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Article 11

Low Functioning to High Functioning Autism: A Prescriptive Model for Counselors Working With Children Across the Spectrum

Paper based on a program presented at the 56th Annual European Branch of the American Counseling Association Conference, October 3–4, 2015, Naples, Italy.

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Abstract

Autism spectrum disorder (ASD) is a profound diagnosis that affects 1% of the world's population (Centers for Disease Control [CDC]; 2014). The CDC (2015b) has recognized ASD as an important public health concern and must be addressed by the counseling profession. With the diagnosis on the rise (CDC, 2015a), many professional counselors will be faced with the joys and challenges of working with children diagnosed with ASD and their families. Thus, information about the treatment of ASD is needed within the field to promote effective practice. To address this, the article will provide an overview of: (a) challenges facing those with ASD, as well as their families; (b) individual treatment interventions that have been successfully utilized; (c) a conceptual model of individual treatment interventions for addressing the child diagnosed with ASD; and (d) ethical obligations and considerations for professional counselors.

Keywords: autism spectrum disorder, professional counselors, interventions

Autism spectrum disorder (ASD) is a complex developmental disorder that affects the lives of children and their families in ever-increasing numbers. According to the Centers for Disease Control and Prevention (CDC; 2015b), 1 in 68 children are diagnosed with ASD, which is 30% higher than the 2012 findings. In addition, males are five times more likely to be diagnosed with ASD than females (CDC, 2015b), and the societal cost to care for a child diagnosed with ASD is over 11 billion dollars per year (CDC, 2015a). Additionally, ASD is more common then Down syndrome, juvenile diabetes, and childhood cancer (Simpson, 2008). Supporting this observation, the CDC (2013) released

a comprehensive report that identified the leading diagnoses among children in order of prevalence: attention deficit/hyperactivity disorder (ADHD), behavioral conduct problems, anxiety, depression, and ASD. Currently, there is no origin or *cure* for ASD (CDC, 2015b); thus, accurate diagnosis and the use of effective treatment interventions are vital to the client and the families we serve.

According to the recent version of *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*, American Psychiatric Association, 2013), ASD is a neurological disorder that (a) affects brain functioning and negatively shapes the child's social interactions and communication skills across multiple contexts and can vary in severity, and (b) recognizes restricted, stereotypical behaviors, interests and activities with varied levels of impairment as the diagnostic criteria. Moreover, individuals with ASD typically present with co-occurring conditions such as intellectual disability (White, 2012), stereotypical and self-stimulatory behaviors, insomnia, seizure disorder/epilepsy, Tourette syndrome, tic disorders, gastrointestinal problems (Ennis-Cole, Durodoye, & Harris, 2013), anxiety, depression (Woods, Mahdavi, & Ryan, 2013), obsessive-compulsive disorder, ADHD, and self-injurious behavior. These diagnoses further intensify the complex disposition and challenges associated with ASD (Simpson, 2008). Thus, accurate assessment and best practice is essential in the treatment of the disorder and must include the family system.

Family-Centered Approach for Addressing ASD

The counselor's role and best practice is to be mindful of the child's needs as well as the overall system the client is a part of (Bennett, Butler, Hunsaker, Cook, & Leland, 2012). When considering the family unit, the difficulties of parenting a child with ASD and managing co-occurring condition(s) is not only overwhelming, but also stressful (McStay, Dissanayake, Scheeren, Koot, & Begeer, 2014). Professional counselors may observe tension in families as well as unhelpful misconceptions regarding the diagnosis. Debunking the myths around ASD is a challenge, but necessary, because myths can negatively influence families (Neely, Amatea, Echevarria-Doan, & Tannen, 2012). Families may hold misconceptions related to ASD including: (a) ASD is a single condition; (b) early intervention offers no benefit because there is no cure; (c) individuals with ASD cannot act independently; and (d) thimerosal vaccines cause ASD (Savoy, 2014). Furthermore, individuals on the spectrum may be limited in their ability to display affection, demonstrate social skills, and manage sensory issues. Therefore, uninformed practitioners run the risk of interpreting theses ASD symptoms as a lack of emotionality rather than viewing them as the ongoing struggle with emotional expression and awareness (Bennett et al., 2012). As a counselor, fostering a strength-based approach is essential when treating ASD (Bennett et al., 2012) as well as recognizing the associated stressors of families rearing a child with ASD.

