants have described avoiding by working with clients' intrinsic motivations and autonomies, rather than against them. Going back to the very first subtheme presented in this chapter, *Critiquing the Premise and Enforcement of Normal in Diagnosis and Treatment*, treating one's neurodivergent body in the way Maria cautioned against here is akin to enforcing normal on the body through control and mandated compliance. She proposed avoiding this path by helping her clients "*really learn to intuit what the [body] is feeling, listen to, honor, and take care of it. It has to be a very close, intimate relationship between the [body] and the [conscious self].*" Again, this is deeply aligned with what previous quotes under this subtheme expressed, but more intensely focused on the client facilitating their own embodied authenticity and autonomy through understanding their whole bodyminds better, with the support of the therapist. Indigo also discussed the autistic nervous system, and specifically shared how clients' focuses on their passions can help their nervous systems feel safer and lead to other positive results for autistic authenticity and autonomy:

> "When [autistic] clients are engaged more meaningfully with things that help bring them joy, fulfillment, and passion, it ends up proving to them and their nervous systems that it is safe, fulfilling, and joyful to engage with life in these ways. Once they experience that – and their nervous systems really experience that as actually true – they start wanting to protect that. And that's where boundaries start being implemented. I notice clients will start more authentically communicating with those trusted support systems… There is a desire to engage as a result of trust in self and boundaries."

Put succinctly, when autistic clients "are engaged more meaningfully" in their special interests or passions, it offers their bodies a deeper sense of safety that they then want to preserve through practices of self-respect, such as boundaries and self-trust. This then preserves their autonomy and authenticity in life. Additionally, it makes facilitating their emergent relationships with their bodies all the more important because, for those stuck primarily focusing on what others expect from them, doing so allows them to access their passions and interests. Jay, like Maria, explained how they facilitate their clients' explorations of their authentic bodily signals, and discussed this stuck-ness functions as masking:

> "When I'm doing my best work with clients, we are in the unknown together holding – we've got Earth, sky, our ancestors – whatever we've got. But we don't know what our body's going to show us next. We don't know what's going to emerge when we open this door. We just know we've got a lot of connection and grounding to help us be with it. And society isn't there. Yet…[neurodivergent people] don't come in going, "Help me get better about this thing." They're like, *"Ahh!"* There may be some specifics. Like, "I want to get on hormones." But it's a lot; it's all over the place. *"I'm freezing! It's in every area!"* And if they're able to get into some connection and have enough support to get away from the [embodied state of] bracing [for self-]protection all the time – which is a *big* if – then they're more okay with the unknown. Like, "Yeah, it is unknown." I mean, there's two sides to it because many autistic people work so hard at masking and protecting themselves that there's a desperate need to know. Like, "How do I do this, right?" And on the other side, there is often an intellectual openness or curiosity like, "Well, we can't know." So as a therapist, I need to really honor that one that's so struggling with being in the world like, "I need to know all this. I need a script.""

In this way, for clients (and therapists) to tune into their bodies and authentic experience of things, they must also access the "connection and grounding" needed to be "in the unknown."

As Jay's quote shows, this might be especially difficult for people with neurodivergent sensory sensitivities, who often get trapped in self-protective freeze-like states (what they called "bracing") to cope with regular sensory bombardment and overwhelming surprises in the world. They also added that – if a client cannot access a greater neurodivergent community in their current circumstances – non-human connections (e.g., Earth, sky, ancestors) can offer meaningful grounding to them. On the other hand, Jay expressed that honoring the part of clients who struggle to live without prescriptivism (e.g., "masking," thinking "I need a script," or having "a desperate need to know") is an equally important part of this work, because these masks still represent authentic parts of clients responding to the world around them. Moreover, their words directly connect masking, "[self-]protection," and bracing, suggesting that *autistic and neurodivergent social masks are actually trauma responses to a world that expects their masks instead of their authentic selves*. In line with Jay's thinking, when asked why authenticity was an important element of his therapy with neurodivergent clients, Ray said:

> "Because so much of our traumas come from this chronic misunderstanding, people saying things and not meaning them, people obscuring things. So authenticity – at least to me as a clinician – means being very open with my process, with what I'm thinking and feeling, and acknowledging biases where they exist as much as I can identify them in the moment. Putting that out there, letting people know how I might be experiencing them, being overt with what I mean, and even what my body is doing. "Oh, you saw me squelch right there. Yeah, no, squelch is the right word, like frown or I had a reaction. And something you said triggered a memory for me that was painful, but has nothing to do with you. So I want you to know that what that reaction is about." Similarly, building the ability to talk about that with my clients. A big part of that comes down to unmasking,

> which kind of goes back to the somatic work. “What does your body want to do in this moment? What does your face want to do in this moment? Do you want to scream? Do you want to stim? Do you want to turn in a circle? Do you want to flap? And also, be honest with how you’re experiencing me.” Including challenging me, and they often do. So as an ADHD person, my difficulties with scheduling, keeping on task, all that stuff can sometimes be dysregulating and annoying to my autistic clients who – the three to five minutes late that I usually am might be very dysregulating for them. So we have discussions about that: “This is what it’s like for me.” “Well, what can I do when I’m dysregulated?” “Are you upset with me?” “Yes, I am.” “Well then, *tell me* because this is what relationships are. Instead of making it a thing of shame, advocate for yourself and what your needs are through the relationship of therapy.””

Ray and Jay both named somatic work as important to their therapeutic practices, and this example shows how this might look in Ray’s work. Furthermore, what Jay called being “in the unknown together” seems similar to what Ray called “authenticity” in his therapy. He demonstrates this with examples of both himself and clients being open and transparent about their bodily and social responses together. Put another way, he facilitates and encourages authenticity to emerge relationally, helping clients explore what mutual neurodivergent authenticity and autonomy feel like within the context of the therapeutic relationship.

Adding to these examples of bodily exploration, authentic expression of neurodivergence within the therapeutic relationship, and trauma-informed work, Hazel gave a meaningful example of how these concepts apply in their work with plural clients, with some interesting parallels to explore when compared to work with autistic clients:

> “There’s a model…where the concept was that you always have an adult self present with plurality, and you never talk or spend time with kid selves unless you have an adult present. And there’s a concept that there’s a main self that you should talk to, and then that one should connect with all of the other selves. The problem with that is that most systems don’t really have a main self, or sometimes the one that’s identified as the main self is struggling more than the others. In the past, some of this came up because some therapists were doing weird things, only hanging out with kids and getting fascinated with the kids. Of course, that’s weird. You don’t want to do that. But I get *so much more* traction going when I sort of do it family style and I talk with whomever wants to talk with me, however they want to pop up. A lot of [clients] have worked with other therapists that use this model, then start to feel dismissed or shamed for showing up or are told that they can’t, and then they don’t know how to connect with the therapist. The therapist is actually missing a lot of authentic and valuable therapy connection by picking and choosing who is the right one to connect with rather than just kind of forming a relationship with [the whole system]. It’s worked a lot better for me, and I’ve gotten a lot more movement with the therapy work. When I’ve provided consultation and kind of had them toss out that model, they’ve been really surprised at how the work starts to work faster. The client starts to lean in and trust. Then there’s more selves that show up, they get more relationship, and then it helps with the collaboration [of the system’s selves].”

They went on to explain what seems to be the ultimate goal of asking plural clients to work in this ineffective, prescriptivist manner:

> “There was this concept that you’re supposed to – rather than collaboration –you’re supposed to do safety first, then you’re supposed to do memory work, and then you’re

> supposed to consolidate everybody to fuse them into one as much as possible. That's what you're supposed to do so that they look like, the term is "singlets" for people who are single. So the goal is to make them into a singlet, ideally, at the end. Because if they're not, if there is any part that's left plural, that means that they are unhealed and unwell. They're still holding trauma. But that doesn't really work well for a couple of reasons. Collaborating and getting connections seems to work better to actually get…wherewithal and teamwork to move them out of a dangerous situation into more safety. Things kind of bounce back and forth. The fusion thing, I mean, it hasn't really proven to be true that, if somebody hasn't decided to consolidate into a single self, that that actually means they're healthy. A lot of times, clients have performed that to make their therapist happy. And then later, *surprise*, it never really actually worked. People were just hiding out because they didn't want to upset the therapist."

In this example, Hazel shared that the foundation of therapy for plural people historically did not prioritize improving their well-being, but rather, "making them into singlets." They explained how well-being has been assumed to mean ridding the client of plurality, because plurality has become conflated with "unhealed" trauma. Additionally, they said that "a lot of times, clients have performed [fusion into a singlet] to make their therapist happy." Hazel's observations of this strategy indicate that it does not actually work at its aim, but rather, encourages masking plurality and slows down work on a system's collaboration instead. Thus, it is another example of "whipping [the horse] and telling it to go there," which does not work for these clients. Hazel's narration is also ironic, because it suggests that this therapy in the name of trauma treatment is likely causing further trauma by requiring clients to force their bodyminds to inauthentically perform neurotypicality (being a singlet) for others. This implies that even trauma treatment needs to be approached with caution when thinking about neurodiversity; everyone's definition of trauma could be different. Finally, Hazel reported that it was better to be facilitate emergent authenticity and autonomy of client systems by "*talk[ing] with whomever wants to talk with me, however they want to pop up.*"

In resonance with this aspect of Hazel's example – and calling back to Ela's example of giving her apraxic clients choices – Tiff addressed how letting go of prescriptivism in therapy has been helpful when learning how to be present with their non-speaking autistic clients:

> "Being open to not knowing things and not having a script as a therapist was really an important shift [for me]. I didn't know CBT didn't work [laughter], but I just knew there was something that wasn't happening for some reason. I think that's where a lot of the fear in working with autistic clients – especially non-speaking autistic clients – is: "Well, what do you do? How do you talk to them? How do you do this?" *You just be with another freaking human*…It was the people in the community themselves that gave me the biggest lesson in my life."

Tiff and Hazel both suggested that, rather than scripting or over-preparing for a therapy session, "just being with" people as they emergently and authentically arrive is something the therapist can do to be supportive. In particular, Tiff's phrase about "not having a script" converges with Sydney's previous statement about moving away from more "structured" approaches to therapy. It also frames the core task of therapy as not just facilitating, but being emergently present with someone else, much like idea of Ray's authenticity together and Jay's idea of being in the unknown together. All participants somehow incorporated *Facilitating Emergent Authenticity and Autonomy for Clients* into their self-described therapeutic philosophies and approaches, reporting a variety of modalities that offered or required of them this type of emergent flexibility; these included parts work, and different iterations of somatic, music, play, relational, and existential therapies. Whether they used the language of being "person-centered," "client-led," or reported working on trauma and embodiment, these therapists found ways to tune into clients' inner experiences, and helped tune into themselves as well. This process allowed for authenticity and autonomy to emerge from the therapeutic encounter.

Noticing and Honoring the Systemic Contributions of Neurodivergent Relationality

The third subtheme of *Facilitating Emergent Authenticity and Autonomy for Clients* involved participants noticing authentic forms of autistic and otherwise neurodivergent relationality, and then honoring their contributions to the world. In particular, the forms of relationality that neurodivergent people contribute to the world encompass the deeply felt interconnections they experience with other beings in the systems around and within them. Indigo started this discussion with the following observations about autistic preferences for relationships and sociality:

> "The norms related to conversational obligation are really common ones that come up in work [as bad fits for autistic clients]. They typically frame this as, "I hate small talk." A lot of clients that I have really dislike polite society obligatory-type conversation, because it can be viewed by autistic people as not genuine and unnecessarily complicated …Autistic clients that I see have naturally gravitated and feel more aligned with their values when they are more genuine and authentic in their expression and their thoughts."

Indigo's thoughts suggest that autistic people have a greater tendency to dislike "polite" and "obligatory" communication, which comes across as insincere and inauthentic to them. Much like Maria's quote about going to the World Autism Conference under the *Embracing*

Resonance and Belonging in Neurodivergent Communities and Cultures subtheme, the implication here is that direct, honest communication is preferred by autistic people for feeling more "*genuine and authentic*." Building on these ideas from Indigo and Maria, Ray postulated how allistic and neuronormative-leaning people tend towards neuronormativity, based on his observations of the differences between their relationality and that of neurodivergent people:

> "My running theory is that neuronormativity has an imperative towards constant social organization or hierarchy. Knowing who's in the in-group, who's in the out-group, and knowing, "Is this person socially on my team or not?" Almost all communication has an underlying social element, and I think that – for neurodivergent people – sometimes there's this naive assumption that, "If we all showed up, we're all going to work on the same thing. Therefore, we are on the same team." Oftentimes, neurodivergent communication is about connecting through projects and information, and seeing if we align in the way we want to do a project or in the way we see the world. The social hierarchy is often in the background – more secondary. It isn't something that has to be constantly brought to light, tested, and recapitulated in every single interaction. There's nothing wrong with that, by the way; it's just a different way of how we organize safety, meaning, and action."

When describing the biggest problems that their autistic and neurodivergent clients tended to report facing in therapy, all participants mentioned the social expectations of other people – of their families, peers, schools, jobs, and/or society at large. What Ray shared here offered a cultural explanation of the mismatch that occurs when autistic and neurodivergent people must live amongst neuronormative social expectations. Based on his much earlier quote about autistic phenomenology, this cultural mismatch starts with the neurocognitive "*sensation*" and *"perception"* differences that autistic and neurodivergent people experience, which then build up to *"differences in meaning-making"* from allistic and neurotypical-leaning people. As an extension of meaning-making, Ray explains here that autistic and neurodivergent people come to different social expectations, priorities, and preferences, and that those differences are more organically at odds with normative oppression and social hierarchy as it currently exists; this is most evident in his phrases: "My running theory is that *neuronormativity has an imperative towards constant social organization or hierarchy"* and "*[The social hierarchy] isn't something that has to be constantly brought to light, tested, and recapitulated in every single interaction [for neurodivergent people]."* Indeed, instead of a greater focus on obligatory politeness for the sake of recapitulating social organization and hierarchy, autistic and neurodivergent participants themselves evidenced more "*connection through projects and information*," and explored their alignment "*in the way we see the world*." Hazel gave a clear example of this preference for connecting with others through projects and information in her work as a neurodivergent therapist:

> "I like the different kinds of creativity from the different kinds of brains and minds of people that I connect with. From the different clinical groups with plural clinicians that I connect with to the clients, the kinds of conversations, creativity, thoughts, and the things that we talk about cover wide ranges of scopes of interests, different concepts and constructs that I don't think that I would get to talk about if I just tried to push people into a single neurotypical frame of being. We can look at things different. We can bounce things off of each other. We can look at things from different angles, break things down together, and check things out. It's helpful if we can all feel more confident in being unique and different and not feel ashamed about that."

