A Literature Review Exploring the Efficacy of Person-Centred Counselling for Autistic People

Introduction

This literature review investigates the suitability of Person-Centred Counselling (PCC) for autistic clients, a subject of particular importance to the author, as an autistic person currently training to become a PC counsellor and having experience of this approach as both client, and practitioner on placement with an autism charity. The PC Approach (PCA) and autism have been well documented, however literature exploring the efficacy of PCC for autistic people is minimal; Buck and Buck (2006) and Rutten (2014) give a useful description of the PC intervention and the autistic condition.

This review is important, due to the known higher prevalence of poor mental health in the autistic population than that which is seen in the neurotypical population, as can be seen in Figure 1 below. Understanding how effective PCC is in supporting this vulnerable client group is vital, and to explore whether adaptations to the approach would be beneficial.

For comparison, this review will begin by exploring the efficacy of Cognitive Behavioural Therapy (CBT) with adaptations on offer for autistic clients, including any barriers, and commenting on the research available; it will then explore whether PCC is enough for autistic people, focussing on Rogers' (1967) core-conditions of the relationship, empathy, unconditional positive regard (UPR) and congruence and how these fit with this client group, including any barriers, progressing to examine what adaptations might be required to make the PCA more accessible to autistic clients. Finally, the quality of the research will be ex-

