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Can therapists be autistic?

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Abstract

This article explores a systemic therapist’s dual role as a family therapist and an autistic person, detailing her journey of integrating her autism diagnosis with her professional identity. The article explores autistic communication in reference to the double empathy problem (Milton 2012), the concept that communication difficulties between autistic and non-autistic individuals are due to mutual misunderstandings, and the importance of direct communication in working with autistic clients. It explores the stigma associated with autism and the considerations of disclosing one's autistic status in therapeutic and personal contexts, highlighting the importance of understanding and accommodating autism in therapeutic settings. Therapeutic approaches with autistic people are explored, such as the PPRR model (Burnham 2017). The paper advocates for post-diagnosis support and longer-term work with families, stressing the value autistic therapists bring to the profession by offering unique insights and validation to autistic clients.

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I work as a systemic therapist within Child and Adolescent Mental Health Services (CAMHS). One aspect of my role involves screening children and young people for autism. In the summer of 2024, I received a diagnosis of autism though my local National Health Service (NHS) trust, placing me in the dual position of service user and clinician within NHS mental health services. This paper explores aspects of the process I have gone through in consolidating my diagnosis and professional identity. I also share some strategies I have used when working with families in CAMHS which have received positive feedback from children and young people and their parents and think about some implications for supervision. It is developed from a presentation at the 4th systemic autism practice conference (Levy, 2023). I use identity-first language rather than person-first language, i.e. “he is autistic” rather than a “person with autism”. Taboas et al. (2023) recommend this as preferred by a majority of autistic adults. “Allistic” specifically refers to non-autistic people, whereas neurodiverse refers to a wide range of people with neurodevelopmental differences. Individuals who do not have any of these differences do not fall under the neurodiverse umbrella are characterised as “neurotypical”.

Hurley-Hanson and colleagues (2020) explore the stigma of autism and how this can impact individuals in their families, at work, for people both with and without a formal diagnosis, and that families of autistic people can also be impacted by stigmatisation. In this paper I explore my experience of this perceived stigma for myself personally and touch on a few case examples from my professional experience. Receiving the diagnosis has reduced internalised shame in one aspect in that it helps to make sense of my behaviour but increased shame in another aspect in wondering how my diagnosis may be perceived by others.

Since I was a child and everyone around me kept telling me I was weird, I developed a special interest in human behaviour, because secretly I thought a lot of people around me who thought I was strange were themselves quite weird and wanted to work out why. I began to develop a special interest in human behaviour, becoming obsessed with reading fiction, trying to work out the motivations and reasons behind the characters’ actions. At the same time my grandma was studying therapy late in life, and I enjoyed reading her therapy books which gave me a different kind of insight into human behaviour. I have been lucky enough to have the opportunity to be an eternal student, initially completing an English degree, training as a teacher, studying a psychology degree, and working as a youth and early help worker. I found it engaging to work with young people who were struggling with relationships or fitting into wider society. This ultimately drew me into systemic training.

Autism is considered an invisible disability (Hurley-Hanson et al., 2020) but from personal experience it is also a visible difference. As a child, when there was little discourse of autism, I experienced myself to be different from others and was similarly identified as different or unusual by peers. I went through a period of blaming myself and others for my lack of understanding of apparently obvious opaque social rules, and for becoming exhausted by tasks that seem to take little energy out of others. Post-diagnosis makes it easier to understand some of the difficulties I experience with reduced blame, shame or guilt. I feel that I am still processing this and am not sure how comfortable I feel making myself so vulnerable in public through this article. However, I also have the urge to express myself to the wider neurotypical public and try to give an insight into my autistic brain, aiming to widen discourse, challenge autism-related stigma, and challenge the idea of “us versus them” in the mental health field.

Several years ago, when applying for the family therapy masters, I mentioned my mum’s autism diagnosis during the application process to one course. When requesting feedback after failing the interview, the interviewer mentioned my mum’s diagnosis and invited me to reflect on our similarities. They provided feedback that due to the differences of my communication style from what is expected for systemic therapists, I did not have the potential to become a systemic therapist.

At the time, I had not considered that I may be autistic, and was very opposed to this and quite angry. I saw autism as something belonging to the Other, I didn’t like to put myself in a position of vulnerability or be positioned by others as someone who may be disabled and in need of help. Despite having a mum who had been diagnosed with autism over 20 years earlier, I did not believe such ideas applied to me personally. I realise this does not speak well of how I must have thought of others diagnosed with autism and feel ashamed and also and somewhat hesitant to name it here. As I had really wanted to be a family therapist, I rejected the notion that I could also be autistic because my interpretation of the interviewer’s feedback was that an authority figure in the systemic field had judged that therapists could not be autistic. This feedback generated a binary existential crisis: *can therapists be autistic*?