In addition to and exploring alignment in the way she sees the world with other neurodivergent people through "*breaking things down together*" and "*checking things out*," Hazel emphasized exploring difference in the way they each see the world together. Her quote references all kinds of differences to explore, which stem from having different "brains and minds," including "*the kinds of conversations, creativity, thoughts*" shared. Similarly, Tiff offered the following method that they use to stay connected with neurodivergent lived experience in their work:

> "I have the privilege of being surrounded by so many different humans and so many different brains, whether it's gender identity, autism, ADHD, whatever it is. That's the collection of humans I have in my world. If you don't have access to those connections, then *start going to* those pride events or whatever they are, right? *Start expanding that.*"

Tiff's advice derives from their personal experiences accessing neurodivergent and other lived experience communities, and expanding the "collection of" different "humans" and "brains" they know. They suggest that getting to connect with all of these communities is a "privilege," that "expands" their world, much like Hazel's expression of appreciation for neurodivergence and difference in their occupational world. Jay expressed a similar priority and ethic to Hazel and Tiff below:

> "I keep thinking about your question, "How has [working with autistic clients] changed me and my sense of normal?" I think I've just gotten further and further out there with what it means to be a human. Not "out there," but in a *deep* and radical in-the-roots way. We need our diversity badly, and we're killing our diversity, which is really doing a number on our sustainability as humans. My mother was, I'm sure, undiagnosed autistic or something, and she once said, "I think we were the ones who went out, people like you

> and me, and we sensed everything. And that was very helpful because we could figure out which foods to eat and where a predator might be coming." …It was her making sense out of her sensitivity, and her not going with other people's ways of doing things. But we need that…So I think it's changed me in needing to integrate a neurodivergent way of thinking or expressing community as a valuable contribution – not a thing to talk *about*, but a thing to talk *from*."

Thus, Jay shared that "a neurodivergent way of thinking or expressing community" has changed them to honor this "valuable contribution" that both (neuro)diversity and neurodivergences offer the world. Both by connecting over alignment (with other autistic or neurodivergent people) and differences (honoring diversity across people). They express this most clearly in the assertion that neurodivergence is "not a thing to talk *about*, but a thing to talk *from*." Furthermore, Jay's statement about getting "*further and further out there with what it means to be a human"* when discussing (neuro)diversity connected to a very interesting observation that several participants made about their autistic clients, specifically concerning their relationality. That is, autistic people seem more likely to develop deep, personified relationships with nature, objects, their special interests, and other non-human beings, expanding their own definitions of being human or a person beyond what others might consider normal. Ray gave an especially interesting example of how this occurs for his autistic clients:

> "[Autistic] people I know have full feelings for trees and rocks, as they would for a pet. Somebody like Greta Thunberg, who feels the death of every animal as if she is losing a human being, because of that intense animistic connection to nature. I see a lot of that, a lot of love of nature, and feeling incredibly connected to nature in that way. They form very deep attachments to their special interests and all the collections associated with it,

> and they talk to them and organize them in ways that they would feel comfortable. A young [client] I used to work with who would line up things and I'd ask why. They would say, "So they're not lonely because *they feel things*, and I don't want them to feel left out like I feel left out," which is a sad projection, but it's also part of that animism. The other manifestation is, I see a lot of hoarding among my autistic clients where they just cannot get rid of something because they have such a deep attachment to it, such a *deep* feeling of it being alive. And the idea of this thing they love being in a trash bin and going to the dump feels completely *horrific*."

Ray's use of the wording "*full feelings* for trees and rocks" is telling because it points out the normative expectation that feelings for non-human or non-animal beings should only be partial, if existent at all. He then referenced the term "*animism*" to describe infusing those full feelings into one's relationship with surrounding non-humans. Interestingly, Jay referenced the very same autistic quality of Greta Thunberg's in their interview. This idea also connects very well with Jay's quote in the previous subtheme about autistic people being able to ground themselves in connection with Earth, sky, and their ancestors. In an example that builds directly upon Ray's quote about autistic animism, Maria also shared how her clients "store" and "process" their emotional memories within the objects around them:

> "This client says, "People think I'm a hoarder because I keep a lot of objects. They represent emotional experiences, but I don't know how to process those emotions. So they're like containers for my emotions. Instead of holding it in my body, I put them in my objects. And my objects are very organized. Every single object is chosen for a reason, and it's stored with care. When I'm able I have extra energy or something, I take out the object, I let the emotion come back, and I process it then. But I do it in small bits

> of the time instead of holding it all in." So what that told me is two things. They're basically using objects as emotional surrogates. The other thing is "externalizing" the system; so instead of holding the traffic jam [of emotions] in their body, that person learned to externalize it. They put it in the cloud so that they can reduce the load inside, and then download it from the cloud when they want to enable it. So those are actually two tools I learned from them. Emotional processing through surrogates and externalizing the system."

Maria added that "externalizing" the system is something Russell Barkley has advocated in order for ADHD people to process information more easily, so she borrowed his language to conceptualize how her clients process their emotions *beyond* their individual bodyminds. Her description of storing and externalizing emotions in objects also adds significantly to Jay's and Ray's observations about autistic people forming deeper relationships with non-human beings; it suggests that autistic people are not simply feeling for and relating to non-human others as deeply as they would for humans and animals, but rather, their nervous systems and feelings figurately and literally extend further into and exist within other, even non-human beings. Maria's observations also held resonance with Hazel's description of working as a plural therapist, and what it is like for them to share one human bodymind (nervous system) with other selves:

> "Especially with complex trauma work, it's almost like folding parts of myself back so that I can actually handle hearing really, really intense content. I don't get the secondary PTSD that I think [singlet therapists] have in hearing about these kinds of things and managing it all day, because [my system] can hold it, we have empathy, *but we don't slide down in it*. That is an intentional choice with managing how we're breaking things down

> for ourselves…And when the self pops in, we kind of blend with each other, so there's not really time loss. There might be a little shift in tone and how we hold our body, face, and language. It's like a whole bunch of knowledge that clicks in at once that I don't have to hold all of the time. Because when a self comes forward, it's almost like the self with their whole library file, then they can back off, and then I have access to different library file…It gives me a bit more flexibility to move in and out, and adjust for some of my clients' needs. It's just kind of pulling forward who might be a better fit for what my client might need."

Both Maria's and Hazel's quotes show how neurodivergent people's nervous systems can *"hold," "break down," "store," and "process"* information and emotions across multiple selves and beings, whether those relationships are viewed as existing within their individual bodyminds or beyond them. Additionally, Hazel explained that many people in autistic and plural lived experience communities are actually aware that there is a high overlap between the two neurodivergences, although this has rarely been explored in research. These similarities could therefore connect through underlying shared experiences. Hazel's experience speaks to a capacity for sharing life experience across multiple people, without some having to fully dominate others. Thus, their way of being collaboratively plural also challenges the "imperative towards constant social organization or hierarchy" that Ray spoke to in his quote on neuronormativity. Olga offered a final, moving explanation of how this constant imperative towards a social hierarchy of humanity and personhood has bigger consequences for the world, and what neurodivergent therapists and clients who challenge hierarchical ways of relating contribute to co-transforming this:

> “It would be audacious if I *did* define what is human. But it’s a valid question to ask and hypothesize about, with the understanding that there’s never going to be an answer. And if you try to narrow it down too much, it might be *dangerous* and have bad outcomes. When you look at history – or you can look at the world now – you see how dehumanization is a step towards violence, annihilation, murder, and death. So I think part of it is understanding that we do not have answers, and we have these big questions. We have questions about ourselves and how we relate to each other…Sometimes when I’m talking about family dynamics or something, I’ll have clients say, “Dogs are people too.” …So I started making that as a disclaimer: “If you feel like your dog, cat, or lizard is a person that’s part of your family, we will define family in that way. Now people are animals and animals are people.” Then I had an autistic teen throw me for a loop. They were like, “In my family, we also have trees.” So they will plant a tree together, and the day that they plant the tree is the tree’s birthday. Then the next year, they’ll celebrate. I was like, “That’s actually really beautiful and that resonates with me a lot.” I think that’s something that we need more of – that sense of connection where we look at a tree and say, “Is it a person? Is it part of our family?...

Olga went on the describe how these questions about who and what is family enable a more systemic way of looking at existence and personhood:

> “That gets us into thinking of our existence: “Are we individuals? Are we part of an interconnected system?” That systemic thinking of… “We’re going to think of how social issues can affect our mental health.” Then we start thinking about, “We are part of an ecosystem, and how much of the problems that we’re having in society are because we have become so divorced from our ecosystem?” You start thinking about some

> Indigenous traditions that look at these things very differently than the standard, dominant capitalist society… I think that, if we're going to be doing therapy and talking about abstract things like health and wellness, it could be really beneficial to think about humanity and personhood as being more expansive and inclusive, because we would not be able to survive without the environment, animals, and plants. Can we be defined outside of our role in the ecosystem? I'm sure that the European Western positivist scientific view would say, "A person has two eyes and two ears, and a person can reproduce with another person to create a baby," but maybe that kind of thinking got us where we are…We've got a lot of food that is produced, *but there's people who are hungry*. We've got a lot of houses that are empty, *and there's homeless people*. Climate crisis and catastrophes create refugees… If we were more connected with how important the ecosystem is and how we're dependent on that, we might be more hesitant to drop a bomb; we might be more hesitant to allow a corporation to poison the water and soil."

Olga's quote explores a more "systemic" way of looking at the world, in which the people who are often called humans would "think about humanity and personhood as being more expansive and inclusive," and be "more connected with how important the ecosystem is and how we're dependent on that." Like Jay, they observed how their (autistic) clients have helped them expand their own definitions of humanity and personhood, largely through their deeper relationships/connections with non-human animals, plants, and whole environments and ecosystems. Looking back to Hazel's and Tiff's earlier quotes expressing appreciation for how neurodivergent differences "connect" and "expand" their social worlds into deeper connections with variant others, a relational and systemic way of thinking seemed to be threaded across these participant statements about authentic neurodivergent relationality. Ultimately, such findings suggest that participants both noticed and honored the systemic contributions of authentic neurodivergent relationality, and were influenced in this way by their therapeutic relationships.

Results Summary

This chapter served as a platform for presenting and connecting participants' experiences and meaning-making. After introducing the participant sample, their journeys into becoming neurodiversity paradigm-informed and co-transforming with clients were detailed and connected. The first superordinate theme, *Recognizing and Opposing Normative Oppression in Therapy*, included three subthemes: *Critiquing the Premise and Enforcement of Normal in Diagnosis and Treatment, Encountering and Unraveling Intertwined Normative Oppressions as Therapists,* and *Rejecting the Expert Role and Saviorism as a Therapist.* The second superordinate theme, *Aligning with Neurodivergent Authenticity and Autonomy*, included three additional subthemes: *Embracing Resonance and Belonging in Neurodivergent Communities and Cultures, Facilitating Emergent Authenticity and Autonomy for Clients,* and *Noticing and Honoring the Systemic Contributions of Neurodivergent Relationality.* For participants, both themes and their respective subthemes interacted and influenced one another in a circular fashion. In the following and concluding chapter, the results presented here will be discussed in relation to broader systemic issues in the world and possible ways therapy can approach those issues, including therapeutic (clinical) implications of this research.

Chapter 5 – Discussion and Conclusion

The following chapter serves as a discussion and conclusion for this research project and dissertation. First, a brief summary of the findings will be provided. The next subsection will offer a discussion and synthesis of these findings, as they relate to concepts, data, and theories explained in previous chapters. Next, the clinical implications of this study's results will be considered for both therapist training and therapeutic practice. Then, the limitations of this study will be addressed, including a discussion of Heidegger's personal background and the impetus for using his approach to phenomenology in the present research. Finally, the chapter will close with a concluding statement on the scope and contributions of this research project.

Summary of the Findings

The present research study started as an effort to reconceptualize "the problem" of autistic being. Not as one of being autistic itself, but the endemic harm towards autistic people in our current world – and what therapies based on such a reconceptualization might look like. As such, it aimed to explore therapist paradigmatic co-transformation (towards the neurodiversity paradigm) with their autistic clients. The results of this exploration were then organized into two superordinate themes with three subthemes each. The first superordinate theme explored participants' journeys *Recognizing and Opposing Normative Oppression in Therapy*, and consisted of *Critiquing the Premise and Enforcement of Normal in Diagnosis and Treatment, Encountering and Unraveling Intertwined Normative Oppressions as Therapists,* and *Rejecting the Expert Role and Saviorism as a Therapist* as subthemes. The second superordinate theme highlighted how participants were *Aligning with Neurodivergent Authenticity, Autonomy, and Connection* in their therapeutic philosophies and work, and encompassed *Embracing Resonance* *and Belonging in Neurodivergent Communities and Cultures, Facilitating Emergent Authenticity and Autonomy for Clients,* and *Noticing and Honoring the Systemic Contributions of Neurodivergent Relationality* as subthemes. Each theme was found to have a circular relationship with one another, in which one would precipitate and reinforce the other. In other words, the more that a therapist would recognize and oppose normative oppression in their therapy work, the more they would align with neurodivergent authenticity, autonomy, and connection, and vice versa.