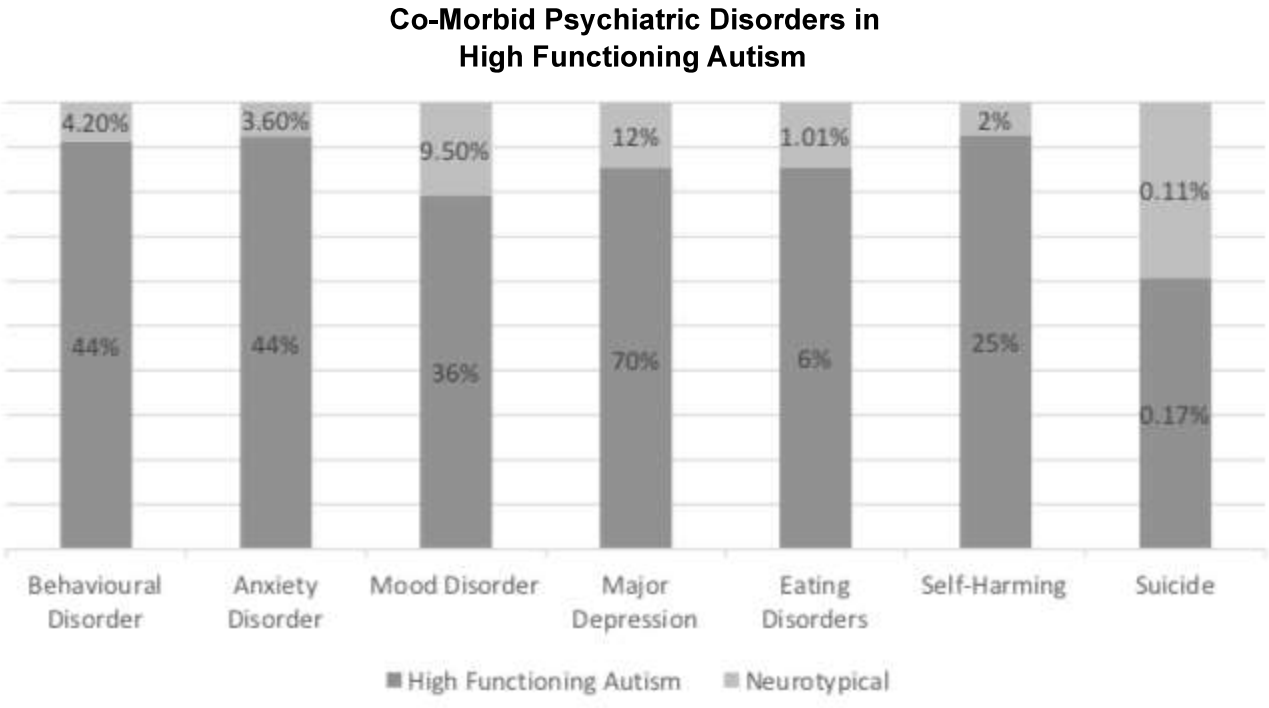

Figure 1. A comparison chart of co-morbid psychiatric disorders commonly found in people with high functioning autism/Aspergers Syndrome, alongside the same disorders found in the neurotypical population. Data for High Functioning Autism; for Behavioural Disorder, Anxiety Disorder, Mood Disorder, and Major Depression, from Lake et al., (2014), for Eating Disorders (minimum of) from Howlin and Magiati (2017) and for Self-Harming, from XI Autism-Europe Conference, (2016). Data for Neurotypical; for Behavioural Disorder and Anxiety Disorder, from Emerson, (2003), for Mood Disorder, from Insel & Fenton, (2005), for Major Depression, from Andrade et al., (2003), for Eating Disorder, from Qian et al. (2013), and for Self-Harming, from XI Autism-Europe Conference, (2016). Data for suicide for Neurotypical and High Functioning Autism, from Kirby et al., (2019).

amined, with recommendations for improvements suggested by Vossler and Moller (2015) and Booth et al. (2016).

Methodology

For this review, a full systematic search was carried out, predominantly using ebsco-host. A reference list check was then completed, then the authors, including Mick Cooper and Chris Abildgaard, were contacted to establish if other research was available.

What is included is believed to be a complete list of all available literature relating to PCC and autism. However, in summary fifty-five pieces of literature were saved for further scrutiny, with a total of thirty-nine being included in the final review. However, there are areas, including gender differences and autism with Intellectual Disability (ID), which were excluded but particularly merit further research in relation to autistic people, these will be further addressed in the Further Research section of this review.

How does PCC compare in effectiveness to CBT? Is CBT a panacea for the autistic client group?

CBT Advantages

Most of the literature available concerning counselling and psychotherapy for autistic people relates to CBT. Prominent authors in this field being Attwood (2015), a staunch CBT advocate, Paxton and Estay (2007) and Purkis et al. (2016). To highlight the disparity of literature on therapy for autistic people, a search on the ebsco-host Database brought up 4013 results with the search parameters 'CBT OR Cognitive Behavioural Therapy AND autism OR Autism Spectrum Disorder OR ASD', compared with 4 results with the search parameters 'Person Centred Counselling AND autism OR Autism Spectrum Disorder OR ASD.' It seems to make sense that the popularity of CBT as the primary therapy offering, could be driven by this disproportionate weight of empirical evidence.

This was supported by Koenig and Levine (2011) who contend in their case study that 'behavioural approaches have solid empirical support with respect to helping individuals with ASDs modify behaviour and improve functioning' helping with 'addressing anger management/obsessive thinking' (p33). This argument is further supported by Lake et al. (2014) stating 'the effectiveness of CBT in addressing anxiety, anger and social deficits... is well documented in the literature... and case studies... suggest CBT is a promising treatment for depression and anxiety in this population' (p4). Furthermore, Rogers (2016) maintains that 'the unique skills of this client group...' including 'strengths related to the need for structure, and a scientific way of thinking, lend themselves to learning opportunities in behavioural experiments' (para 5-6). The empirical evidence appears positive for CBT being effective for the autistic client group.

Adaptations

This evidence comes with a caveat. Similarly to findings by Cooper et al. (2018), Blainey et al. (2017) found in their study of 81(N) autistic adults with no ID, that results indicated 'preliminary evidence' showed 'CBT-based psychological therapy provided within a specialist service may be effective at reducing general psychological distress in adults with Autism Spectrum Disorder (ASD) and comorbid mental health difficulties' (p01479). These results support the National Institute for Health and Care Excellence (NICE, 2012) recommendations, which advise: adaptations to the delivery method of CBT will need to be met for the autistic client's cognitive and social communication needs when treating mental health conditions. What seems clear from the literature, is that standardly delivered CBT training is not suitable for autistic people; indeed, adaptations to meet the needs of this group are recommended.