Whilst I had challenging experiences while qualifying as a family therapist, I had one consistent clinical supervisor who helped me come to terms with my own internalised disablism and provided a secure base at a pace that felt comfortable to me. She consistently encouraged me to seek diagnosis to rule autism in or out, but I ignored this possibility for several years until another supervisor suggested the same thing, leading me to conclude it probably wasn’t a quirk of my first supervisor but maybe something to do with me and perhaps I should listen to their suggestions. The NHS autism assessment process was quite prolonged given the length of waiting lists but I experienced this as a benefit as it gave me nearly three years to process the idea of me being autistic, I also quite enjoyed the ambiguity of not knowing and gave the presentation this paper is based on while on the waiting list where I reflected on this idea of being both autistic and non-autistic at the same time (Levy 2023).

The process of linking my autistic and professional identities further developed when I presented a session on autism at a conference and followed this up with a presentation to family therapy colleagues at my trust and received feedback. One of the ideas was to connect my diagnosis to the responses of my own family. Although initially resisting this idea as making this article even more like academic reality TV, I can see how this makes sense as a family therapist to incorporate the views of my own family into an article detailing personal experience aimed at family therapists. I asked my mum what it was like being a parent of an autistic child, she replied that she found it easy parenting me because I responded to things similarly to her, and she considered my behaviour to be normal, and the behaviours of my (presumably allistic) younger siblings were what came as a surprise. (I think my dad, who died more than a decade ago, would have said the opposite). When I sought a diagnosis, it took her some time to get used to it, as she had thought of herself as the only autistic person in the family, but she has now reflected on the many similarities between us. My mum has also described how revealing her diagnosis to her wider family “sent shock waves through the family” as her biological relatives considered this was “just how people are.”

Double empathy problem

Milton (2012) developed the theory of the “double empathy problem”, presenting autistic people’s perceived communication deficits as a mutual misunderstanding existing between autistic and allistic people that lead to significant communication barriers. These difficulties impact social interactions and opportunities for autistic people in societies dominated by allistic social norms. Autistic people have historically been characterised as lacking empathy in comparison to their allistic peers (Baron-Cohen and Wheelwright, 2004). The double empathy concept suggests that this lack of empathy may exist between neurotypes, with both autistic and allistic people experiencing difficulties understanding the other’s perspective. In this way it echoes the social model of disability (Finkestein 2000) which puts the case for the need for change in the way society views and responds to disability, rather than placing the onus for change on the disabled person themselves. Milton (2012) outlines some ways in which autistic and neurotypical people may experience shared communication difficulties, as illustrated in diagram 1:

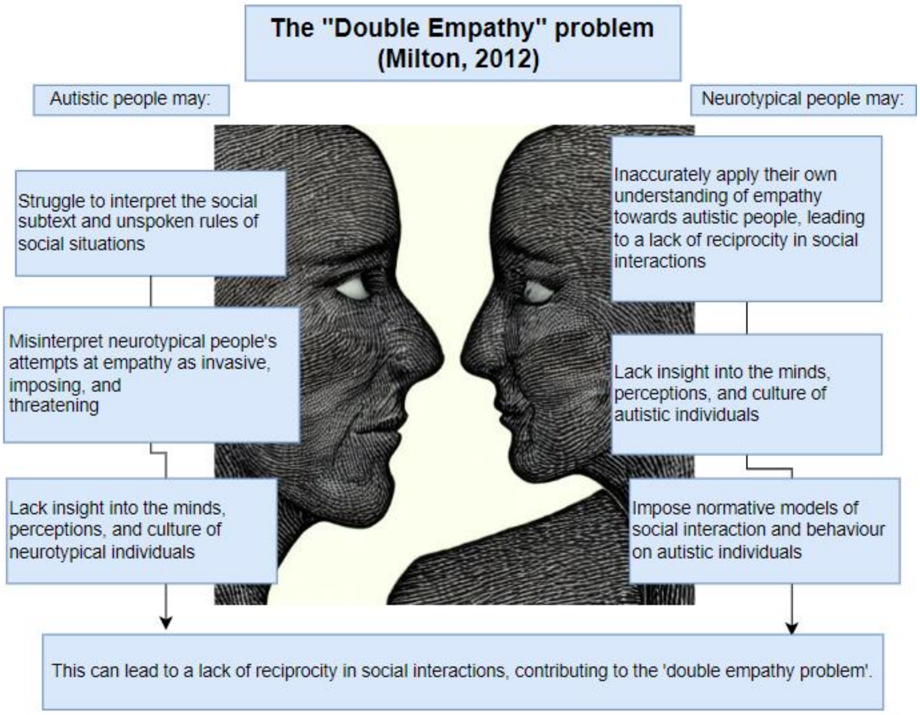

Diagram 1. Illustration of the double empathy problem (Milton 2012)