Discussion and Synthesis of the Findings

The intention of this discussion and synthesis is to connect experiential themes and subthemes with higher order concepts associated with challenging neuronormativity in therapeutic practice and society at large. Additionally, this discussion will include my personal experience as the researcher. The first subsection, *Settler-Colonial Capitalism, and Normal-Enforcing Therapy*, will discuss the large-scale sociopolitical implications of this study's results, by putting them in conversation Indigenous scholar Aaron Mills and Martin Heidegger. The second subsection, *Forsaking the Sovereign Therapist Role and Healing from Kyriarchy*, will utilize the scholarship of Elisabeth Schüssler Fiorenza to explore how the therapist's role under the pathology paradigms causes harm and prevents true collective healing. The third and final subsection, *Reconnecting-in-the-World through Emergent Strategy*, introduces Adrienne Marie Brown's "emergent strategy" as a way to make sense of participants' attendance to emergence in their work as therapists, and how this might have helped facilitate reconnection-in-the-world.

Settler-Colonial Capitalism as Normal-Enforcing Therapy

Participants repeatedly delineated the systemic consequences that autistic (and otherwise neurodivergent, disabled, and marginalized) clients experience as a result of living in a settler-colonial capitalist social-real landscape. Participants also described various ways they came to recognize the systemic nature of these consequences, both directly alongside their clients and in their lives beyond work. These systemic consequences included the normatively oppressive impacts that were described within the following subthemes: *Critiquing the Premise and Enforcement of Normal in Diagnosis and Treatment* and *Encountering and Unraveling Intertwined Normative Oppressions as Therapists*. To make sense of what participants shared, it is important to understand settler-colonial capitalism as a *holistic* phenomenon, and to avoid divorcing world histories of violent European settlement and colonization from present-day globalized capitalism, which continues carrying out those histories. Capitalism cannot be understood in a vacuum, because it depends on the settlement and colonialization of racialized and gendered spaces and beings. It claims ownership of their labor and resources under the threat of violence, and undervalues said labor and resources to sell them for a profit (Goldstein, 2017). Because capitalism must constantly procure new resources and labor which can be devalued to create "profit," it relies upon the violent and exploitative processes of continued settlement and colonization.

Thus, *settler-colonial capitalism is an inherently cannibalizing process and, in our interdependent world, it is also a self-cannibalizing process*. The worldly beings seen as least useful and/or most exploitable tend to be harmed first and worst. Yet arguably, even those at the top of this hierarchy are harmed via their interdependence with the rest of the world and their internalized oppression, which keeps them living through a scarcity mindset. In this way, the unaffected and unharmed person under settler-colonial capitalism is a *myth*. From here, we can better understand the perspectives of participants, who frequently observed how their experiences of being human have deep and complex entanglements with the environments and cultures in which we all live, as well as other beings co-existing and interdependent within them. Indigenous scholar Aaron Mills (Anishinaabe, Couchiching First Nation; 2018) greatly deepens this conversation about how settler-colonialism enacts violence towards Indigenous peoples (italics added for emphasis):

> "*Colonialism* isn't merely a process of newcomer settlement and Indigenous displacement; *it's a mode of relationship* between settler peoples, Indigenous peoples, and land in which all are harmed (albeit certainly not equally). Settler peoples…harm themselves in founding their political community upon *violence*, which slowly *destroys it from within.* So long as they maintain their *earth-alienated* constitutional order, *which treats non-humans as resources to be exploited*, there is no escape from this fate, although settlers are always welcome to abandon their current constitutional project and, through treaty, root their political communities in earth." (p. 135)

According to Mills, colonialism is "a mode of relationship," in which settlers harm everyone by founding our principles of community upon violence, including violence towards ourselves. He further warns that remaining disconnected from our fellow beings-in-the-world, including our non-human earthly connections, dooms us to this self-cannibalizing fate. These ideas overlap greatly with higher-order concepts that participant themes indicated. As a researcher reviewing myriad disheartening participant quotes about the state of our current world (and psychotherapeutic practices towards neurodivergent people), it became very hard to separate the notion of a pathology paradigm-informed therapy from a settler-colonial capitalist-informed therapy. I, the researcher, came to believe that they were one and the same. This is because settler-colonial capitalism *requires* social-real systems that pathologize individuals so that it may justify changing them to suit *its* needs for a pliable workforce. Heidegger (1977) himself offered a very similar take in his essay, *The Question Concerning Technology*, which explores technology as a mode of worldly relationship, and carries resonances with Mills' description of colonialism (italics added for emphasis):

> "Only to the extent that *man for his part is already challenged to exploit the energies of nature* can this revealing that orders happen. If man is challenged, ordered, to do this, then *does not man himself belong even more originally than nature within the standing-reserve? The current talk about human resources, about the supply of patients for a clinic, gives evidence of this.* The forester who measures the felled timber in the woods and who to all appearances walks the forest path in the same way his grandfather did *is today ordered by the industry that produces commercial woods, whether he knows it or not*." (p. 18)

When Heidegger says "revealing," he means the illumination of truth behind a mystery, and when he says "orders," he is talking about the categorized organization of being. His first sentence thus describes how Western humanity exploits nature to the degree that it attempts to reveal all truths behind extant mysteries, usually through rigorous empirical categorization and organization projects (including the premise and enforcement of normal in psychotherapy). This closely connects with two participant quotes. The first was when Jay said, "We need to be community-in-change. The principles [of community] have to exist in the unknown, rather than there be a structure that fights off the unknown;" which questions the urgency placed on revealing all truths behind extant mysteries as a way to relieve a fear of the unknown. The second participant quote that connects to this is from Olga:

> "It could be really beneficial to think about humanity and personhood as being more expansive and inclusive, because we would not be able to survive without the environment, animals, and plants. Can we be defined outside of our role in the ecosystem? I'm sure that the European Western positivist scientific view would say, "A person has two eyes and two ears, and a person can reproduce with another person to create a baby," but maybe that kind of thinking got us where we are."

This quote argues against the valuation of humanity separately-and-above the rest of nature because *what we call humanity depends on and is part of its ecosystem*. It directly criticizes Western thought for being stuck in rigid categorization and organization of humanity and personhood, and suggests that this way of thinking causes contemporary problems. Another quote shared from Olga offers her perception of how these contemporary problems are manifesting within the field of psychotherapy:

> "That's the expectation… "We just need to get therapists to fix somebody's way of thinking so they can adhere more to this capitalist system. So they can just show up to work and be the little cog in the machine." We're supposed to grease and make that machine of capitalism run more smoothly, *even if it's just grinding people up*."

Olga alludes to a means-to-ends, machine-like treatment of human workforces akin to that shown in *The Matrix* (Wachowski et al., 1999), and invokes Heidegger's earlier question: "If man is challenged, ordered, to [exploit the energies of nature], then *does not man himself belong even more originally than nature within the standing-reserve?"* When using the term "standing-reserve," Heidegger refers to a technological view of the world and its beings as objects on "stand by," ready to be used (AKA ready-to-hand). He then shares evidence that humanity itself is already fodder in this standing-reserve, in our roles as "human resources," "supplies" for medical institutions, and "ordered" workers. Therefore, Olga's arguments that normal-enforcing psychotherapies serve to "fix" clients "so they can just show up to work and *be the little cog in the machine*" and "*grease and make that machine of capitalism run more smoothly*" are aligned with Heidegger's conceptualization of technology as a mode of relationship which treats the entire world as a standing-reserve, ready for exploitation. In other words, *normal-enforcing therapies serve to "fix" clients so that they are more efficiently exploitable under settler-colonial capitalism*. Both of Olga's quotes synchronize with Mill's (2018) aforementioned quote about settlers being "earth-alienated," treating non-human beings "as resources to be exploited," and "founding their political community upon *violence,* which slowly *destroys it from within*" (p. 135). Thus, the Western, settler-colonial capitalist, technological mode of relationship can be holistically conceptualized as one founded upon violent exploitation of earthly beings – including the fellow human, fellow settler, and even the settler-self. To this end, normal-enforcing therapy becomes a method to repeatedly shape Western subjects into sufficient human resources.

Adding to this conversation, Mills (2018) also explained that there are three forms of violence that settlers specifically enact upon Indigenous peoples: first, "individual-centered" violence towards Indigenous "bodies, minds, and spirits;" second, "group-centered" violence towards Indigenous community practices and identities; and third, "structural violence" towards Indigenous "life ways" (pp. 135-136). He elaborates on this third form of violence below (italics added for emphasis):

> "The third form of violence, to Indigenous life ways and thus to indigenous constitutional orders…*denies us our ability to speak and,* over enough time, *even to imagine our lives lived within our own understandings of what a person is, what a community is, and what*

> *freedom looks like.* Life ways aren't about specific shared practices or qualities, but rather about how the world appears to us: the ontological, epistemological, and cosmological system within which a people consistently becomes itself, within which forms and substance continually change. This third, structural violence *demands that any changes Indigenous peoples make to their lives occur within the settler concept of persons, freedom, and political community*…Eventually we come to see our own life ways as anachronistic; we internalize the Western progress epic and become capable of seeing ways we lived and acted otherwise only as a kind of "going back." …*We're only capable of imaging our freedom from them within the range of settler visions of freedom, applied to our unique contexts.* Lost is the sense of our own notions of persons, freedom, and belonging." (p. 136)

In other words, after centuries of deliberate genocide and erasure of Indigenous and other colonized peoples, *the "settler concept of persons, freedom, and political community" eventually obfuscates and eclipses all other ways of seeing and being*, even to those who once embodied them. This is because Western societal functioning *depends on* anointing the settler-colonial capitalist way – the technological, exploitative, and violent mode of relationship within the standing-reserve – as *the* way of seeing and being, above all others. Heidegger (1977) himself warned audiences about this deterministic (in his words, "destining"), self-fulfilling prophecy towards only one way of seeing and being (italics added for emphasis):

> "*The destining of revealing is* in itself not just any danger, but *the* danger…As soon as what is unconcealed no longer concerns man even as object, but exclusively as standing-reserve, and *man* in the midst of objectlessness *is nothing but the orderer of the standing-reserve*, then he comes to the very brink of a precipitous fall; that is, he comes to the

> point where *he himself will have to be taken as standing-reserve.* Meanwhile, *man*, precisely as the one so threatened, *exalts himself and postures as lord of the earth.* In this way the illusion comes to prevail that everything man encounters exists only insofar as it is *his* construct. This illusion gives rise in turn to one final delusion: it seems as though man everywhere and always encounters *only himself.*" (pp. 26-27)

In Heidegger's view, this Western, technological mode of relationship (towards a presumed destiny of illuminating all mysteries) coerces all of humanity to serve and become victim to an exploitative way of being *under the delusion of being in control of it*. Additionally, he indicates that this creates an illusion in which humanity views everything it encounters as its mental creation or as evidence of anthropocentrism. His ideas support Mill's explanation of colonialist structural violence against Indigenous peoples, as well as participants' explanations of the harms enacted upon neurodivergent clients in normal-enforcing therapy. In particular, Heidegger's breakdown reveals why the Western, technological mode of relationship *must* eclipse other ways of seeing and being – to justify its commitment to fully knowing and controlling everything in the world, under the delusion of being *on top of* or *in charge of* said world. Those on top or in charge (including therapists who engage as enforcers of normal) then cope by pretending that they are reigning over the exploited "other," rather than grieving that *they, too, are part of the standing-reserve*. Thus, one might view Heidegger's earlier explorations of phenomenology as the beginnings of his own path towards a much deeper exploration: deconstructing the Western, technological mode of relationship that fractures the interior self from the exterior world/others, facilitates this self-over-the-world style of being, and disconnects persons from their more authentic, interdependent modes of being-in-the-world.

In light of these ideas, one could infer the following about the present-day Western, technological, settler-colonial capitalism: It functions to extinguish modes of being and thought that do not meet its ever-increasing demands for efficiency, conformity, and relentless pursuits of knowing (or, "unconcealment"). Modes of being and thought historically targeted for extinguishment included colonized lands and peoples. Presently, *ABA's attempts to extinguish autistic being within individuals are just one, miniscule iteration of this colossal, dystopian project*. Hazel summarized how ABA extinguishes of modes of being and thought that do not conform to a U.S. societal notion of normal in the following passage:

> "With ABA, you're forcing kids to do things that don't feel natural and ignoring. And it increases dissociation in general, because they're not supposed to be uncomfortable with certain textures or lights, and they're not supposed to talk about it. They're supposed to force eye contact and do things for long hours in a day that aren't comfortable. So you're teaching kids to detach and dissociate more and more from their body to look "like everybody else." Having them smile, not do meltdowns, probably doing more shutdowns instead so that other people will not think that they're autistic – which is shorthand for weird. They'll be able to do this job and this function and fit in with capitalist society and not make waves. And yeah, *that is trauma. That is traumatic*. That's not teaching them to trust their gut. It's not teaching them that they can say no to people or set healthy boundaries. It's not teaching them that their body is their own body. It's not teaching them to respect the limits of their body. So it can set them up for abuse more in the future, which is *terrifying*. It's really just to make whomever, parents or school, happy."

Hazel's quote also points out how ABA – by coercing people into conformity – undermines autistic clients' abilities to understand and access their own bodies, feelings, and instincts. It essentially *disconnects* autistic people from their own authentic ways of being in the name of functioning within a capitalist society, parallel to how settler-colonial capitalism commits violence towards Indigenous ways of being. Therefore, Mills' (2018) rejection of anachronistically framing Indigenous resurgence as a "going back" is important. Perhaps people robbed of their most authentic modes of being under settler-colonial capitalism are *reconnecting with* these modes of being that they were violently severed from, rather than "going back" to them. When participants came to recognize and oppose normative oppression as a project of therapy, they also came to align and *reconnect with* authentic modes of being for themselves and their clients. Eschewing prescriptivism in favor of cultivating authenticity was the most obvious evidence of this shift in their therapeutic approaches. Yet, this shift required a concurrent rejection of the expert role and saviorism, so that clients' authentic ways of being could be treated – to invoke Jay's words – as "something to talk from*"* and learn from, rather than something to dismiss and oppress. The sociopolitical implications of therapists rejecting saviorism will be discussed further in the following section.