A study by Cooper et al. (2018) of 54(N) psychological therapists aimed to ascertain 'their current knowledge and past experience of working within a cognitive behavioural framework with autistic people' (p44). Results demonstrate the need, as posited by other authors, such as Rosslyn (2018), Murphy et al. (2017) and Attwood (2015) for adaptations to CBT. All 54(N) participants reported making some adaptations, including 'an in-

creased use of written and visual information' (p43). In line with NICE (2012) guidelines, the participants 'emphasised behavioural change over cognitive approaches, having well explained guidance and rules of therapy' (p43). They recommend 'involving a friend, family member or carer, having breaks, incorporating special interests and avoiding ambiguous use of language' (p44). Cooper et al. (2018) acknowledge that a weakness of this report is that it is not representative of all CBT therapists working with autistic clients. The participants were surveyed whilst attending a training event to learn how to adapt CBT for autistic clients. Therefore, they are likely to already have a specialist interest and knowledge in this group. This has caused result bias, which Booth et al. (2016) would posit has 'erroneously influenced the conclusions' (p153) of this group. Potentially, this has given an inaccurately high view of the level of therapist confidence in working in this group; Cooper et al. (2018) recommend 'future studies should recruit a wider range of therapists' (p49). Regrettably, many autistic people will not be fortunate enough to find themselves placed with a therapist with autism specialism, especially as Hearst (2014) explains 'most adult autism is undiagnosed' (p26). The report also highlights many other barriers of CBT for autistic clients.

Barriers

Cooper et al. (2018) found many 'barriers' to the effectiveness of CBT for autistic clients, largely around the 'cognitive' element. The CBT practitioner participants reported 'the most frequently reported barrier... was rigidity of thinking or Black and White thinking'... and 'found that the cognitive style of autistic people was not always amenable to this approach' (p48).

The American Psychiatric Association (APA) (2013) detail rigid thinking patterns in autism in the Diagnostic and Statistical Manual of Mental Disorders (5th Ed; DSM-5). In a report by Rogers (2016) investigating how to adapt CBT for children with autism, it was disclosed that Rogers will not offer CBT 'if the child... has an extremely rigid thinking style' (para 10). Cooper et al. (2018) insist that if a therapist were to pursue the cognitive element of CBT with an autistic client, the therapist and the client could become quite frustrated and contribute to, as Eaton (2018) further argues, the client's experiences of 'a high level of social rejection... this would to some extent, serve to reinforce their negative beliefs' (p116-p117) which they hold about themselves.

Negative beliefs can be further adversely affected by poor executive functioning commonly experienced by autistic people. Ross (2018) explains that 'executive-functioning deficits affect planning, time management, organisation, prioritisation, inhibition, focus, task initiation (and persistence), transitions, working memory and attention to detail' (p7). This explains why the CBT practitioner participants in Cooper et al.'s (2018) study reported challenges with the 'pacing of therapy and completing of homework' (p48).

The literature suggests, unless allowances and adaptations are made to CBT to make it accessible to autistic people, the results could be detrimental and lead to, as Cooper et al. (2018) propose, 'a less favourable therapeutic outcome' (p48).

Research

Most of the research seems to be based on adapted versions of CBT, Attwood (2015) agrees with Paxton and Estay (2007) arguing; 'there has been evidence that this is an effective approach with persons on the autism spectrum' (p12). However, there appears to be some weakness in this evidence. Weston et al. (2016) agree with Murphy et al.'s (2017) counter-argument, stating that the available studies are 'problematic, as there are no large-scale definitive trials in this area making use of robust methodologies. As such, the conclusions reached within this meta-analysis and previous meta-analyses are potentially limited' (p51).

Furthermore, it is a limitation that most of the trials of CBT detailed in the literature, as Murphy et al. (2017) explain, saw CBT tested most commonly against 'active' or 'passive' controls (usually defined as 'waitlists'). This argument is supported by Weston et al. (2016), whose meta-analysis of 48(N) studies 'investigating the effectiveness of CBT when used with individuals who have ASD' (p41) had no comparisons to other therapy modalities.

This review found only one study comparing CBT to PCC, namely a study by Murphy et al. (2017), which was a very small-scale Randomised Control Trial (RCT) with 47(N) participants. This produced interesting results; despite the acknowledged benefit of adaptations being applied to CBT (in this case the adapted version of CBT was Multimodel Anxiety and Social Skill Intervention MASSI), unadapted PCC fared equally well, demonstrating similar efficacy. This begs the question, if adaptations had been made to PCC, would it have been shown to be more effective than CBT?

Summary

Murphy et al. (2017) and Lake et al. (2014) agree with Blainey et al. (2017), arguing that 'although CBT is the intervention with the greatest evidence-base, alternative forms of psychotherapy could be explored for people with Autism Spectrum Condition (ASC), enabling parity of choice' (p01483). It seems unjust and discriminatory that despite the British Association of Counsellors and Psychotherapists (BACP) (2019) detailing 30 different therapy modalities, only one type, CBT, is targeted towards autistic people.