The double empathy problem has been further studied by Crompton and colleagues (2020a, 2020b, 2021). They suggest (2020b) that interactions between allistic/allistic and autistic/autistic pairs result in higher rapport than between allistic/autistic pairs, indicating that rapport is influenced by a match or mismatch in autism status. Their research suggests autistic people may have a distinctive way of interacting and building rapport in comparison to allistic people and may make social judgments using non-traditional criteria. The way autistic and allistic people communicate has been compared to speaking different languages. Crompton and colleagues (2020a) report that communication styles are similar among autistic people, making interautistic conversations more comfortable and understandable. Autistic people also expressed that they can be their authentic selves without the need to "mask" or camouflage their behaviours when interacting with other autistic people. Masking could be compared to attempts autistic people are making to "speak in a neurotypical language". Mixed-neurotype communication could be interpreted in Co-ordinated Management of Meaning theory (CMM) terms as "uncoordinated communication" (Pearce, 2005).

Therapy with autistic people and their families

An increasing number of children and young people are presenting at the CAMHS I work at with a request for neurodevelopmental assessments for autism and ADHD. This reflects a wider national picture of increased requests for assessments and increased waiting times (NHS, 2023). With the increasing prevalence of autism, the importance of family therapists working in a neurodevelopmentally-sensitive way is increasing. While a therapeutic conversation is a very specific type of conversation, therapeutic communication styles often echo those which we are used to using in wider society, i.e., there is a preference for neurotypical models of communication within the therapy room (Jones 2024). This might look like more indirect questions or suggestions which give the opportunity for the client to come to their own conclusions and not feel pressured by the therapist's line of questioning. However, autistic people may become confused or irritated by such methods of communicating, preferring a more direct statement or comment from the therapist which appears more concrete and understandable to an autistic client, but may appear to an allistic observer as clumsy or rude.

Pre-diagnosis case example

A 16-year-old taking part in family therapy who was also on the autism waiting list told me she didn't want to be brave, or strong, or for people to look up to her and admire her. She never asked to be special or unique but just wanted to be normal. As a teenager, when the social pressure to conform is even stronger than for adults, the shame and humiliation of knowing you are different can be compounded in navigating your family's, peers' and teachers' responses to your diagnosis. Some young people I have worked with prefer to keep their diagnosis to themselves and do not wish to share with their peers or even teachers. The older they are at the point of diagnosis, the more control the child will be able to have on who will know this information about them.

One of the themes I have noticed shared by #actuallyautistic people on social media relating to communication style that has personally resonated has been the idea that when someone is sharing an experience, we connect by relating a similar experience that happened to us, but that communicating in this way is often perceived as rude and self-interested by allistic people. This reflects Crompton and colleagues' theory (2020a) that that autistic people often like to respond to a story in social communication with another story about their own life to build connection and relatability.

Roberts (2005) explores the affordances and constraints of therapist self-disclosure within family therapy. Within a therapeutic setting, I have sometimes chosen to share my autism diagnosis with families; I decide whether or not I share on a case-by-case basis. Affordances of sharing my status include reducing the stigma of autism and opening a conversation to invite other family members or parents to reflect on their own neurotype; this may support the family to see autism as more relational within the family rather than based in one individual, potentially decreasing problem-saturated narratives. Constraints of sharing my diagnosis include using my power as a therapist to shut down potential narratives the individual or family may wish to explore about the difficulties of having autism as they may worry about offending or upsetting me as another autistic person. In addition, the family, particularly the parents of an autistic child, may feel called into a care-giving position towards me as another autistic person, taking the intended focus off the person or family seeking treatment.

Individuals I am working with and their parents often express ambivalence about seeking a diagnosis, particularly given the long waiting lists which can add to a very painful uncertainty that can be difficult for families to live with. Pre-diagnosis, I often use a modified version of Problems, Possibilities, Resources and Restraints (PPRR) (Burnham 2017) with families seeking diagnosis or assessment with potentially autistic clients at Child and Adolescent Mental Health Services (CAMHS) (figure 2). This can happen with an individual (usually an adolescent or older) or in a family or parental session, which gives the opportunity for more perspectives to emerge and be explored within the wider family context.