Forsaking the Sovereign Therapist Role and Healing from Kyriarchy

As a reminder, participants indicated that the expert role and saviorism create a hierarchy in which the therapist resides above the client and is presumed to have more valuable knowledge or expertise than them. Critical feminist theologian Elisabeth Schüssler Fiorenza (2013) contributes helpful terminology when discussing the inherent problems of the expert role and saviorism in therapy and beyond. Specifically, she coined the term "kyriarchy" as a more intersectional, historically fluid reconceptualization of the term "patriarchy." She offered the following definition of this word and its intended use below:

> "I have proposed early on to replace the category of "patriarchy" with the neologism *kyriarchy*, which is derived from the Greek words *kyrios* (lord/slavemaster/father/husband/elite/propertied/educated man) and *archein* (to rule, dominate). In classical antiquity, the rule of the *kyrios* to whom disenfranchised men and all wo/men were subordinated is best characterized as *kyriarchy*…Kyriarchal relations of domination are built on elite male property rights as well as on the exploitation, dependency, inferiority, and obedience of wo/men who signify all those subordinated. Such kyriarchal relations are still today at work in the multiplicative intersectionality of class, race, gender, ethnicity, empire, and other structures of discrimination. In short, kyriarchy is constituted as a sociocultural and religious system of dominations by intersecting multiplicative structures of oppression. The different sets of relations of domination shift historically and produce a different constellation of oppression in different times and cultures." (p. 7)

Kyriarchy is a helpful concept because it possesses a *plasticity* that allows its meaning to fluidly adjust to ever-shifting cultural variations in oppressor roles. Furthermore, it helps root the problems of a "sovereign" role in its many historic, often patriarchal avatars (e.g., lord, slavemaster, father, husband, elite, propertied, educated, etc.). Based on the observations of this study's participants, such avatars of a "sovereign" role (a ruler above others) include *expert* and *savior* therapist roles. This claim is made for several reasons. First, as participant quotes pointed out, asserting oneself as an expert *over* another person's experience has the effect of *dismissing* their own lived experience-based expertise. As Tiff had said: "We're supposed to be *the knower of all things.* But no, *my client is the boss of their story. My client is the expert of their story, not me*. I'm here to facilitate." Tiff argues that – by trying to be the "knower of all things," including the right way to make sense of client experiences – therapists attempt to become the "boss" or "expert" *over* clients' stories. Their critique of the therapist as "the knower of all things" also aligns with Heidegger's critiques of "the destining of revealing" all truths behind extant mysteries in the world; they are both wary of believing it is possible to know everything. Heidegger, in particular, is wary of dictating what the future must be by convincing oneself that it is possible to know everything. Olga also expressed this wariness in the following statement: "*It would be audacious if I did define what is human…There's never going to be an answer*. And if you try to narrow it down too much, *it might be dangerous and have bad outcomes*."

The second reason to argue that participants evidenced how expert and savior roles are avatars of a sovereign role is that *they pointed out how acting like a savior means that clients are beneath them and in need of saving* – that there is "Something Wrong With You" (Walker, 2021, p. 18) the therapist must help clients fix, *and which the therapist resides above*. For instance, Hazel had shared how she was discouraged from sharing her plurality with clients (she was told it was "unprofessional" by other therapists), and the message this communicated to her: "It felt like there was this weird hiding in the room like, "*I'm supposed to be in a hierarchy above."…I'm supposed to* have it together and *not be plural,* and *then help those poor dears who are*." Based on what Hazel described, when there is "Something Wrong with You" as a neurodivergent therapist, the pathology paradigm also assumes you are not capable of helping clients to navigate that lived experience, and that only respectively "normal" therapists can and should try. It also implicitly promotes a social contagion logic, wherein a "sick" therapist might pass said sickness on and make a similarly sick client "worse." Indeed, there is an irrefutable hierarchy here, in which the therapist must be "saving" someone from a "sick" part of who they are. Hazel also explained how she avoids this savior-saved dynamic in the following quote, detailing why self-disclosing her neurodivergence is helpful for her clients:

> "…Having them talk about their [neurodivergent] experiences means that they're crazy, broken, and there's stuff that's wrong with them…[Instead, for me to say,] "This is something I experienced too, and it's a different way of being that isn't wrong, that other people and I live in"…makes them feel less alone with it."

Hazel demonstrated how the therapist unapologetically embodying the thing that is "wrong" or "sick" is them *stepping down from* the savior role, and *joining the client* in a more egalitarian form of relationship based on their shared experiences. Thus, the "well" therapist who is an *expert* on wellness and who *saves* the client from their contrasted "sickness" *plays an inherently kyriarchal, sovereign role*. Put another way, the therapist as a savior or expert is inherently hierarchical and oppressive towards their clients, and *pathologizing neurodivergence as illness is actually oppression disguised as cure*. As Walker (2021) points out in her work, the pathologizing view of neurodivergence is indeed a *paradigm* – a perspective so deeply shaped by our prior knowledges and experiences that we automatically take it as self-evident, thereby presuming other ways of understanding are nonsensical. Therefore, the paradigm shift required to reframe things most therapists believe are "helping," "healing," and "saving" clients as oppressive and harmful, is actually a rather difficult and painful shift to make.

Yet, this is an important shift to make because *it is hard to think about offering a truly anti-oppressive, socially just, and culturally humble therapy without considering the kyriarchal role that therapists play in annihilating neurodivergence – and by extension – other non-normative ways of being*. It was no coincidence that Ela's Latino autistic client had presented to therapy ashamed of both his racial/ethnic traits and his neurodivergent traits when he was surrounded by a neuronormative, white supremacist, and Eurocentric colonialist culture founded upon kyriarchy. Nor was it incidental that Sydney's autistic clients were "insidiously" stuck in practices of “mental self-harm” after undergoing ABA; extreme behaviorism is a mode of relationship not only founded upon (neuro)normative oppression of autistic people, but kyriarchal oppression of anyone beneath a given sovereign. In this instance, the sovereigns are the normal-enforcing therapists (or, in Olga’s words, the “psychology cops”). Returning to an idea from the previous subsection, therapists might be tempted to cope with feeling exploited in the world by acting as *sovereigns over* their clients, rather than grieving that *they are also being exploited* by settler-colonial capitalism. Hence, Ela indicated that medical and behavioral models are focused on “compliance and control,” and Hazel’s stepping down from the sovereign role as a therapist required her being able to face, accept, and begin grieving her own oppression in the world as a neurodivergent person.

In opposing the pathologization and normative oppression of their clients and rejecting the sovereign therapist role, the ultimate conclusion that participants seemed to reach was that both they themselves and their clients were healing together from the same oppressive forces. Rather than *abandoning* their clients in their struggles with oppression – by casting them as the *separate-and-below victims* of omnipresent oppressive forces – these therapists *grieved and healed in community with their clients*. They focused on their commonalities with clients, not in ways that drew false equivalences, but that fostered connection and “mutual healing” (Savarese, 2013). These included disclosing how they themselves also diverged from norms, and – regarding their oppression – were still in need of mutual healing. At a certain point, the healing agent was understood to be the relationship itself, whether that be the therapist-client relationship, the human and non-human relationship, or any other kind that they could find “connection and grounding” in, per Jay. The healing came from being in community with one another, and *reconnecting with the world as a part of it* rather than *separate-and-above* or *separate-and-below it*; the healing came from the experience of a *connected, mutual relationship with another being*. The thing being healed from, then, was not an imagined and constructed sickness within the individual, but rather, the violent, collective severing of connection and community that *all* beings-in-the-world are enduring under settler-colonial capitalist kyriarchy *right now*. The following subsection will more fully explore what this collective healing and reconnection might look and feel like, in conversation with participants, Adrienne Marie Brown, and myself (Jim).

Reconnecting-in-the-World through Emergent Strategy

Jay directly referenced Adrienne Marie Brown's (2017) *Emergent Strategy* – and by extension, Octavia Butler – in their interview, and this text offers a powerful interpretation of participants' experiences of co-transformation. To start this conversation, it is helpful to understand Brown's conceptualization of "emergence" as a phenomenon:

> "Cells may not know civilization is possible. They don't amass as many units as they can sign up to be the same. No—they grow until they split, complexify. Then they interact and intersect and discover their purpose—I am a lung cell! I am a tongue cell!—and they serve it. And they die. And what emerges from these cycles are complex organisms, systems, movements, societies. Nothing is wasted, or a failure. Emergence is a system that makes use of everything in the iterative process. It's all data." (p. 13)

Upon first encountering this quote, I immediately had a flashback of great significance to me that exemplifies Brown's point. In 2018, I began a master's program in Marriage and Family Therapy at a university in the middle of rural Appalachia in the southeastern United States. At that time, I was a young, not yet self-realized transgender, queer, and autistic person with a great deal of internalized oppression to work through. I did not have much awareness of any of this at the time, but I was aware that I carried a deep sense of anxiety and insecurity as a person. The younger me worried that he could never create any change in the world without "making things worse," so he hid behind social scripts, agreeableness, obedience, and often, isolation. Since that time, I have reflected back on how hard it was for me to get through the entirety of that program (and afterward, a doctoral program in the same field), and sometimes wonder how on earth it was possible. But part of the answer was simple: one of my mentors at that program, Jon Winek, was like this inexplicable, constant force of present, connected, and authentic being, guiding my peers and I through things we doubted we could do. He even guided us in the face of our incredible skepticism and confusion about him and this chaotic way of being he seemed to embody.

However, the more that my nervous system felt what it was like to be in Jon's presence – how it could relax and allow itself to struggle and "fail" with less fear of retribution (because he did not role-model living in fear of this retribution) – the more that I could allow myself to actually live, take risks, and reconnect to the world around me, including my eventual therapy clients. Through knowing and sharing space with him as a student for two years, I increasingly learned how to embody this way of being myself. Jon had this habit that is very common in neurodivergent cultures, in which he would quote books, movies, and shows he liked repeatedly, often as inspiration for relational concepts we discussed in class. Sometimes he told us what the source of his quote was, and other times we figured it out later. One of the most important things he would say, especially whenever we believed we had "failed" in our endeavors as fledgling therapists, was "*it's all data*." Now, after all these years, I think I know where he got that phrase from, because Brown's book had just come out in 2017. And that simple phrase, for all these years, kept me going and slowly gravitating towards this new way of being and seeing. It led me to share more of myself in class, so that my peer noticed and informed me that I sounded like a masking autistic person, so that I would then find my place in the amongst neurodivergent communities and cultures, so that I would then apply for a doctoral program to study neurodiversity paradigm-informed therapy, so that I would then encounter Nick Walker's work and bring her into my committee, so that I would then feel the emergence in everything I was studying and deciding, calling me to this exact moment on the eve of my discussion chapter deadline. All of this happened, only to realize that this was just one big loop of emergence that led me right back to the source.

In the fall of 2018, I did not know that this project and the version of myself that was necessary to create it were possible. I did not enter a master's in Marriage and Family Therapy program to become an autistic autism researcher and a Doctor of Philosophy. No – I grew and unraveled until my existence became more complex. I interacted and intersected with others until I found my place amongst them – I am an autistic person! I am a researcher! – and played it out. And now I am on the cusp of leaving academia (and one day, I will definitely die). And what emerged from these cycles were relationships, sparks of inspiration, moments, paradigm shifts, and new experiences. Nothing was wasted, or a failure. This emergent way of being made use of everything connected to my existence, including Brown's quote. *It was all data*. Thus, it felt like a very emotional, meaningful coming home as I first read those words in Brown's book, much like Maria described when she talked about the feeling of "coming home" at the World Autism Conference. It feels like a return to something very deep and authentic within me, buried after years of societal conditioning. As Brown (2017) said, "we are already emergent beings just by our very existence. But we've been tricked away from it" (p. 33). She proposes a particular kind of return to emergence – one that is also strategic in its aims to change the world. Fittingly, Brown calls this "emergent strategy," and gives the following definition (italics added for emphasis):

> "*Emergent strategies are ways for humans to practice complexity and grow the future through relatively simple interactions*. This juxtaposition of emergence and strategy was what made the most sense to me when I was trying to explain the kind of leadership I see in Octavia [Butler]'s books. It isn't just that her protagonists are Black, female, or young leaders… Or maybe it is because of all of those things: who leads matters. But what I noticed is that her leaders are *adaptive—riding change like dolphins ride the ocean*. Adaptive but also *intentional, like migrating birds who know how to get where they're going even when a storm pushes them a hundred miles off course.* Humans? Some of us are surviving, following, flocking—but *some of us are trying to imagine where we are going as we fly.* That is radical imagination. Octavia's protagonists were also interdependent, often polyamorous. I suspect that Octavia understood from her own feelings of loneliness, desire, and pleasure that the personal is political, and that *pleasure evokes change—perhaps more than shame*. More precisely, where shame makes us freeze and try to get really small and invisible, *pleasure invites us to move, to open, to grow*." (p. 17)

Based on this working definition, emergent strategy is similar to what the previous chapter described as *emergent responsiveness* to clients (e.g., being client-led, person-centered, being in the unknown together, being authentic together). As in, participants had exemplified remaining responsive and open to what authenticity emerged from clients in their sessions, while maintaining a sense of intention and direction in their work (such as enacting their particular methods for facilitating client emergence and connection). Jay, as an invested reader of Brown's work, gave the most resonant description of this:

> "Philosophically, spiritually, I hope that we're in this together – that my clients are going to change me. We change each other…Every interaction has changed, and I will be changed. And I need to be both open and grounded so that, whatever change I can metabolize, I can choose what to do with it or whether to be changed in that way."

Jay described how 1) emergent change is constant in interaction and 2) they do their best to be open and grounded with clients so that they can "choose what to do with [the change]," or as Brown had depicted, "riding change like dolphins ride the ocean." Elizabeth had described a similar orientation towards being both adaptive and intentional by saying, "I'm very *purposeful* about *moving through the world in the way that works for me*…At the end of the day, the world is not built for you. So then *how are you going to build your world?*" Indeed, her final question evokes Brown's imagery of "trying to imagine where we are going as we fly" and "radical imagination." By just daring to imagine that the world could be different and supporting their clients in doing the same, participants were employing emergent strategy or responsiveness in their work as therapists.