There are numerous research studies that outline the effects a child diagnosed with ASD will have on the family, parents, and the parents' marriage (Estes et al., 2014; Hock, Timm, & Ramisch, 2012; Marciano, Drasgow, & Carlson, 2015; McStay et al., 2014; Neely et al., 2012; Pollard, Barry, Freedman, & Kotchick, 2013; Ramisch, 2012; Ramisch, Timm, Hock, & Topor, 2013). Studies illustrate that parents of children with ASD experience significant levels of emotional distress (i.e., anxiety and depression) and

consistently express feelings of isolation (Benson, 2006; Hock et al., 2012; Ramisch, 2012), compared to parents of children diagnosed with other disorders (e.g., Down syndrome or developmental delay; Layne, 2007; McStay et al., 2014). Depending on the severity of the child's symptoms and behaviors, evidence confirms these presenting issues are a strong predictor for parental stress (Johnson, 2012; Lyons, Leon, Roecker Phelps, & Dunleavy, 2010; White, McMorris, Weiss, & Lunsky, 2011) as well as higher rates for alcoholism within the family (Layne, 2007). Parents who were preparing to raise a neurotypical child may experience ongoing challenges when adjusting to rearing a child on the spectrum. These adjustments many include coping with their own feelings of disappointment, guilt, and emotional pain (Neely et al., 2012). Further, parents' concerns about targeting a treatment that works while also managing the many appointments to maintain treatment can be exhaustive and overwhelming (Hock et al., 2012). Currently, there is no collectively accepted best course of treatment (Simpson, 2008), leading parents to become distressed and unsure where to go next. It is clear that parents raising a child with ASD experience higher levels of stress, caregiver burden (Lyons et al., 2010), and divorce rates (Ramisch, 2012) compared to families with children diagnosed with a developmental disorder.

Family members, professionals, policymakers, and the general public receive confusing information regarding ASD, creating treatment challenges (Simpson, 2008). Historically, services for children with ASD were highly specialized and were regulated by Applied Behavioral Analysis (ABA) specialists and special education teachers (White, 2012). Currently, the field of ASD is moving towards programs utilizing interdisciplinary, comprehensive approaches considering the whole person in treatment (Cox, 2012). White (2012) outlined the importance of consistency and communication across treatment settings to enhance treatment outcomes. Due to the improved precision of diagnosing ASD by the age of two (CDC, 2015c; Layne, 2007), counseling professionals will be a part of this process and must be knowledgeable in the countless issues pertaining to the family and individual treatment of ASD.

Treatment Considerations

Typically when treating a client on the autism spectrum, the client is most likely involved with various interventions (e.g., occupational therapy, physical therapy, pharmaceutical management, ABA specialist, school personnel, etc.), which can promote symptom reduction *if* all specialists are communicating (Bradshaw, Steiner, Gengouz, & Koegel, 2015; Cox, 2012; Layne, 2007). There is a current push for a multidisciplinary approach to increase the health and well-being of children and families with ASD (Bennett et al., 2012; VanBergeijk, Klin, & Volkmar, 2008). However, there are few articles in the counseling literature that summarize and guide our profession in solidifying appropriate treatment interventions when working with this population. Ultimately, counselors can be an integral part to the treatment process and interdisciplinary approach.