There are useful adaptations being made by CBT practitioners to make it more accessible to autistic people. However it is possibly not a panacea for all autistic people and has its limitations. The evidence-base is weak, with larger-scale reviews required, including more comparisons to other therapies, including PCC.

Is person-centred counselling enough for autistic People? What are the barriers?

The data available, to be able to judge whether PCC is 'enough' for autistic people, is minimal and qualitative in nature, and could be viewed as falling significantly short, compared to the more predominantly empirically based quantitative data available for CBT.

For this review, due to the piecemeal nature of the evidence which is available, research cannot be disseminated in an objective way, therefore inferences will need to be made in the collation of this limited data. Despite uneven data, the qualitative data which is available is promising, particularly around the benefits of Rogers' (1967) core conditions, the first of which being the relationship between the counsellor and client.

Relationship

The significance of the relationship is proposed by Purkis et al. (2016) who state 'the therapeutic alliance is particularly important for people with autism. They may have issues trusting others and have more difficulty than neurotypical people in knowing who is and isn't trustworthy' (p188). Hodge and Rutten (2017) further purport that autistic people 'experience a very limited number of positive relationships; the act of regular and predictable engagement with another person that enables being heard and feeling understood... might go a long way to raising self-esteem and improving quality of life' (p514).

The therapeutic alliance may take more time and work to form, as Keonig and Levine (2011) argue 'a lack of, or much under-developed, "sense of the other"... for those with ASD' means 'establishing and maintaining relationships is an effortful process that requires understanding and patience on the part of all participants' (p29). Accepting and prizing the client for who they are phenomenologically, with Rogers' (1967) UPR, may provide a strong base in forming this therapeutic alliance.

The PC Core Conditions

Autistic people may have experienced very little prizing in their previous relationships. Knibbs and Rutten (2017) claim autistic people 'are subject to heightened conditions of worth' (p2). Research suggests that being different from peers and society as a whole can have a negative impact on mental health, as demonstrated by Lester (2014), who found that, for autistic people, 'there is a lot of negative stigma generated by society at large. Stigma has been associated with normal/abnormal dichotomy, with those oriented to as 'abnormal' often being stigmatised' (p187). Furthermore, a study by Cooper et al. (2017) of 272(N) explores factors that could interfere with the development of positive social identity' (p844), which would lower personal self-

esteem and increase depression and anxiety. This study posits that having a negative social identity directly and negatively affects self-esteem.

Rutten (2014) further explains that for autistic people 'whose difficulties are largely in the social domain, life is likely to start off with disadvantages... it is probable that social interactions with significant others in early life present people with autism with very high levels of conditionality. Whilst conditions of worth and incongruence develop' (p81). It seems autistic people are often subjected to, largely unachievable, externally imposed conditions of worth. The ensuing struggle to try to 'fit-in' to societal expectations, results in them living incongruently and increasing the likelihood of experiencing a high degree of failure in this respect.

The PCA, offering Rogers' core conditions of a counsellor giving UPR, empathy and congruence could help a client to experience a relationship which gives them what Cooper et al. (2017) describe as 'a positive social identity' ... which has the potential to increase their 'personal self-esteem, and in turn, would reduce depression and anxiety' (p846). In the mini society which exists in the counselling room, the autistic client would hopefully experience a positive identity within the therapeutic alliance. In finding more acceptance of themself, and, as Cooper et al. (2017) term their 'autism identity'. The hope would be that, with the support of a congruent and non-judgmental counsellor, they could become free to be happier in their identity, and therefore more congruent in their own way of being.

Buck and Buck (2006) carried out a case-study reflecting on an autistic client's experience of PCC, when the sessions came to an end, they report that the client 'discovered that the therapist was really interested in him and for the first time in his life nobody judged' (p71). Buck and Buck believe the therapy was useful to this client, reporting that 'the potential for a more fulfilling life is more likely now' (p71). The PC counsellor gave him the trust to discover 'the most suitable way forward for himself' with his own 'unique way of seeing the world' (p71). The client was able to move to a place of congruence.