The last part of Brown's passage is crucial because it describes a key ingredient of living towards emergence. Specifically, the shift of living towards pleasure rather than freezing in fear of shame was so important and evident in participant statements. For instance, Sydney had said:

> "I think the world socially from puberty on kind of ABA'd me into compliance and performance. And I think it made me not trust my gut as much and be embarrassed of those things that society deems embarrassing. As I've done this work and seen how helpful it is for others and myself, and I'm going to show up and ask others to do this, I

> should be able to do some of this stuff myself. I think it's made me more authentic, made me be able to trust myself more and trust my gut more, lean into my interests more. One of the things I love about working with autistic folks and their passions is that it is almost contagious to see that energy and to feel it."

In other words, Sydney described being frozen in shame (i.e., being compliant, embarrassed, and non-trusting of himself), and then shifting to living towards pleasure (i.e., becoming more authentic, developing self-trust, leaning into his interests, and loving the feeling of being around autistic passions). Brown says that this way of living towards pleasure drives change *better than* shame does, which Sydney's quote certainly seems to indicate. Sydney's quote is also evidence of another assertion Brown made:

> "Many of us have been socialized to understand that constant growth, violent competition, and critical mass are the ways to create change. But emergence shows us that adaptation and evolution depend more upon *critical, deep, and authentic* connections, a thread that can be tugged for support and resilience. *The quality of connection* between the nodes in the patterns. Dare I say love. *And we know how to connect—we long for it*." (p. 14)

Whereas "constant growth, violent competition, and critical mass" are reflective of the kyriarchal and Western settler-colonial capitalist imperatives discussed earlier in this chapter, "critical, deep, and authentic connections" that can be "tugged for support and resilience" are more reflective of what both Sydney and Jay described, along with the entire superordinate theme of *Aligning with Neurodivergent Authenticity, Autonomy, and Connection*. This longing is most evident in Maria's statement: "All my life– you're in a culture where certain things are never done. You want to do them, but you hold back. And *you finally go to a place where nobody* *holds back, and it's amazing*." In fact, when I (Jim) first revisited that quote from Maria on my own, I cried because of how deeply it made me feel that longing for connection within myself. For many therapists, I imagine this is why we enter the field – for those "critical, deep, and authentic connections" with others. As Elizabeth put it: "That's the most rewarding part for me, is that *folks would trust me enough to let me into their world and walk beside them* while they're doing all this cool stuff." The expectation that we hide most of our struggles and messiness from clients, supervisors, colleagues, etc. is not only inauthentic but *disconnecting.* It interferes with our emergence and all of the beautiful, authentic possibilities for deeper connection that might come about as a result. As simple as it sounds, the healing might be in our presence and reconnection with the infinite beings-in-the-world around us, and whenever ethical, *pleasuring our longing for emergent connection and presence rather than shaming it*.

Therapeutic (Clinical) Implications

Implications for Therapeutic Practice

Participants critiqued how the DSM itself is treated as a more legitimate basis of knowledge for understanding clients than their own lived experiences, and indicated that this results in a focus on evidence-based therapies which are of limited benefit to neurodivergent people. In response, each participant described doing their own work researching and learning from the lived experiences of neurodivergent people to inform their therapeutic work, whether they did so by talking to other people in these communities, learning from neurodivergent communities and cultures online, and/or reading neurodivergent people's writings about their own experiences. This is the simplest, and straightforward therapeutic implication: autistic and other neurodivergent people need to be consulted with, and their lived experience-based knowledges listened to by therapists and other healthcare professionals.

Participant experiences offered powerful evidence that the "social deficits" observed in autistic people's relationship practices are not actually deficits, but a by-product of the double empathy problem, wherein autistic interaction and allistic interaction collide in ways that discourage rapport and create awkwardness. According to participants, neurodivergent communities and cultures were found to be far more accepting of autistic, ADHD, plural, and otherwise neurodivergent ways of being, and allowed for more authentic interactions between neurodivergent people. These authentic interactions supported participants' efforts to unmask themselves. This was important because, as Jay, Ray, Maria, and Indigo's perceptions of trauma and masking seemed to suggest, *neurodivergent masking is a trauma response that occurs when the world is not safe for neurodivergent people to be themselves*. Therefore, therapists aiming to be more neurodiversity paradigm-informed in their work would benefit from reconceptualizing how trauma works for neurodivergent people. Specifically, presuming that "helping" autistic and neurodivergent people "fit in" better might actually be retraumatizing rather than helpful. Jay also described it being important that their therapeutic work help clients develop the "connection and grounding" needed to face the unknown, since the fear of the unknown seemed to precipitate the pressure to conform in the first place. Setting the intention to approach therapy in a manner that facilitates more emergent and authentic reconnections-in-the-world – whether through the "emotional surrogates" Maria described, the "full feeling for trees or rocks" Ray described, holding "Earth, sky, our ancestors" as Jay described, or a system's "collaboration" that Hazel described – might be a more emergently strategic way to begin exploring neurodiversity paradigm-informed work.

A discussion of this study's implications for therapeutic practice must also contend with the frequency that prescriptivist, behavioral, and medicalized models of therapy were critiqued by participants, including ABA and extremely popular evidence-based treatments (EBTs) such as Cognitive- Behavioral Therapy (CBT) and Dialectical-Behavioral Therapy (DBT). Starting with ABA, Tiff described themself as "anti-ABA," Ray said that neurodiversity paradigm-embracing ABA "cannot exist," Maria expressed a positive reaction to the fact that the American Medical Association "have withdrawn their endorsement of ABA as a treatment," Hazel said "with ABA, you're forcing kids to do things that don't feel natural and ignoring. And it increases dissociation," Olga said they tried "stuff" from ABA earlier in their career and did *"not have any success,"* and Ela recommended reaching out and listening to autistic people previously enrolled in ABA "or any other therapy that *wasn't helpful or was traumatic*." Sydney also identified the major consequences that ABA's monopoly on "autism treatment" has for autistic clients who want to access other forms of therapy:

> "None of [the insurance companies] will reimburse if the diagnosis is just autism…The reasons my clients have come back and said that they were told, which is probably not verbatim, but I wouldn't be surprised is because "Adults aren't autistic, and if they were, they'd be getting ABA therapy and not talk therapy." And same with the youth that I serve. Their parents are like, "Well, they told us to look into this thing called ABA therapy instead, and that'll save us money because it's within our insurance plan." …Insurance companies would rather funnel money into that than reimburse my clients for coming here…because it's been touted as like the gold standard and it's a multimillion-dollar industry – the name recognition of it. And I also wonder, is it somehow cheaper compared to what my clients would be getting reimbursed for like four

> sessions a month with me private pay out-of-pocket? …I assume in some ways it might be because a lot of those folks, at least here locally, you only have to have a high school diploma or an AA. So maybe they can reimburse at way lower rates than for someone who's got a master's and is fully licensed."

These quotes communicate several things. First, ABA was only brought up by participants who were critical of it, meaning that out of this whole study of neurodiversity paradigm-embracing therapists, nobody spoke positively about ABA. Second, some participants did not feel that ABA was helpful and/or connected it to autistic client traumatization. Third, Sydney's statement gives additional context that the existence of ABA is currently preventing autistic clients with only an autism diagnosis from being able to afford psychotherapies via their insurance coverage. Moreover, his thought process suggests that the prioritization of ABA – and other approaches to working with autistic people – might not necessarily be reimbursed by insurances or predominant approaches because they are helpful, but rather, because they are cheap and/or make a lot of money for their leadership. This suggests that medicalized and financialized landscapes of mental healthcare can result in major systemic failures to therapy clients, and do not necessarily have their well-being in mind.

Regarding CBT and DBT, Maria said that the effects of CBT "tend to be very temporary" in her opinion and experience, and she started having more curiosity about where clients' "cognitive distortions" were coming from; Tiff indicated that "CBT didn't work" for their clients and they noticed while using CBT that "there was something that wasn't happening for some reason;" Hazel suggested that the prescriptivist assumptions of what will happen in various CBT models are "not really realistic;" and Sydney said he had the following thought during his internship's DBT-based program: "This DBT thing doesn't seem to make a difference for any of these kids." Once again, Ray had said the following about CBT, manualized treatments, and even the framing of therapy as "modern mental health:"

> "With insurance companies, capitalism, CBT, and all these other cultural forces – as well as our own sense of inferiority compared to the medical industry – we decided we wanted to be like medical people and hard scientists and prove our worth. And it created modern mental health, which is *completely broken* and separated from what *actually* makes us human. It's all about symptoms and disorders, and manualized treatments; they're of very limited utility when it comes to truly being human, how we connect in therapy, and how we connect as people outside of therapy."

All of these observations from other participants in combination with Ray's quote paint a larger, more worrisome picture about the popularity of highly prescriptivist and manualized evidence-based therapy modalities. That is, these approaches are not necessarily popular because they are truly healing (i.e., emergent and reconnecting); they simply have lots of evidence, or "critical mass," behind them. In fact, they might actually be *blocking* reconnection and emergence by enacting a more technological mode of relationship, because they are "destining towards revealing" a certain (evidence-based) outcome – a certain *truth*. Olga gave the following warning about the real-world consequences of maintaining this prescriptivist orientation towards being, without questioning and transforming it within one's therapeutic philosophy and practice:

> "Shain Neumeier had an article about neurodiversity lite…This is like when we get people just taking out the old terminology, slapping on some new terminology without really changing their thinking, without asking all these difficult questions that we've been talking about today…They're not asking like, "What is the role of therapy within an oppressive system?" They're just like, "Let's put this new language. We're going to take

> the *special needs*, and then we're going to call them *neurodiverse needs*." So that's something I've seen…Or, I've seen ABA people saying they're doing neurodiversity-affirming ABA… I just googled neurodiversity-affirming ABA and found these companies. Literally it's like plug-and-play. But then when you look at "our philosophy" where they describe what they're doing, it's the same thing…The more that the neurodiversity paradigm spreads and gets normalized, I think the more that's going to happen…They're going to be like, "Well, we won't *force* eye contact, but we're still going to *encourage* it." So they're going to make some really superficial changes at most, change some of their terminology, keep operating with the same ideas, keep working with that same ableism."

Therefore, *the* danger with committing to neurodiversity lite and other forms of prescriptivism in therapy is this: most therapists will continue to follow a script without questioning it, cause harm they misunderstand as helpful, traumatize or stall out clients in the process, and thus, prove that neurodivergent people need their therapies indefinitely. It will make the leaders of these evidence-based and manualized treatments a lot of money, and it will cost clients the same amount. It will keep the world on its current path of self-fulfilling prophecy towards unwanted outcomes (i.e., compliance and control), and it will not meaningfully heal the authentic connections and love that have been lost along with our emergence. Participant experiences showed that – in learning how to co-transform and unravel with clients – therapists and clients can co-create a process that deconstructs internalized normative oppressions and heals their resulting disconnections together. This mutuality creates space for both parties to embrace their humility as they re-orient themselves *towards* ongoing relational growth and *away from* freezing in the fear of individual failures and limitations. The final takeaway for any therapist and/or client reader is this: Therapists do not have to save clients by eternally investigating and studying how to do the most efficient and evidenced therapies, and likewise, clients do not have to save therapists by proving that their therapies destine pre-planned outcomes. In truth, therapists and clients simultaneously heal themselves and each other every time they emergently reconnect, because *they are both part of the world*, and therefore, *part of each other*.

Implications for Therapist Training

Given that therapist training was such a major part of the data and experiences wrestling with normal-enforcing therapy, the implications for therapist training environments and programs are explored here. First, participants shared that therapist training environments were often teaching the DSM without question, critique, or contextualization, which led to very dehumanizing applications of it in their therapeutic work and instructions to trainees. Participants complained that these programs made them feel pressured to write, discuss, and present their work in ways that they did not ethically agree with. In order to avoid doing so, Jay had described hiding their disagreement from mentors during the course of their master's internship, presumably for fear of being gatekept from the profession if they expressed their dissent openly. As Sydney had indicated, veering too far from faculty perceptions could result in a poor grade and a greater risk of not passing a program's assessment and diagnosis-focused coursework. Ray had suggested that – based on his better experience within a program that was more critical and contextualizing of medical models of therapy – teaching how to work with the DSM only for pragmatic purposes (i.e., billing and insurance coverage, access to accommodations, etc.) whilst teaching students to question and think beyond the DSM framework for lived experience was a preferrable, more “holistic” way to teach.

Additionally, Tiff, Maria, and Sydney had indicated that their therapist training programs prioritized more prescriptivist and behavioral approaches to therapy, such as CBT and DBT. Moreover, they noticed later on that these approaches did not work well for their clients and described learning to veer away from them after leaving their training environments. Ela directly acknowledged how training programs usually focused medical and behavioral models of therapy (and hers included teaching some ABA), which she suggested was a by-product of focusing too much on outcomes of “compliance and control.” Not only this, but Ela and Olga had spoken to the regret they felt for applying some ABA-based behaviorist techniques, and lamented that they did not know better at the time. Ultimately, it seems that many training programs are harming their students (and their students’ future clients) when they do not sufficiently critique these approaches, nor teach other approaches to work with clients, especially autistic and ADHD clients more often targeted for behavioral “intervention.” Based on the totality of participant responses, early career therapists who bump up against the pathology paradigm in their training and internship environments likely feel an immense pressure to conform so they may secure their places in the field; they may also feel peer pressure from colleagues and supervisors to “fit in” with contemporary therapist worldviews, such as the belief that autism is a disorder or that CBT is the most effective approach to therapeutic work. This peer pressure isomorphically reflects that which their clients face as neurodivergent people in the world, which just further reinforces the problem of forced conformity in the name of “fitting in.” Indigo offered some very practical, specific feedback for training programs and accrediting bodies who might be interested in shifting away from pressuring students to use pathologizing and behavioral models towards a more neurodiversity-affirming approach to therapy work and training altogether:

> "When I think about accrediting bodies, for example, I think about their requirements for training institutions. And I think incorporating and defining objectives that include the neurodiversity framework or paradigm and affirmative [approaches]. Instruction that specifically discusses or targets pathologizing conceptualization or language, and the impact on clients, instruction, and training…specifically about client experiences of therapy and interventions, as opposed to just the one-directional learning of interventions to apply to clients. There is essentially no training that I'm aware of that really highlights and instructs clinicians on how to solicit feedback or to change the direction of therapy in response to collaborative client needs and feedback…The majority of the training is on what to do to be a therapist, right? But it's not about how to really assess your therapeutic relationship for effectiveness with a client, apart from administering a scale or something that'll quantify this. It's not based *in* the therapeutic relationship. So on the accrediting body level, to implement objectives and provide direction for the implementation of those objectives related to client experiences, and affirming and non-pathologizing approaches, would be a good way of starting to apply this more broadly across different training institutions."