Before a child with ASD begins treatment, counselors must be mindful and obtain a "measurement of academic treatment, adaptive behavior, cognitive capacity, developmental history, emotional and behavioral patterns, motor skills, sensory patterns, social capacities and behaviors, and speech and language abilities" (Bennett et al., 2012, p. 8). Further, treatment should be *systematically individualized* for the child's

developmental needs and unique characteristics, which factors into successful treatment (Kim, Wigram, & Gold, 2009; Layne, 2007). Having a thorough conceptualization of the child enables the counselor to move forward in treatment by considering the individual's interests, strengths, and limitations (Bennett et al., 2012). As previously noted, family involvement is a necessity when treating a child with ASD due to the pervasiveness of the diagnosis (White, 2012). Thus, a collaborative partnership among parents, professionals, and the child is best practice and an opportunity for empowerment (Murray, Ackerman-Spain, Williams, & Ryley, 2011). Additionally, ABA is considered the overarching framework to guide treatment for a child with ASD and many of the main elements can coincide harmoniously with counseling (Sheperis, Mohr, & Ammons, 2014). Counseling a child diagnosed with ASD can be a difficult task, especially when symptoms and characteristics are broad. Moreover, a child receiving treatment may be experiencing co-occurring symptoms. In sum, due to the complexity of the disorder, where the child falls on the spectrum constitutes a starting point for counselors.

Individual Treatment Interventions

The intent of this article is to address individual interventions across the spectrum (i.e., low functioning autism spectrum disorder [LFA] to high functioning autism spectrum disorder [HFA]), with the assumption that family interventions are coinciding with treatment. Before discussing LFA and HFA, an outline of early interventions of ASD is warranted, because it is difficult to place a young child on the spectrum before school age (Bradshaw et al., 2015).

Early Interventions of ASD

Clinicians may be able to identify characteristics of ASD (i.e., impaired language, social interactions, cognitive and adaptive functioning, and play skills) as early as 18 months (Bradshaw et al., 2015; CDC, 2015c; Layne, 2007). After the initial diagnosis, families are connected to an array of services from intensive behavioral therapy to medication management (White, 2012). At this developmental stage, it is important to tailor interventions to the individual and implement structured, routine play interactions (Layne, 2007). Several studies have identified play therapy as an effective intervention following diagnosis (Layne, 2007; Parker & O'Brian, 2011). Play therapy increases language, attention skills, (Layne, 2007), and social and emotional growth (Parker & O'Brian, 2011). Play therapy allows the child to communicate through play, problem solve, and express feelings through toys to resolve conflicts (Parker & O'Brian, 2011). For example, Parker & O'Brian (2011) outlined one effective intervention (i.e., sandplay) and how it is particularly useful when working with a child with ASD in session. As such, children with ASD are provided with beneficial opportunities for growth when administered this intervention post-diagnosis. Another evidenced-based play therapy intervention related to forming early attachment relationships with primary caregivers is theraplay (Simeone-Russell, 2011). Theraplay assists with developing a sense of self and establishing trust in others through natural playful interactions with the primary caregiver (Simeone-Russell, 2011), which is critical for ASD treatment. Family involvement is necessary at this stage and teaching parents how to transfer therapeutic techniques to the home environment (Estes et al., 2014) is essential for counselors to communicate

(Murray et al., 2011). In addition, several empirically-based parent training programs are relevant for this diagnosis, including, Parent-Child Interaction Therapy (PCIT; Masse, McNeil, Wagner, & Chorney, 2007), Social Communication, Emotional Regulation, and Transactional Supports (SCERTS; Sheperis et al., 2014), Early Start Denver Model (P-ESDM; Estes et al., 2014; Sheperis et al., 2014), Treatment and Education of Autistic and Communication Handicapped Children (TEACCH; Sheperis et al., 2014), and Stepping Stones Triple P (Positive Parenting Program; Whittingham, Sofronoff, Sheffield, & Sanders, 2009). Ultimately, the role of the counselor pre- and post-diagnosis is critical for successful treatment of the child as well as with the family and siblings (Layne, 2007).