Rogers (1951) believed that seeing the world through the client's eyes empathically is fundamental to the PCA. Hodge (2012) further argues that it is important to 'appreciate what being in the world might mean to a client who is on the autism spectrum', warning counsellors to be aware that often the 'problem' is not within the 'individual, rather in the environments that clients inhabit...' failing to appreciate this might cause 'counsellors...' to 'try to restore a "normal self" within a client who is not necessarily biologically configured in ways that will allow him/her to ever meet the requirements of being "normal"' (p106). Perhaps it is enough to reflect that a client can struggle, sometimes, in what can be a confusing society to an autistic person, and so it is beneficial to avoid directing them in ways in which they can become more 'normal' to enable them to 'fit-in.'

Purkis et al. (2016) add that it is important that autistic clients have access to a counsellor who can 'understand the particular needs not only of autistic people generally, but also the autistic individual they are working with, can be seen as essential to a good therapeutic alliance for autistic people' (p188). Each autistic person needs to be treated as a unique individual who is the expert and driver of their own life.

Knibbs and Rutten (2017) reiterate 'as described in detail elsewhere, person-centred theory presents core beliefs that the client is expert; this maps neatly on what people on the autism spectrum say they need from practitioners' (p5). Buck and Buck (2006) agree with Knibbs and Rutten (2017), arguing 'the person-centred perspective is central in recognising each individual's uniqueness, and in achieving true empathic understanding...' it 'also provides a model for considering the complex conditions of worth and accompanying challenges for individuals with social learning difficulties' (p1). In their work with autistic clients they aim to 'achieve conditions where clients feel accepted and valued, listened to and understood, not judged or required to conform to inappropriate expectations' (ibid). PCC offers conditions which have the potential to be an effective therapeutic approach that is 'enough' for helping autistic people, but it is not without some possible barriers.

Barriers

The Autistic Client

There appear to be significant barriers in autistic people being able to benefit from counselling. Vogan et al.'s (2017) study, assessing the experiences of 40(N) autistic people, highlights difficulties accessing health services. They found counselling to be the most 'commonly accessed health service beyond a family doctor' (p267). Despite this, participants reported there were 'overwhelming steps to finding and obtaining services' (p268). Hodge (2012) agrees 'there are barriers for disabled people to even get as far as the counselling room in the first place. The cost can be prohibitive... for disabled people who often have fewer financial resources' (p106-107). Arriving at counselling can be challenging for the autistic client group.

Once an autistic client has managed to navigate these obstacles and arrived at counselling, there can be further barriers, including, as Hodge (2012) and Cooper et al. (2017) argue 'some autistic individuals see the condition negatively and attempt to distance themselves from the autism label' (p844), possibly leading to masking and ultimately incongruence. Autistic clients may struggle to find words for feelings, a condition known as alexithymia. Blainey et al. (2017) explain 'alexithymia, or difficulty understanding internal states such as thoughts or feelings, is well documented amongst people with ASC' (p01481).

Alongside the difficulty in accessing and describing thoughts and feelings, they may also have a tendency to blame others and not take accountability for their own actions, Hodge (2012) explains 'some people with autism may focus on the need for the world to change' (p106-107).

The autistic person presenting to the counsellor could be quite confusing to the counsellor as a result of these complications, particularly around the struggles with feelings, accountability and possibly the negativity and defensiveness towards their own autism, possibly causing masking behaviour and incongruence.

The counsellor

The sometimes unfamiliar dichotomy of the experiences and worldview of an autistic person, compared to those of a neurotypical counsellor, can present further barriers. There was an overwhelmingly common finding in the research, that autism knowledge, training and confidence of counsellors who found themselves working with autistic clients was lacking.

Cooper et al. (2018), Hodge and Rutten (2017) and Purkis et al. (2016) agreed with Brookman-Freeze et al. (2012), who conducted a survey which assessed 13(N) therapists'"perceptions of their knowledge and confidence serving children with ASD' (p1656). They found that 'therapists have limited training in ASD and are highly frustrated serving this population' (p1652).

The danger is this frustration and lack of confidence may show itself in the counselling room. Unsurprising, then, that many autistic people, as Vogan et al. (2017) report, have 'negative experience of professionals' (p268). Purkis et al. (2016) further claim 'lack of knowledge in itself is not a barrier to being a good therapist, a lack of acceptance and understanding the experiences of an individual with autism... should be an indicator that the therapist may not be the right person to help' (p186).

Unfortunately, due to a chronic lack of counsellors trained in autism, this makes accessing appropriate therapists very difficult for the autistic population. Not only does awareness and training need to develop in the counselling profession, including in PCC, to make it 'enough' for people with autism, but counsellors also need to gain approval and confidence in adapting their approach, where necessary, to make counselling accessible to autistic people.