Indigo's insights specifically highlight how moving away from old pathologizing language towards new, neurodivergent community-created terms allows for training therapists to conceptualize and approach their work in non-traditional ways, thereby bringing forward more generative possibilities. Finally, Elizabeth added in her interview that there are major structural and financial barriers that Black and Brown people face when attempting to entering the therapeutic field, which include accessing what are usually expensive training programs, and not being paid during their clinical internships as medical students might for their residencies. Furthermore, she described how the racism that these training therapists experience in relationships during their training takes a significant toll on their mental well-being and impacts their capacities to finish the training stages of a therapeutic career. Similarly, other participants' experiences indicate that the mental well-being of neurodivergent therapists is diminished when they are trying to enter the field, and constantly being forced to endure pathologizations of themselves and others like them. These are some of the most important barriers that training programs must remove in order to stop facilitating systemic racism and ableism, and unjustly gatekeeping trainees from the field.

Limitations

Study Limitations

In a broad sense, the strengths of a phenomenological qualitative study are equivalent to its limitations. Any form of phenomenology allows for incredible depth of exploration and holistic analysis all at once, but on a very small scale (Smith et al., 2022). Thus, while this study served as a profoundly in-depth exploration of a particular, small group's experiences, it cannot claim to be generalizable to a whole "population" of neurodiversity paradigm-informed therapists (nor does it ascribe to the belief that generalizability is the best way to gauge research quality). Instead, this study is best understood as *one possible way* to make sense of a *particular* lived experience – being a therapist in (neurodiversity) paradigmatic co-transformation with their autistic clients. For reasons harmonious with emergent strategy and a Heideggerian form of phenomenology, it is important that this study's interpretations and resulting recommendations not be treated as *the* way to conduct neurodiversity paradigm-informed therapy, or whatever else it offers wisdom about. It is simply an offering of worldly connection for others to ground themselves in, relate to, and co-transform with, as they feel compelled.

Other limitations of this study are more specific and concrete to its sampling. First, only four out of ten participants were BIPOC, limiting the breadth of racial/ethnic experiences and interpretations represented in this study. The forms of disablement experienced by participants were also limited, with no blind, Deaf, nor ambulation-impaired participants represented, for instance. Additionally, the forms of neurodivergence experienced by participants were primarily autism and ADHD, and representations of other marginalized neurodivergences were limited (i.e., there were no known bipolar participants). Importantly, the entire group of participants was limited to those practicing and living within the United States, so the results were contextualized entirely within U.S. mental healthcare systems. Future research bringing more of these lived experiences into focus on the topic of neurodiversity paradigm-informed therapy will be crucial in expanding the connectedness of this research with the broader world of experiences. Finally, just as “the limits of my language mean the limits of my world” (Wittgenstein, 1981, p. 74), the limits of my (Jim) current understanding as the interpreter of this project mean the limits of its worldly connectedness and co-understanding. For more perspective on my limits, please review the reflexivity statement provided in Chapter 3. The following will directly address the limits of Martin Heidegger as a being-in-the-world, and explain the reasoning behind engaging with his iteration of phenomenology for this project’s methodology (and thus, its philosophy).

Acknowledging Heidegger’s Limits While Embracing Heideggerian Phenomenology

Readers of this project familiar with Martin Heidegger's legacy as a willing Nazi party member (and later on, an ex-Nazi who never delivered a public apology) were patiently holding tremendous dissonance whilst witnessing his phenomenology applied in favor of an anti-kyriarchal, post-humanist ethic of interdependent relationship. Indeed, it is hard to comprehend the total existence of a person who willingly participated in a regime of such blatant bigotry, kyriarchy, and genocide, and simultaneously, whose writings lend themselves so well to the undoing of self vs. other binarism and supremacy that is at the core of Western settler-colonial capitalist being (and ironically, Nazi being). *The Question Concerning Technology* seems particularly at odds with kyriarchy in a way fully incompatible with the Nazi party's eugenicist beliefs and practices. One might wonder how someone who willingly aligned with the Nazi party for years of his life could also conceptualize and critique something like the "standing-reserve" view of beings-in-the-world, which is fairly harmonious with Indigenous and Eastern thought-based critiques of the disconnectedness of being of kyriarchy pervading Western thought. Some of these contradictions in Heidegger's beliefs may be explained by Daoist influences on his thinking, starting with an introduction through *The Book of Tea* by Okakura Kakuzō, which he received as a gift eight years prior to the publication of *Being and Time* (Nelson, 2024). According to Nelson, Okakura's book conveys (italics added for emphasis):

> "The Daoist awareness of how *self and world are relationally bound together*, and it is only in practices that freedom occurs. *Freedom is not a quality of the self but is thoroughly relational*. This Daoist worldly art consists of *an ethos of continual adaptation and readjustment to the environment* where one *maintains relationships and makes room for things and others without abandoning one's position*." (p. 15)

This simple summation of Daoist awareness beautifully articulates what distinguishes Heidegger's phenomenology from that of Husserl – a sense of self and world being inseparably connected and that mattering for one's existential, relational freedom. After reading Heidegger's Dao-influenced writing, I (Jim) realized that leaning into a Heideggerian iteration of phenomenology and its influence on Interpretative Phenomenological Analysis (IPA) – as opposed to a Husserlian one – was crucial for this study, which began with the realization that *autistic being is inherently relational and must be recontextualized within the world*. Later on, I found that Heidegger's brand of phenomenology was also more harmonious with the perspectives of the study's participants and their respective influences (such as Brown's *Emergent Strategy*). Heidegger's concept of the hermeneutic circle – unlike Husserl's bracketing – makes fuller space for the self-of-the-researcher to be present, accounting for the fact that self (researcher) and world/other (participants) *cannot* and *should not* be separated in a hierarchy of studier vs. studied (Smith et al., 2022). The researcher simply constitutes another layer of interpretation, which I argue *cannot be bracketed off in any way*. I felt it was very important that my participants more fully access and co-transform with me, rather than bumping up against me trying to bracket myself away to observe them from an imagined ivory tower. Therefore, I consciously unmasked myself in the course of all interviews, hoping that my authenticity would make the same more possible between us as people. Similarly, I opened myself up to any points of connection that I could feel with participants' experiences, deliberately cultivated curiosity towards anything they said that was new to me, and felt them transforming and influencing me in turn. To me, this felt like the most ethical, and anti-kyriarchal way to conduct this research.

Conclusion

This chapter served as a discussion and conclusion of the research study's results, starting with a brief summary of the findings from the previous chapter. The main discussion included a deeper exploration of study findings, which spanned the broad sociopolitical implications of this work all the way to the premise of what therapy is when it harms clients, versus when it heals them. The clinical implications of the study were then presented, followed by the limitations of this research. This chapter also concludes the entire dissertation project, which served as a holistic deconstruction and unraveling exercise, starting with ABA and autism, and ending with the *us*-in-the-world. In embarking on this research project with the constant help of my connections, I endeavored to facilitate the opening of new possibilities in the world of psychotherapy, particularly for autistic clients. Finally, this project contributes to the current literature by offering a vision of what neurodiversity paradigm-embracing therapy might look like from the perspective of neurodivergent therapists with a range of experiences, licenses, and approaches. I (Jim) hope that you have found something helpful in this journey alongside me, and I am grateful for your company, whoever and wherever you are right now.

References

Adams, D., & Young, K. (2021). A systematic review of the perceived barriers and facilitators to accessing psychological treatment for mental health problems in individuals on the autism spectrum. *Review Journal of Autism and Developmental Disorders*, *8*(4), 436–453. https://doi.org/10.1007/s40489-020-00226-7

Anderson, H., & Gehart, D. R. (Eds.). (2007). *Collaborative therapy: Relationships and conversations that make a difference*. Routledge.

Anderson, H., & Gehart, D. R. (Eds.). (2023). *Collaborative-dialogic practice: Relationships and conversations that make a difference across contexts and cultures*. Routledge.

Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 25–39). Sage Publications, Inc.

Asperger syndrome: A systemic approach. *Human Systems: Journal of Systemic*

Asperger, H. (1991). 'Autistic psychopathy' in childhood. In U. Frith (Ed.), *Autism and Asperger Syndrome* (1st ed., pp. 37–92). Cambridge University Press. https://doi.org/10.1017/CBO9780511526770.002

Baron-Cohen, S., Leslie, A. M., & Frith, U. (1985). Does the autistic child have a "theory of mind" ? *Cognition*, *21*(1), Article 1. https://doi.org/10.1016/0010-0277(85)90022-8

Bateson, G. (1978). *Steps to an ecology of mind: A revolutionary approach to man's understanding of himself* (7. printing). Ballantine Books.

Beals, F., Kidman, J., & Funaki, H. (2020). Insider and outsider research: Negotiating self at the edge of the emic/etic divide. *Qualitative Inquiry*, *26*(6), Article 6. https://doi.org/10.1177/1077800419843950

Bleuler, E. (1950). *Dementia praecox or the group of schizophrenias* (J. Zinkin, Trans.). International Universities Press.

Blumer, H. (2009). *Symbolic interactionism: Perspective and method* (1. paperback print., renewed). Univ. of California Press.

Botha, M., & Cage, E. (2022). “Autism research is in crisis”: A mixed method study of researcher’s constructions of autistic people and autism research. *Frontiers in Psychology*, *13*, 1050897. https://doi.org/10.3389/fpsyg.2022.1050897

Botha, M., & Frost, D. M. (2018). Extending the minority stress model to understand mental health problems experienced by the autistic population. *Society and Mental Health*, *10*(1), Article 1. https://doi.org/10.1177/2156869318804297

Bottema-Beutel, K., & Crowley, S. (2021). Pervasive undisclosed conflicts of interest in applied behavior analysis autism literature. *Frontiers in Psychology*, *12*, 1–7. https://doi.org/10.3389/fpsyg.2021.676303

Bradford, K. (2010). Brief Education About Autism Spectrum Disorders for Family Therapists. *Journal of Family Psychotherapy*, *21*(3), Article 3. https://doi.org/10.1080/08975353.2010.505529

Bradley, L., Shaw, R., Baron-Cohen, S., & Cassidy, S. (2021). Autistic Adults’ Experiences of Camouflaging and Its Perceived Impact on Mental Health. *Autism in Adulthood*, *3*(4), Article 4. https://doi.org/10.1089/aut.2020.0071

Brockman, M., Hussain, K., Sanchez, B., & Turns, B. (2016). Managing child behavior problems in children with autism spectrum disorders: Utilizing structural and solution focused therapy with primary caregivers. *The American Journal of Family Therapy*, *44*(1), 1–10. https://doi.org/10.1080/01926187.2015.1099414

Brown, A. M. (2017). *Emergent strategy: Shaping change, changing worlds*. AK Press.

Cage, E., Di Monaco, J., & Newell, V. (2018). Experiences of autism acceptance and mental health in autistic adults. *Journal of Autism and Developmental Disorders*, *48*(2), Article 2. https://doi.org/10.1007/s10803-017-3342-7

Carr, A. (2015). The evolution of systems theory. In T. L. Sexton & J. Lebow (Eds.), *Handbook of family therapy* (1st ed., p. 17). Routledge. https://doi.org/10.4324/9780203123584

Cascio, M. A., Weiss, J. A., & Racine, E. (2020). Making autism research inclusive by attending to intersectionality: A review of the research ethics literature. *Review Journal of Autism and Developmental Disorders*. https://doi.org/10.1007/s40489-020-00204-z

Chapman, R. (2020). The reality of autism: On the metaphysics of disorder and diversity. *Philosophical Psychology*, *33*(6), Article 6. https://doi.org/10.1080/09515089.2020.1751103

Charmaz, K. (2014). *Constructing grounded theory* (2nd edition). Sage.

Chen, M. Y., & Luciano, D. (Eds.). (2015). *Queer inhumanisms*. Duke University Press.

Choi, K. R., Bhakta, B., Knight, E. A., Becerra-Culqui, T. A., Gahre, T. L., Zima, B., & Coleman, K. J. (2022). Patient outcomes after applied behavior analysis for autism spectrum disorder. *Journal of Developmental & Behavioral Pediatrics*, *43*(1), 9–16. https://doi.org/10.1097/DBP.0000000000000995

Clare, E. (2017). *Brilliant imperfection: Grappling with cure*. Duke University Press.

Cohen, I., & Sudhalter, V. (2005). *The PDD behavior inventory professional manual*. Psychological Assessment Resources.

Consultation and Management, 15(4), 257-354.

Cooper, K., Smith, L. G. E., & Russell, A. (2017). Social identity, self-esteem, and mental health in autism: Social identity, self-esteem, and mental health in autism. *European Journal of Social Psychology*, *47*(7), Article 7. https://doi.org/10.1002/ejsp.2297

Crompton, C. J., Ropar, D., Evans-Williams, C. V., Flynn, E. G., & Fletcher-Watson, S. (2020). Autistic peer-to-peer information transfer is highly effective. *Autism*, *24*(7), Article 7. https://doi.org/10.1177/1362361320919286

Czech, H. (2018). Hans Asperger, National Socialism, and “race hygiene” in Nazi-era Vienna. *Molecular Autism*, *9*(1), 29. https://doi.org/10.1186/s13229-018-0208-6

Daly, K. J. (2007). *Qualitative methods for family studies & human development*. Sage Publications.