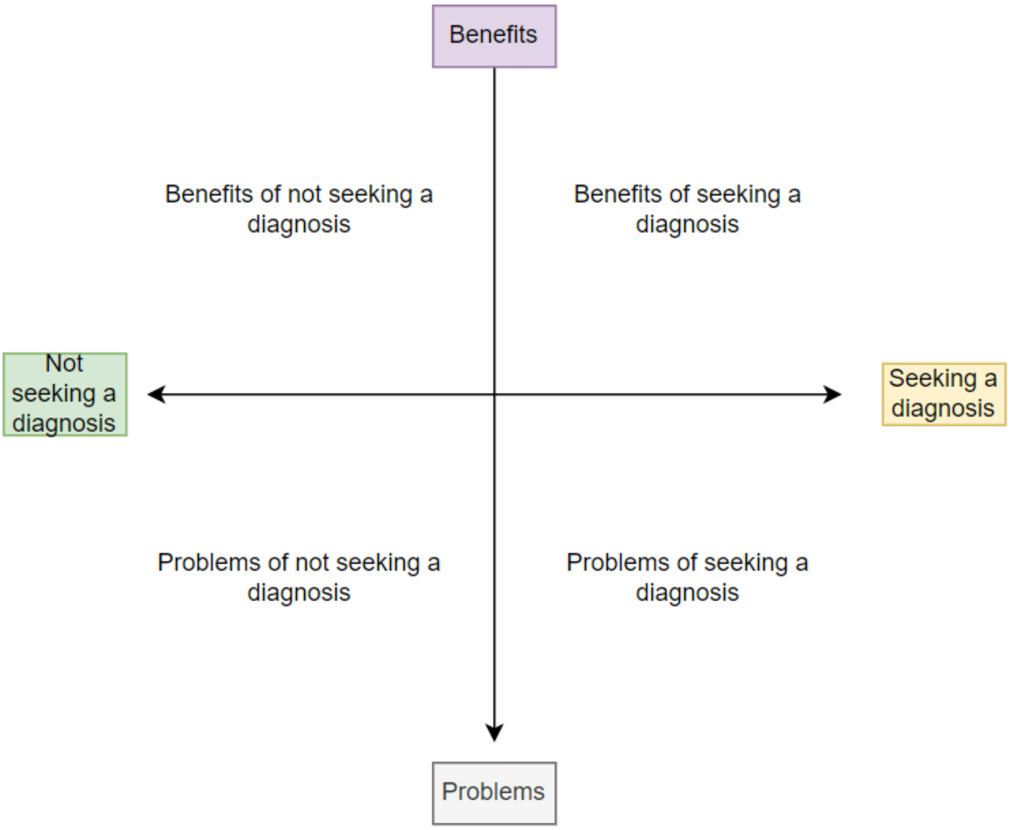

Figure 2. PPRR model to explore the possibility of exploring diagnosis with a potentially autistic person and their family

Post-diagnosis: Autism in a family context

One question which has arisen in CAMHS is how parents should share the diagnosis of autism with their children. A 7-year-old I was working with learnt of her diagnosis when she heard her parent discuss this on the phone, when the mum was seeking support from SEND services. The child's initial perception of her diagnosis was as something which was wrong with her or something that had to be fixed and she responded to this internalised shame with externalising and internalising behaviours at home and school. Due to the increasing pressures on neurodevelopmental services and lengthening waiting lists (NHS, 2023), post-assessment support for families where a young person has just received an autism diagnosis may be limited.

Almog and colleagues (2019) developed the "Why-When-How-What" Model of Parental Disclosure, which interviewed autistic adults about how they would have liked their parents to share the news about their diagnosis with them when they were children. Participants were in favour of sharing the child's diagnosis with them as soon as possible in an age-appropriate way. They also highlighted the importance of discussing autism as a neutral or positive quality, while recommending connecting the child with an autistic network. The study highlighted the significant impact an autism diagnosis has on one's sense of self, emphasising the benefits of knowing one's diagnosis, for example increased self-understanding, self-advocacy skills, and a sense of authenticity. Almog and colleagues (2019) also explored negative reactions which may come from the diagnosis, including relief, shock, disappointment, and self-identity issues. Family therapy presents a helpful opportunity for all family members to be supported in processing and understanding a child or young person’s diagnosis, supporting the parents to support their child in developing their understanding of autism and providing a space for parents to come to terms with their child being different.