Low Functioning Autism Spectrum Disorder (LFA)

Children with LFA typically present with restricted language (Preissler, 2008), behavioral and emotional issues, severe memory impairment (Boucher, Bigham, & Mayes, 2012), poor adaptive behaviors (i.e., struggles with transitions, repetitive behaviors, and sensory-related issues; Hall & Graff, 2011), and limited social skills (Holt & Yuill, 2014). By reading this, counselors may feel inadequate to treat LFA, but they can be a benefit to treatment by contributing unique skills for family intervention (Neely et al., 2012) and individual interventions as described below. First, counselors need to establish rapport and create individualized goals (Bennett et al., 2012). Counselors should be equipped with sensory-related objects (e.g., sensory room, weighted blanket, stimulating lights or music, sand and/or water play), which can be utilized as a reward *or* used when the client is escalating. Furthermore, social stories (Goodman-Scott & Carlisle, 2014) and Picture Exchange Communication System (PECS) can also be implemented (McCurdy & Cole, 2014; Preissler, 2008) to provide a *structured* and *predictable* schedule for the session to alleviate anxiety and negative behaviors (Bennett et al., 2012). What can also extinguish maladaptive behaviors is positive reinforcement (Masse et al, 2007), which can be done verbally or with a preferred reinforcer (e.g., food, toy, etc.). This technique can assist with maintaining a predictable schedule and keeping the child on task. In addition, music therapy is gaining recognition as an effective intervention for LFA. Music therapy engages the client in spontaneous self-expression, and emotional and social communication (Kim et al., 2009) to meet the therapeutic needs of the child with ASD. Furthermore, technology-based interventions are considered an evidence-based treatment for individuals with ASD and should be utilized throughout treatment (Knight, McKissick, & Saunders, 2013). For example, Robins, Dautenhahn, te Boekhorst, and Billard's (2004) research outlined the use of robots in therapy to model social communication. Generally, robots and computer technology are predictable and typically preferred by those on the spectrum and can be used as a tool to increase communication (Robins et al., 2004). Counselors can utilize YouTube and other resources for vicarious reinforcement of the skills by imitating behavior through video modeling.

It is critical for counselors to be creative when identifying what works in treatment (Bennett et al., 2012) and to always be in communication with parents and school personnel to increase success in all areas of treatment. Layne (2007) suggested counselors can be effective with the child's behavioral management, counseling the parents, facilitating support groups, and meeting with typically developing siblings to foster psychological well-being. As such, most of the current research surrounding LFA

is in marriage and family therapy or other disciplines. However, there is a substantial amount of evidence-based practices for children with HFA.

High Functioning Autism Spectrum Disorder (HFA)

Children with HFA typically present as having developed language and cognitive abilities, but experience social difficulties, and sensory and motor issues (Lopata et al., 2010; Woods et al., 2013). Due to the lack of social skills, usually, depression and anxiety are present when treating a child with HFA (VanBergeijk et al., 2008; Woods et al., 2013). Cognitive-behavioral approaches can be utilized to successfully treat depression and anxiety for individuals with HFA (White, 2012). Further, cognitive-behavioral therapy (CBT) can address adjustment issues to social situations and basic emotional states in individual and/or group settings (Bennett et al., 2012; Epp, 2008; Scattone & Mong, 2013). Furthermore, modeling appropriate communication, identifying what the counselor is experiencing in the moment with the client, setting boundaries, encouraging eye contact, explaining non-verbal behaviors, and reflecting feelings for the client to develop appropriate social skills are essential in treatment (R. Hock, personal communication, October 15, 2014). Like LFA, video modeling and technology-based interventions (e.g., YouTube, emotions apps, and robots) can be utilized to increase social communication (Knight et al., 2013). Thus, discussing and developing social skills can be attended to in counseling (VanBergeijk et al., 2008; Woods et al., 2013).