Department of Defense. (2020). *The department of defense comprehensive autism care demonstration annual report 2020* (pp. 1–31). United States of America. https://therapistndc.org/wp-content/uploads/2020/08/Annual-Report-on-Autism-Care-Demonstration-Program-for-FY-2020.pdf

Dickter, C. L., Burk, J. A., Zeman, J. L., & Taylor, S. C. (2020). Implicit and Explicit Attitudes Toward Autistic Adults. *Autism in Adulthood*, *2*(2), Article 2. https://doi.org/10.1089/aut.2019.0023

Dolbin-MacNab, M. L., & Gale, J. E. (2014). Qualitative research for family therapy. In R. B. Miller & L. N. Johnson (Eds.), *Advanced methods in family therapy research: A focus on validity and change* (pp. 247–265). Routledge, Taylor & Francis Group.

Dreiling, N. G., Cook, M. L., Lamarche, E., & Klinger, L. G. (2022). Mental health Project ECHO Autism: Increasing access to community mental health services for autistic individuals. *Autism*, *26*(2), 434–445. https://doi.org/10.1177/13623613211028000

Dumont, R., Cruse, C. L., Alfonso, V., & Levine, C. (2000). Book Review: Mullen Scales of Early Learning: AGS Edition. *Journal of Psychoeducational Assessment*, *18*(4), 381–389. https://doi.org/10.1177/073428290001800409

Dychtwald, K. (1986). *Bodymind*. J.P. Tarcher ; Distributed by St. Martin's Press.

Earthy, S., & Cronin, A. (2008). Narrative analysis. In N. Gilbert (Ed.), *Researching Social Life* (3rd ed., pp. 420–439). Sage.

Eisner, M., Humphreys, D. K., Wilson, P., & Gardner, F. (2015). Disclosure of financial conflicts of interests in interventions to improve child psychosocial health: A cross-sectional study. *PLOS ONE*, *10*(11), e0142803. https://doi.org/10.1371/journal.pone.0142803

Ferenchick, E., & Rosenthal, D. (2019). Identified patient in family systems theory. In J. L. Lebow, A. L. Chambers, & D. C. Breunlin (Eds.), *Encyclopedia of Couple and Family Therapy* (pp. 1431–1433). Springer International Publishing. https://doi.org/10.1007/978-3-319-49425-8_282

Froese, T., & Gallagher, S. (2012). Getting interaction theory (IT) together: Integrating developmental, phenomenological, enactive, and dynamical approaches to social interaction. *Interaction Studies*, *13*(3), Article 3. https://doi.org/10.1075/is.13.3.06fro

Fu, C.-P., Hsieh, C.-L., Tseng, M.-H., Chen, Y.-L., Huang, W.-T., Wu, P.-C., & Chiang, F.-M. (2016). *Chinese Psychoeducational Profile—Third Edition* [dataset]. https://doi.org/10.1037/t56050-000

Gallagher, S., & Varga, S. (2015). Conceptual issues in autism spectrum disorders: *Current Opinion in Psychiatry*, *28*(2), Article 2. https://doi.org/10.1097/YCO.0000000000000142

George, R., & Stokes, M. A. (2018). Sexual Orientation in Autism Spectrum Disorder: Sexual orientation in ASD. *Autism Research*, *11*(1), Article 1. https://doi.org/10.1002/aur.1892

Gernsbacher, M. A., & Yergeau, M. (2019). Empirical failures of the claim that autistic people lack a theory of mind. *Archives of Scientific Psychology*, *7*(1), Article 1. https://doi.org/10.1037/arc0000067

Gillberg, I. C., Helles, A., Billstedt, E., & Gillberg, C. (2016). Boys with Asperger Syndrome grow up: Psychiatric and neurodevelopmental disorders 20 years after initial diagnosis. *Journal of Autism and Developmental Disorders*, *46*(1), 74–82. https://doi.org/10.1007/s10803-015-2544-0

Goldberg, A. E., & Allen, K. R. (2015). Communicating qualitative research: Some practical guideposts for scholars. *Journal of Marriage and Family*, *77*(1), Article 1. https://doi.org/10.1111/jomf.12153

Goldstein, A. (2017) On the reproduction of race, capitalism, and settler colonialism. In A. Roy (Ed.), *Race and capitalism: Global territories, transnational histories* (pp. 42-51). https://challengeinequality.luskin.ucla.edu/2017/10/20/race-and-capitalism-digital-volume/

Gorycki, K. A., Ruppel, P. R., & Zane, T. (2020). Is long-term ABA therapy abusive: A response to Sandoval-Norton and Shkedy. *Cogent Psychology*, *7*(1), Article 1. https://doi.org/10.1080/23311908.2020.1823615

Gotham, K., Risi, S., Pickles, A., & Lord, C. (2007). The autism diagnostic observation schedule: Revised algorithms for improved diagnostic validity. *Journal of Autism and Developmental Disorders*, *37*(4), 613–627. https://doi.org/10.1007/s10803-006-0280-1

Gratton, F. V. (2019). *Supporting transgender autistic youth and adults: A guide for professionals and families*. Jessica Kingsley Publishers.

Guignon, C. B. (1983). *Heidegger and the problem of knowledge*. Hackett Pub. Co.

Hand, B. N., Gilmore, D., Harris, L., Darragh, A., Hanks, C., Coury, D., Moffatt-Bruce, S., & Garvin, J. (2021). "They looked at me as a person, not just a diagnosis": A qualitative study of patient and parent satisfaction with a specialized primary care clinic for autistic adults. *Autism in Adulthood*, *3*(4), Article 4. https://doi.org/10.1089/aut.2020.0082

Haraway, D. J. (2016). *Staying with the trouble: Making kin in the Chthulucene*. Duke University Press.

Hardy, K. V. (2007). Healing the world in fifty-minute intervals: A response to "Family therapy saves the planet." *Journal of Marital and Family Therapy*, *27*(1), Article 1. https://doi.org/10.1111/j.1752-0606.2001.tb01135.x

Hargrave, T. D., & Pfitzer, F. (2003). *The new contextual therapy: Guiding the power of give and take*. Brunner-Routledge.

Heasman, B., & Gillespie, A. (2019). Neurodivergent intersubjectivity: Distinctive features of how autistic people create shared understanding. *Autism*, *23*(4), Article 4. https://doi.org/10.1177/1362361318785172

Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). Harper and Row.

Heidegger, M. (1977). *The question concerning technology and other essays* (W. Lovitt, Trans.). Harper and Row.

Helps, S. (2016). Systemic psychotherapy with families where someone has an autism spectrum condition. *NeuroRehabilitation*, *38*(3), Article 3. https://doi.org/10.3233/NRE-161314

Hirvikoski, T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P., & Bölte, S. (2016). Premature mortality in autism spectrum disorder. *British Journal of Psychiatry*, *208*(3), Article 3. https://doi.org/10.1192/bjp.bp.114.160192

Hofvander, B., Delorme, R., Chaste, P., Nydén, A., Wentz, E., Ståhlberg, O., Herbrecht, E., Stopin, A., Anckarsäter, H., Gillberg, C., Råstam, M., & Leboyer, M. (2009). Psychiatric and psychosocial problems in adults with normal-intelligence autism spectrum disorders. *BMC Psychiatry*, *9*(1), 35. https://doi.org/10.1186/1471-244X-9-35 http://www.humansystemsjournal.eu/library/volume-15-2004-3/volume-15-2004-issue-4

Hull, L., Mandy, W., Lai, M.-C., Baron-Cohen, S., Allison, C., Smith, P., & Petrides, K. V. (2019). Development and validation of the camouflaging autistic traits questionnaire (CAT-Q). *Journal of Autism and Developmental Disorders*, *49*(3), Article 3. https://doi.org/10.1007/s10803-018-3792-6

Hull, L., Petrides, K. V., Allison, C., Smith, P., Baron-Cohen, S., Lai, M.-C., & Mandy, W. (2017). “Putting on my best normal”: Social camouflaging in adults with autism spectrum conditions. *Journal of Autism and Developmental Disorders*, *47*(8), Article 8. https://doi.org/10.1007/s10803-017-3166-5

Jackson, Z. I. (2020). *Becoming human: Matter and meaning in an antiblack world*. New York University Press.

Jackson, Z. I. (2020). *Becoming human: Matter and meaning in an antiblack world*. New York University Press.

Kanner, L. (1943). Autistic disturbances of affective contact. *Nervous Child*, *2*, 217–250.

Kerns, C. M., Newschaffer, C. J., & Berkowitz, S. J. (2015). Traumatic Childhood Events and Autism Spectrum Disorder. *Journal of Autism and Developmental Disorders*, *45*(11), Article 11. https://doi.org/10.1007/s10803-015-2392-y

Koldewyn, K., Jiang, Y. V., Weigelt, S., & Kanwisher, N. (2013). Global/local processing in autism: Not a disability, but a disinclination. *Journal of Autism and Developmental Disorders*, *43*(10), Article 10. https://doi.org/10.1007/s10803-013-1777-z

Kupferstein, H. (2018). Evidence of increased PTSD symptoms in autistics exposed to applied behavior analysis. *Advances in Autism*, *4*(1), Article 1. https://doi.org/10.1108/AIA-08-2017-0016

Lai, M.-C., Kassee, C., Besney, R., Bonato, S., Hull, L., Mandy, W., Szatmari, P., & Ameis, S. H. (2019). Prevalence of co-occurring mental health diagnoses in the autism population: A systematic review and meta-analysis. *The Lancet Psychiatry*, *6*(10), 819–829. https://doi.org/10.1016/S2215-0366(19)30289-5

Latour, B. (1993). *We have never been modern* (3. print.). Harvard Univ. Press.

Leaf, J. B., Cihon, J. H., Leaf, R., McEachin, J., Liu, N., Russell, N., Unumb, L., Shapiro, S., & Khosrowshahi, D. (2022). Concerns about ABA-based intervention: An evaluation and recommendations. *Journal of Autism and Developmental Disorders*, *52*(6), 2838–2853. https://doi.org/10.1007/s10803-021-05137-y

Lipinski, S., Blanke, E. S., Suenkel, U., & Dziobek, I. (2019). Outpatient psychotherapy for adults with high-functioning autism spectrum condition: Utilization, treatment satisfaction, and preferred modifications. *Journal of Autism and Developmental Disorders*, *49*(3), 1154–1168. https://doi.org/10.1007/s10803-018-3797-1

Lipinski, S., Boegl, K., Blanke, E. S., Suenkel, U., & Dziobek, I. (2021). A blind spot in mental healthcare? Psychotherapists lack education and expertise for the support of adults on the autism spectrum. *Autism*, 1–13. https://doi.org/10.1177/13623613211057973

Luciano, D., & Chen, M. Y. (2015). Has the Queer Ever Been Human? *GLQ: A Journal of Lesbian and Gay Studies*, *21*(2–3), Article 2–3. https://doi.org/10.1215/10642684-2843215

MacLeod, A., Lewis, A., & Robertson, C. (2013). ‘Why should I be like bloody Rain Man?!’ Navigating the autistic identity. *British Journal of Special Education*, *40*(1), Article 1. https://doi.org/10.1111/1467-8578.12015

Maddox, B. B., & Gaus, V. L. (2019). Community mental health services for autistic adults: Good news and bad news. *Autism in Adulthood*, *1*(1), Article 1. https://doi.org/10.1089/aut.2018.0006

Malatino, H. (2019). *Queer embodiment: Monstrosity, medical violence, and intersex experience*. University of Nebraska Press.

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2018). *Socioculturally attuned family therapy: Guidelines for equitable theory and practice* (First edition). Routledge, Taylor & Francis Group.

McGill, O., & Robinson, A. (2020). “Recalling hidden harms”: Autistic experiences of childhood applied behavioural analysis (ABA). *Advances in Autism*, *ahead-of-print*(ahead-of-print), Article ahead-of-print. https://doi.org/10.1108/AIA-04-2020-0025

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), Article 5. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H. (2007). Prejudice and discrimination as social stressors. In *The Health of Sexual Minorities*. Springer Science and Business Media, LLC.

Mills, A. (2018). Rooted constitutionalism: Growing political community. In M. Asch, J. Borrows, & J. Tully (Eds.), *Resurgence and reconciliation: Indigenous-settler relations and earth teachings* (pp. 133–174). University of Toronto Press.

Milton, D. E. M. (2012). On the ontological status of autism: The ‘double empathy problem.’ *Disability & Society*, *27*(6), Article 6. https://doi.org/10.1080/09687599.2012.710008

Milton, D. E. M., Heasman, B., & Sheppard, E. (2018). Double Empathy. In F. R. Volkmar (Ed.), *Encyclopedia of Autism Spectrum Disorders* (pp. 1–8). Springer New York. https://doi.org/10.1007/978-1-4614-6435-8_102273-1

Monteiro, M. J. (2016). *Family therapy and the autism spectrum: Autism conversations in narrative practice*. Routledge, Taylor & Francis Group.

Murray, D., Lesser, M., & Lawson, W. (2005). Attention, monotropism and the diagnostic criteria for autism. *Autism*, *9*(2), Article 2. https://doi.org/10.1177/1362361305051398

Neely, J., Amatea, E. S., Echevarria-Doan, S., & Tannen, T. (2012). Working with families living with autism: Potential contributions of marriage and family therapists. *Journal of Marital and Family Therapy*, *38*, 211–226. https://doi.org/10.1111/j.1752-0606.2011.00265.x

Nelson, E. S. (2024). *Heidegger and Dao: Things, nothingness, freedom*. Bloomsbury Academic.