Another characteristic of autism is sensory needs (Hazen et al., 2014). A particularly helpful element of my own diagnostic process was taking part in an occupational therapy assessment. The occupational therapist highlighted reasonable adjustments which could be made to support me in a work and interview environment, and with my consent shared this letter with my employer. While NHS buildings tend to be quite clinical and impersonal, some modifications can be made to the room which may help the autistic person to feel more comfortable depending on the individual’s particular sensory needs, such as dimmed lighting, a comfortable temperature, and background noise or lack depending on preference. I also have a personal preference for using fiddle toys, especially magnetic beads or squishy toys/slime – encouraging playfulness, expelling excess energy, and expressing emotions non-verbally. I really like Lego because it has solid, fixed blocks, but can also be moved into multiple configurations. Sometimes I have to be mindful that I am bringing in my own personal preferences, for example I use random Lego, but this can also be distressing to some young people who want to use Lego kits to make a specific model. I feel like Lego can reflect how people see autism, as something that is not creative and is fixed and can’t be changed, but actually depending on who is building it, it can be very innovative and creative and can create different things.

Supervision

I have another special interest in making sense of ambiguity. From very young I became frustrated when things did not fit into neat categories, it is a form of thinking I may return to when particularly stressed or frustrated. I try to make things perfect to reduce uncertainty about the future and when I have got an idea in my head that something should be done a particular way I feel very attached to this idea and impossible to move away from it. Binary thinking has had an impact in relation to my own perception of my work, often seeing it as either successful/unsuccessful with little in between. I put a lot of myself into my work and sometimes this becomes overwhelming to myself or others. I can take things personally and become uncontained after completing a difficult session. My supervisor has noted that I have chosen to enter a profession which specialises in exploring and understanding nuance and wonders the reason behind this.

My tendency to binary thinking has also impacted how I received the feedback from my unsuccessful MSc interview, where the interviewer mentioned about my mum being autistic, asked me the question “do you think you are a lot like your mum?” and then followed this up with a comment that they "did not think I was right for family therapy as I did not have the capacity to work with more than one client at once.” I interpreted this feedback as meaning that therapists cannot be autistic. Alternatively, the interviewer could have been trying to open my curiosity about my neurotype to recommend me to explore further whether or not I was autistic. Nevertheless, I still maintain that during an emotionally vulnerable time of receiving unsuccessful interview feedback was an inappropriate place for such explorations. I feel this reflects both the importance of the supervisory relationship being strong, and of the timing being right when sharing information. This is of course the case whatever someone's neurotype is, but perhaps with an autistic person who may have had many setbacks or experiences of feeling othered, the importance of the supervisory or therapeutic relationship having a secure base is particularly important. When I think about the children and young people I work with, and also their parents, many of whom may also be autistic, I feel disappointed that funding constraints do not allow for us to work longer term with families to develop that feeling of safety and to work post-diagnosis to give the family space to process how they feel about their diagnosis.

I have just started supervising at work and am due to start the supervision course. A reviewer of this paper noted that they felt I was too positive towards supervision in this article, making the interesting comment that they felt it is difficult for most people to be critical of those who exercise power over them, which may end up that they may seek to turn any negativities against the self instead of against the other. I wonder how completing the supervision course will impact my view of supervision as both supervisor and supervisee and how in the future I will reflect differently on the experiences described in this article.

Just as the earth is covered in many different layers of rock, the process of coming to understand myself as an autistic person has been one of working through layers of shame. When writing this article, instead of pushing these feelings away, I attempted to sit in discomfort in an effort to make myself more understandable to others. In the past I have often thought that I have let down my own potential and disappointed others' expectations. Coming from a middle-class white background I have had access to privileges which protected me from many real possibilities of failure and gave opportunities denied to others, and also experienced pressure to fulfil goals which felt heavy at times. The diagnostic process has helped me develop strategies I use to manage myself – feeling less ashamed of this such as taking rest breaks, asking for accommodations, reducing stigma through openness.

I cannot seek to speak for other autistic therapists in this article but hope that through exploring this journey to accepting myself as an autistic therapist I can reflect more broadly on issues we as systemic therapists may consider when working with autistic people and their families, many of whom may also be autistic. I now feel that autistic therapists can be valuable to the profession as we can give an insider understanding of what it means to be autistic and the ability to be able to communicate this with others, as well as making connections with autistic clients in a way which could be experienced as helpful and validating to them.

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