Counselors can also engage the client in dance movement therapy (DMT) with the goal of increasing body-awareness, improved self-other distinction, and improved social skills (Koch, Mehl, Sobanski, Sieber, & Fuchs, 2015). Counselors can also utilize directive counseling with HFA, as well as psychoeducation to gain insight into clients' emotional states (VanBergeijk et al., 2008). Counselors must also be cognizant of sensory/motor issues, and it may be valuable to ask if there is anything in the environment that is overwhelming to the individual (Woods et al., 2013). Additionally, counselors can be advocates for clients and encourage peer support as an intervention as well (McCurdy & Cole, 2014). In general, peer support is connecting the child with HFA with typical peers who can assist with communication, enhance social competence, and increase self-monitoring behavior (McCurdy & Cole, 2014). Further, counselors can promote the transition process to college. By doing this, counselors can recognize if the institution fits the client's needs, discussing the importance of self-identifying, and educating the individual on the Americans with Disabilities Act (ADA; VanBergijk et al., 2008). Thus, counselors can play a critical role in assisting an individual with HFA by serving as a counselor, group leader, advocate, coach, or (psycho)educator.

Interventions Across the Spectrum

Much research is focused on both ends of the spectrum (i.e., LFA and HFA) and does not address the middle, where many clients with ASD might fall. Scant research exists examining effective interventions for individuals with ASD who fall in the "middle." Therefore, the following section combines interventions from LFA, HFA, and anecdotal experiences to present potentially beneficial techniques for clients with ASD who fall in the middle of the spectrum.

Depending on where the client is developmentally, there are many interventions that will be relevant for treatment. Counselors need to incorporate a structured schedule

throughout counseling to reduce frustrations and decrease anxiety. Furthermore, counselors must remember to be *creative* when working with a child with ASD, as well as *flexible,* to create an environment that decreases the likelihood of overstimulation (Bennett et al., 2012). The reader can pull from the interventions outlined in the LFA and HFA sections since techniques may be relevant. A helpful list of interventions created for counselors by Sheperis et al. (2014) outlines treatments appropriate for children on the spectrum and provides relevant resources for each intervention. Other interventions that

Table 1

List of Individual, Group, and MFT Interventions Across the Spectrum

First author (year)	Spectrum	Type	Intervention
Layne (2007)	ASD	Early Identification	Role of counselor pre/post diagnosis
Estes (2014)	ASD	Early Identification	MFT
Bradshaw (2015)	ASD	Early Identification	Overview of interventions
Masse (2007)	HFA	EI, MFT	Parent-Child Interaction Therapy (PCIT)
Preissler (2008)	LFA	Individual	PECS
Robins (2004)	LFA/HFA	Individual	Robotic Assistants in Therapy
Woods (2013)	HFA	Individual	Overview of interventions
Lopata (2010)	HFA	Individual	Response-cost program (RCT)
VanBergeijk (2008)	HFA	Individual	Independent living, social, vocational
White (2012)	ASD	Individual	Overview
Parker (2011)	ASD	Individual	Play Therapy
Kim (2009)	ASD	Individual	Music Therapy
Ennis-Cole (2013)	ASD	Individual	Multicultural Best-Practice
Bennett (2012)	ASD	Individual	Overview of interventions
O'Haire (2013)	ASD	Individual	Animal-Assisted Intervention (AAI)
McCurdy (2014)	ASD	Individual	Peer-Support Intervention
Goodman-Scott (2014)	ASD	Individual	Social Stories Intervention
Epp (2008)	ASD	Individual/Group	Art Therapy
Simeone-Russell (2011)	ASD	Individual/Group	Theraplay
Scattone (2013)	ASD	Individual/Group	CBT-Anxiety for adolescents
Knight (2013)	LFA/HFA	Individual/Group	Technology-Based Interventions (TBI)
Koch (2015)	HFA	Individual/Group	Dance Movement Therapy (DMT)
Laugeson (2012)	HFA	Group Counseling	PEERS Program
Murray (2011)	ASD	Psychoeducation	Project PACE
Ramisch (2012)	ASD	MFT	Couples work
Hock (2012)	ASD	MFT	Couples work
Pollard (2013)	ASD	MFT	Sibling work
Ramisch (2013)	ASD	MFT	Emotionally Focused Therapy (EFT)
Johnson (2012)	ASD	MFT	Marriage-Friendly Therapy
Benson (2006)	ASD	MFT	Stress/depression proliferation
McStay (2006)	ASD	MFT	Overview of parental stress
Lyons (2010)	ASD	MFT	Overview of parental stress
White (2012)	ASD	MFT	Overview of families in crisis
Lock (2010)	ASD	MFT	Overview of supports for families
Neely (2011)	ASD	MFT	Overview of MFT interventions