Nicolaidis, C., Raymaker, D. M., McDonald, K. E., Lund, E. M., Leotti, S., Kapp, S. K., Katz, M., Beers, L. M., Kripke, C., Maslak, J., Hunter, M., & Zhen, K. Y. (2020). Creating accessible survey instruments for use with autistic adults and people with intellectual disability: Lessons learned and recommendations. *Autism in Adulthood*, *2*(1), Article 1. https://doi.org/10.1089/aut.2019.0074

Parker, M. L., & Mosley, M. A. (2021). Therapy outcomes for neurodiverse couples: Exploring a solution-focused approach. *Journal of Marital and Family Therapy*, 1–20. https://doi.org/10.1111/jmft.12526

Pellicano, E., & Burr, D. (2013). When the world becomes 'too real': A Bayesian explanation of autistic perception. *Trends in Cognitive Sciences*, *16*(10), 504–510. https://doi.org/10.1016/j.tics.2012.08.009

Pellicano, E., & Heyworth, M. (2023). The foundations of autistic flourishing. *Current Psychiatry Reports*. https://doi.org/10.1007/s11920-023-01441-9

Politte, L. C., Howe, Y., Nowinski, L., Palumbo, M., & McDougle, C. J. (2015). Evidence-based treatments for autism spectrum disorder. *Current Treatment Options in Psychiatry*, *2*(1), Article 1. https://doi.org/10.1007/s40501-015-0031-z

Raymaker, D. M., Teo, A. R., Steckler, N. A., Lentz, B., Scharer, M., Delos Santos, A., Kapp, S. K., Hunter, M., Joyce, A., & Nicolaidis, C. (2020). "Having all of your internal resources exhausted beyond measure and being left with no clean-up crew": Defining autistic burnout. *Autism in Adulthood*, *2*(2), Article 2. https://doi.org/10.1089/aut.2019.0079

Reynell, J., & Gruber, C. P. (1990). *Reynell developmental language scales: Manual*. Los Angeles, California. 12031 Wilshire Boulevard, Los Angeles 90025: WPS, Western Psychological Services.

Rifai, O. M., Fletcher-Watson, S., Jiménez-Sánchez, L., & Crompton, C. J. (2022). Investigating markers of rapport in autistic and nonautistic interactions. *Autism in Adulthood*, *4*(1), Article 1. https://doi.org/10.1089/aut.2021.0017

Rutter, M., Le, C. A., & Lord, C. (2013). *ADI-R: Autism diagnostic interview revised: Manual*. Los Angeles, California: Western Psychological Services.

Sandoval-Norton, A. H., & Shkedy, G. (2019). How much compliance is too much compliance: Is long-term ABA therapy abuse? *Cogent Psychology*, *6*(1), 1641258. https://doi.org/10.1080/23311908.2019.1641258

Sandoval-Norton, A. H., Shkedy, G., & Shkedy, D. (2021). Long-term ABA therapy is abusive: A response to Gorycki, Ruppel, and Zane. *Advances in Neurodevelopmental Disorders*, *5*(2), Article 2. https://doi.org/10.1007/s41252-021-00201-1

Satir, V. (1988). *The new peoplemaking*. Science and Behavior Books.

Savarese, R. (2013). From neurodiversity to neurocosmopolitanism: Beyond mere acceptance and inclusion. In C. D. Herrera & A. Perry (Eds.), *Ethics and neurodiversity* (pp. 191–205). Cambridge Scholars Publishing.

Schleiermacher, F. (1998). *Hermeneutics and criticism and other writings* (A. Bowie, Trans.). Cambridge University Press.

Schüssler Fiorenza, E. (2013). Introduction. In *Changing horizons: Explorations in feminist interpretation* (pp. 1–21). Fortress Press.

Sheffer, E. (2018). *Asperger's children: The origins of autism in Nazi Vienna* (First edition). W.W. Norton & Company.

Shyman, E. (2016). The reinforcement of ableism: Normality, the medical model of disability, and humanism in applied behavior analysis and ASD. *Intellectual and Developmental Disabilities*, *54*(5), Article 5. https://doi.org/10.1352/1934-9556-54.5.366

Sickels, L. (2021). Neurodiverse relationships: When partners' brains are wired differently. In S.-J. Dodd (Ed.), *The Routledge international handbook of social work and sexualities* (1st ed., pp. 300–315). Routledge.

Silberman, S. (2015). *NeuroTribes: The Legacy of Autism and the Future of Neurodiversity*. Penguin Publishing Group.

Simon, G. (2004). Systemic family therapy with families with a child who has a diagnosis of

Simon, G., Evans, M., Cano, F. U., Helps, S. L., & Vlam, I. (2020). Autism and systemic family therapy. In K. S. Wampler & L. M. McWey (Eds.), *The Handbook of Systemic Family Therapy* (1st ed., pp. 407–432). Wiley. https://doi.org/10.1002/9781119438519.ch98

Smith, J. A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being*, *2*(1), 3–11. https://doi.org/10.1080/17482620601016120

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd edition). SAGE.

Smock Jordan, S., & Turns, B. (2016). Utilizing solution-focused brief therapy with families living with autism spectrum disorder. *Journal of Family Psychotherapy*, *27*(3), 155–170. https://doi.org/10.1080/08975353.2016.1199766

Solomon, A. H., & Chung, B. (2012). Understanding autism: How family therapists can support parents of children with autism spectrum disorders. *Family Process*, *51*(2), 250–264. https://doi.org/10.1111/j.1545-5300.2012.01399.x

Spain, D., Sin, J., Paliokosta, E., Furuta, M., Prunty, J. E., Chalder, T., Murphy, D. G., & Happé, F. G. (2017). Family therapy for autism spectrum disorders. *Cochrane Database of Systematic Reviews*, *2017*(5). https://doi.org/10.1002/14651858.CD011894.pub2

Sparrow, S. S., & Cicchetti, D. V. (1989). The Vineland adaptive behavior scales. In C. S. Newmark (Ed.), *Major psychological assessment instruments,* Vol. 2, pp. 199–231. Allyn & Bacon.

Strang, J. F. (Ed.). (2023). Special issue: LGBTQIA+ autistic adults. *Autism in Adulthood*, *5*(2).

Strang, J. F., Kenworthy, L., Dominska, A., Sokoloff, J., Kenealy, L. E., Berl, M., Walsh, K., Menvielle, E., Slesaransky-Poe, G., Kim, K.-E., Luong-Tran, C., Meagher, H., & Wallace, G. L. (2014). Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder. *Archives of Sexual Behavior*, *43*(8), Article 8. https://doi.org/10.1007/s10508-014-0285-3

Strömberg, M., Liman, L., Bang, P., & Igelström, K. (2022). Experiences of sensory overload and communication barriers by autistic adults in health care settings. *Autism in Adulthood*, *4*(1), Article 1. https://doi.org/10.1089/aut.2020.0074

Tillett, J. I. S., Shivers, C. M., & Apple, R. (2023). Autistic perspectives of sibling relationships: Clinical implications for the use of quantitative measures in family autism research. *Contemporary Family Therapy*. https://doi.org/10.1007/s10591-023-09679-4

Tilsen, J., Russell, S., Michael, & Nylund, D. (2005). Nimble and courageous acts: How Michael became the boss of himself. *Journal of Systemic Therapies*, *24*(2), Article 2. https://doi.org/10.1521/jsyt.2005.24.2.29

Tubío-Fungueiriño, M., Cruz, S., Sampaio, A., Carracedo, A., & Fernández-Prieto, M. (2021). Social camouflaging in females with autism spectrum disorder: A systematic review. *Journal of Autism and Developmental Disorders*, *51*(7), 2190–2199. https://doi.org/10.1007/s10803-020-04695-x

Turnock, A., Langley, K., & Jones, C. R. G. (2022). Understanding stigma in autism: A narrative review and theoretical model. *Autism in Adulthood*, *4*(1), 76–91. https://doi.org/10.1089/aut.2021.0005

Wachowski, L., Wachowski, L., Silver, J., Davis, D., Pope, B., Paterson, O., Staenberg, Z., & Ping, Y. W. (1999). *The matrix*.

Wagner, D. V., Borduin, C. M., Kanne, S. M., Mazurek, M. O., Farmer, J. E., & Brown, R. M. A. (2014). Multisystemic therapy for disruptive behavior problems in youths with autism spectrum disorders: A progress report. *Journal of Marital and Family Therapy*, *40*(3), 319–331. https://doi.org/10.1111/jmft.12012

Walker, N. (2021). *Neuroqueer heresies: Notes on the neurodiversity paradigm, autistic empowerment, and postnormal possibilities*. Autonomous Press.

Whitaker, C. A., & Bumberry, W. M. (1988). *Dancing with the family: A symbolic-experiential approach*. Brunner/Mazel.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends* (1st ed). Norton.

Williams, D. (1996). *Autism, an inside-out approach: An innovative look at the mechanics of "autism" and its developmental "cousins."* Jessica Kingsley Publishers.

Wing, L. (1981). Asperger's syndrome: A clinical account. *Psychological Medicine*, *11*(1), Article 1. https://doi.org/10.1017/S0033291700053332

Wittgenstein, L. (1981). *Tractatus logico-philosophicus* (C. K. Ogden, Trans.). Routledge.

Wolf-Meyer, M. J. (2020). *Unraveling: Remaking personhood in a neurodiverse age*. University of Minnesota Press.

Wood, C., & Freeth, M. (2016). Students' Stereotypes of Autism. *Journal of Educational Issues*, *2*(2), Article 2. https://doi.org/10.5296/jei.v2i2.9975

Yafai, A.-F., Verrier, D., & Reidy, L. (2014). Social conformity and autism spectrum disorder: A child-friendly take on a classic study. *Autism*, *18*(8), Article 8. https://doi.org/10.1177/1362361313508023

Yergeau, M. (2018). *Authoring autism: On rhetoric and neurological queerness*. Duke University Press.

Yergeau, M., & Huebner, B. (2017). Minding theory of mind. *Journal of Social Philosophy*, *48*(3), Article 3. https://doi.org/10.1111/josp.12191

Yu, Q., Li, E., Li, L., & Liang, W. (2020). Efficacy of interventions based on applied behavior analysis for autism spectrum disorder: A meta-analysis. *Psychiatry Investigation*, *17*(5), 432–443. https://doi.org/10.30773/pi.2019.0229

Appendix: Demographic Questions

1. What is your name (first and last)?
2. How old are you?
3. What U.S. state do you live in?
4. Please describe your race/ethnicity.
5. Please describe your gender.
6. Please describe your sexual orientation.
7. Please describe any disabilities you experience which are important to you to mention.
8. Which psychotherapeutic license do you currently hold (i.e., LMFT, LCSW, LPC, CMHC, etc.)?
9. How many years have you spent practicing psychotherapy?
10. If you had to estimate, how many autistic therapy clients have you worked with?

Appendix: Semi-Structured Interview Protocol

The following items serve as a flexible set of possible questions to ask interview participants. As participants begin to expand their descriptions relevant to study topics, the interviewer may deviate from this protocol and ask probing questions about what the participants share. Additionally, the interviewer may prioritize the questions that best capture the study's research aims (questions 5-7) if the interviewees provide long responses to questions early on.

1. First, please describe your therapeutic philosophy.
    - <u>Possible Prompts</u>:
        - What modalities do you use?
        - How do you view change in therapy?
        - How do you de-pathologize autism in your therapeutic approach?
        - Please briefly describe the breadth of experience you have working with autistic clients.
2. For my second question, and my wording is left intentionally vague here on purpose, what do you think autism is?
    - <u>Possible prompts</u>:
        - When you were first becoming a therapist, how would you have answered this question?
        - If you encountered another therapist trying to learn more about autism, what you would recommend they do?
3. Tell me about the therapeutic work you have done with an autistic client that you found the most fulfilling (This can be for either an individual or relational case.)
    - <u>Possible prompts</u>:

        - What was so rewarding about it?
        - How did you notice yourself change during that experience?
        - How did you notice the client(s) change during that experience?

4. Tell me about the therapeutic work you have done with an autistic client that you found the most unpleasant (This can be for either an individual or relational case.)
    - <u>Possible Prompts</u>:
        - What was so unpleasant about it?
        - How did you notice yourself change during that experience?
        - How did you notice the client(s) change during that experience?
5. Overall, how has your work with autistic clients altered your perspective of what is socially, relationally, or societally 'normal?'
    - <u>Possible prompts</u>:
        - Can you think of a specific example of this happening for you? If so, please tell me about it.
        - Did your client(s)' perspective(s) shift with yours? If so, how?
6. What do you think makes it most difficult for your autistic clients to be themselves? (If they ask what you mean, offer examples such as their embodiment, in relationships, communication, connectedness to the world, etc.)
    - <u>Possible prompts</u>:
        - What do you think would make the biggest difference to change this? (Your response doesn't have to be about therapy, but it can be).
        - (If not already answered) How do you think your therapeutic work changes this?

7. Can you recall a time when your work with an autistic client altered your perspective (i.e. about relationships, connections, life, etc.) in a major way? If so, please tell me about it.
    - Possible prompts:
        - What was it like for you when your perspective was shifting?
        - Did you notice the client(s)' perspective(s) shift? If so, how?
        - What was it like for you when their perspective(s) were shifting?
8. How has your language about autism/autistic people changed over the course of your therapeutic work autistic clients? (If they ask what you mean, offer examples such as functioning labels, identity vs. person-first, non-pathologizing, etc.)
    - Possible prompts:
        - How have you noticed these changes impacting your perspective of autism?
        - How have you noticed these changes impacting your clients' perspectives of autism?
9. Take a moment to think about your therapeutic work with cases including autistic clients. What do the clients tend to view as the presenting problem in these cases?
    - Possible Prompts:
        - How do you respond?
        - What do you spend the most time working on with this type of case?
10. What do you think that psychotherapists, in their therapist role, can offer their autistic clients?
    - Possible Prompts:

- How do therapeutic approaches, techniques, or perspectives lend themselves to interacting with autistic clients?
- What do you wish other therapists understood about autistic clients?
- How have you noticed the broader psychotherapeutic field responding to the concept of neurodiversity so far?