may be relevant include: animal-assisted intervention (AAI; O'Haire, 2013), technology-based interventions (Knight et al., 2013; Robins et al., 2004), social stories (Goodman-Scott & Carlisle, 2014), music therapy (Kim et al., 2009), dance movement therapy (DMT; Koch et al., 2015), play therapy/theraplay (Parker & O'Brian, 2011; Simeone-Russell, 2011), group counseling (Epp, 2008), art therapy (Epp, 2008), group theraplay (Epp, 2008), and cognitive-behavioral interventions (Scattone & Mong, 2013). Following is a prescriptive model for counselors relevant to school-aged children with ASD.

A Prescriptive Model for Counselors

To further enhance counselors' work with children diagnosed with ASD and their families, it is important to address a prescriptive model for counselors to utilize when treating children with ASD. Based on the current research in the field, Figure 1 is a prescriptive model related to the new diagnostic criteria for ASD in the *DSM-5* and represents all areas of the diagnosis (American Psychiatric Association, 2013). The revised diagnosis in the *DSM-5* classifies ASD on a single spectrum and better reflects the symptom depiction (Kaufmann, 2012). The prescriptive model (Figure 1) recognizes LFA to HFA and characteristics across the spectrum as well as the roles counselors can play while treating a child with ASD. The model is organized from LFA, middle spectrum, to HFA, where counselors can reference interventions relevant to the profession based on research articles written for the diagnosis. Additionally, characteristics across the spectrum are organized for the benefit of the counselor and the role(s) the counselor might engage in. Table 1 is for the ease of the counselor to consult to educate him or herself on the identified interventions across the spectrum for the prescriptive model.

Due to the complexity of the diagnosis, a counselor can quickly utilize the model (Figure 1) by recognizing the presenting ASD symptoms of the client. The counselor can then reference the above interventions and have an idea of where the child falls on the spectrum. For example, if a client displays restrictive language, limited social skills, and severe memory impairment, the counselor would reference the characteristics of Figure 1 and place the child on the lower end of the spectrum (i.e., LFA). The counselor would then reference the above evidence/empirically-based interventions for LFA and choose the most appropriate intervention depending on the child and family needs (Bennett et al., 2012). Furthermore, the counselor would also need to be cognizant of the client's: (a) educational interventions; (b) social skill interventions; (c) behavioral interventions; (d) medical interventions; (e) occupational interventions; and (f) supportive interventions (Bennett et al., 2012) outside of the counseling session. Having this information is best practice and adds to the treatment process.

Discussion

The purpose of the article was to outline the latest research pertaining to ASD on an individual level and best practice for professional counselors. A prescriptive model was organized to further assist counseling professionals in treating this diagnosis. ASD is a complex disorder with diverse characteristics, but the model is a starting point to

connecting counselors to current evidence/empirically-based treatment. Overall, there is a lack of research in the counseling field on how counselors can be effective in the treatment of individuals with ASD, but ASD has been heavily researched in regards to family-related issues.

Marriage and family therapists (MFT) have contributed to the field of research as it relates to ASD and family interventions (Johnson, 2012; Lock, Hendricks, Bradley, & Layton, 2010; Neely et al., 2012; Ramisch, 2012; Ramisch et al., 2013). Counselors can support families in exploring the emotions around the diagnosis, examining individual interventions for the child, serving as a coach/mediator, and affirming family competence and strengths (Neely et al., 2012). Early intervention is imperative and is an evidence-based practice for ASD (Bradshaw et al., 2015; Savoy, 2014). Therefore, parents need to be committed and involved in the treatment process (Ramisch, 2012). With restrictive research in the counseling field as it applies to individual interventions, it was difficult to outline a prescriptive model for the counseling profession.

The prescriptive model was constructed to assist counselors with exploring individual interventions (Figure 1). The model addressed characteristics across the spectrum and what symptoms one might treat in counseling. Further, the model outlines the many role(s) a counselor might hold when treating a child and family with ASD. The model addresses individual interventions with the understanding that family work is concurrent with individual treatment. Family members must be a part of the process for individual interventions to be effective (Bennett et al., 2012). Counselors who have worked with clients with ASD understand the diagnosis is multifaceted, thus, creativity and flexibility throughout treatment is crucial (Bennett et al., 2012).

The likelihood of treating a client on the spectrum is almost certain and must be addressed. Typically, Pediatricians, Developmental Pediatricians, Child Neurologists, and Child Psychologists or Psychiatrists provide a comprehensive diagnostic evaluation after the initial developmental screening (CDC; 2015c). Even though professional counselors do not initially diagnose ASD, counselors are essential in referring a child to a specialist as well as the post-diagnosis treatment (Layne, 2007). Thus, counselors need to begin to distinguish themselves as competent professionals with this population and become a relevant part to the interdisciplinary approach to treatment.

Implications for Counselors

It is fundamental for counselors to be informed on key issues pertaining to ASD and be equipped with accurate information to assist families and the individual with services (Neely et al., 2012). Counselors across disciplines must have basic knowledge of the diagnosis and how to treat it due to the ever-increasing numbers of children with ASD (Bennett et al., 2012). We have an ethical obligation to be a part of the interdisciplinary force behind holistically viewing the client and their family (Cox, 2012). By expanding our expertise, we can help alleviate burden on the families (White, 2012). As a profession, we have an ethical obligation to be competent in treating ASD as well as considering the impact of culture on the diagnosis and treatment (Ennis-Cole et al., 2013).

Counselors must be aware of the potential threats to support including factors related to socioeconomic status, spousal relations, availability of social support, and the

number of children in the family with disabilities (Estes et al., 2014). Additionally, a family's socioeconomic status (SES) is a factor in receiving intervention planning, education, technology use, and support services for the child and the family (Ennis-Cole et al., 2013). When working with diverse families and their child with ASD, the counselor must employ a personal awareness, appropriate skills, creativity to meet needs, and advocacy competencies (Ennis-Cole et al., 2013). The American Counseling Association has endorsed specific advocacy competencies within the profession that are necessary when working with the many systems in which clients are involved (Lewis, Arnold, House, & Toporek, 2003). Some examples include: (a) identifying strengths and resources of the client; (b) teaching clients self-advocacy skills; (c) negotiating relevant services for the client; and (d) assisting the client to gain access to needed resources (Lewis et al., 2003). As an ethical and competent counselor, embracing the advocacy role is essential to treatment.

Additionally, ACA (2014, p. 3) *Code of Ethics* mandates that counselors are "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts." ACA recently addressed *Multicultural and Social Justice Competencies*, which recognizes the value of acknowledging one's own attitudes and beliefs when working with clients who are diverse, the importance of building one's knowledge and skills, and then putting these into action (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015). Thus, the counselor must ensure they are competent to treat ASD and the family as well as incorporate advocacy into their work with this population. Finally, embracing an interdisciplinary approach is best practice and counselors need to communicate with other professionals and engage in ethical principles while doing so (Cox, 2012). All in all, ASD is a multifaceted diagnosis and empirical research needs to be addressed. There is a widespread use of unproven methods in treatment utilized across disciplines that are in need of empirical support (White, 2012). Simpson (2008) outlined the call for systematic and objective procedures to establish standards of practice. Counselors can be at the forefront of this call when working with children diagnosed with ASD.

Limitations

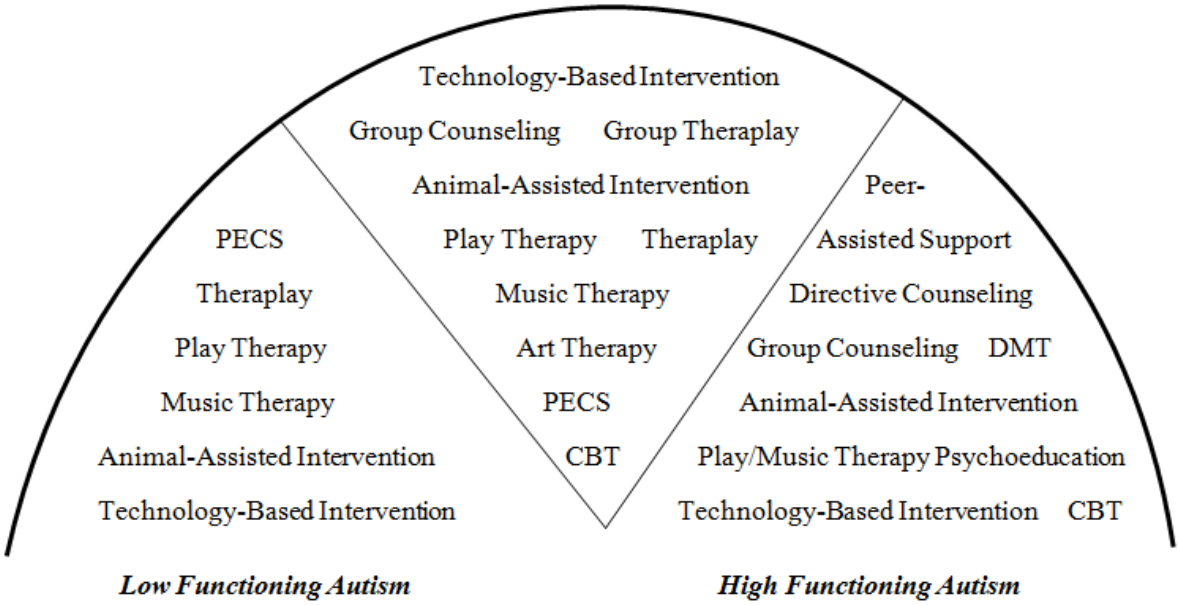
The model provides a starting point for counselors. Placing the individual's interventions across the spectrum is a difficult task due to the complexity of the diagnosis and the need for future research verifying treatment success. Overall, many of the interventions have not been rigorously or systematically supported. Thus, empirically and evidenced-based research needs to be addressed in the counseling profession as well as the need to identify the purpose in treatment.

Conclusion

The pervasiveness of ASD is steadily increasing, which mirrors the unanswered questions of families. Traditionally, ASD has a profound impact on families as well as on the individuals themselves. Children with ASD are eminently unique and it is difficult to determine a seamless treatment. Further, families are requesting the counseling profession to alleviate their stress surrounding the diagnosis. Professional counselors' must be prepared for this call. No longer should we be referring clients with ASD out

when we can provide the treatment. As a profession, we must be active in the research and add to best practice. Counselors can play a dynamic role in treating ASD and promoting greater life satisfaction for the child and the family; we just have to believe it and grab a piece of the puzzle.

Counselors' Role Across the Spectrum: Counselor (for child with ASD, family, and siblings); Advocate/Liaison; Coach; (Psycho)Educator



Characteristics:	**Characteristics:**	**Characteristics:**
Restricted Language	Sensory Problems	Social Difficulties
Behavioral & Emotional Issues	Emotional Difficulties	Motor Skill Delay
Severe Memory Impairment	Behavioral Issues	Sensory Issues
Difficulty with Adaptive Behaviors	Uneven Cognitive Abilities	Pedantic Speech
Limited Social Skills	Repetitive Body Movements	Rigid Rules/Routine
Self-Injurious Behaviors	Need For Routine	Emotional Issues
Sensory Issues	Sensory Issues	Behavioral Struggles

Figure 1. ASD Interventions Across the Spectrum for Counseling Professionals

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://www.counseling.org/knowledge-center/vistas