Summary

Although empirical research is lacking in the area of efficacy of PCC for autistic people, the available literature is supportive of the benefits to autistic people of the counsellor offering of Rogers' core conditions: relationship, UPR, empathy and congruence. This may be the first time an autistic person has experienced a relationship of this type.

There are, however, some barriers to overcome for an autistic client entering into counselling, such as the client initially reaching the

counselling room, and support required around struggles describing thoughts and feelings (alexithymia) for example. Additionally, barriers have been identified with the counsellor, there is a general lack of confidence and training in autism.

Nevertheless, with the right training and knowledge it looks promising from the literature that PCC is 'enough' for autistic clients, with the caveat that adaptations may need to be made.

What adaptations can/need to be made to PCC to make it 'enough' for autistic clients?

The UK government have recognised that health and care services need to be adapted to make them more suitable and accessible to autistic people. They have launched a consultation with a proposal for 'learning disability and autism training for health and care staff' (2019). The proposal states that all health and care staff working in the National Health Service (NHS) will have 'mandatory learning disability and autism training' (para. 1). This will bring counsellors who work in the NHS up-to-date with the Autism Act 2009 and the Equality Act 2010 which, as Rowe (2017) advises 'anyone working with a person who has ASD ought to make reasonable adjustments to the way they work' (p79). The hope is that this will contribute to improving counsellor confidence when working with autistic clients and give them the ability and skills to adapt appropriately to meet the needs of these clients.

Personal and Body Language

It is hoped that any autism training packages would include recognising and responding appropriately to different body language and personal language of autistic individuals. Mearns and Thorne (2007) comment 'as the counsellor learns the personal language of her client his behaviour becomes progressively easier to see and to accept' (p102). Rosslyn (2018) purports that, for the neurotypical counsellor, it can be 'bewildering... to find a client on the spectrum carefully avoiding eye-contact... giving...one-word replies... bundled up in their outdoor coat... and on the edge of their chair... playing with a shoelace... they may seem reluctant to engage' (p29). Rosslyn explains that an experienced counsellor would know this autistic client 'is in a state of high anxiety and sensory alert...' this client knows 'they will be alone with a stranger for an hour, having to simulate eye contact and follow another person's expectations' (p290). Aston (2011) agrees that autistic clients 'are working hard just to keep up to speed with interactive communications' (para. 11). Rosslyn (2018) explains that this more unusual body and personal language could lead a counsellor to make assumptions based on more neurotypical behaviour, leading them to think their client could be 'depressed, traumatised...' or 'hostile' (p29). Lester (2014) questions 'who and what positions behaviour as "normal" and "abnormal?"' and calls for 'careful attention to the consequences for how, when and where notions of "normalness" are made "real"' (p190). Counsellors and researchers need to show caution in relation to the assumptions that they make, not least around eye-contact in autistic people.

In Guest and Ohrt's (2018) study into the effectiveness of Client-Centred Play Therapy (CCPT) for autistic children, they took eye-contact as a positive outcome; commenting that an autistic participants 'eye contact improved' (p162). This outcome is alarming, as a study by Hadjikhani et al. (2017) found 'constraining individuals with ASD to look into the eyes... results in activation of the subcortical pathway' meaning 'direct eye-contact may be experienced as stressful in autism' (p3-4). Aston (2011) concludes that, for autistic people 'making or maintaining eye-contact can be very difficult' (para. 13). A strategy for a counsellor to help their client feel more relaxed in therapy would be to give them permission not to have to maintain eye-contact.

Communication

The 'learning disability and autism training for health and care staff' (2019) highlights the need to 'use appropriate communication skills when supporting a person with autism' (p10). Woods et al. (2013) carried out a review of which adaptations counsellors were currently

making for autistic clients. They propose these clients 'typically have problems with social communication, particularly conversation, non-verbal cues and reciprocal interaction... have difficulties in empathy and theory-of-mind' (p34). Rogers (2016) adds that autistic people can 'interpret language in a literal manner' (para 13). Aston (2011) additionally comments that eighty-five percent of autistic people suffer from 'alexithymia... which simply means no words for feelings' (para 15). Autistic people can therefore struggle to describe their feelings. Woods et al. (2013) and Rogers would agree with Aston's (2011) recommendations that autistic clients are given 'clear instructions and logical options to consider' (para. 16). Additionally, Abildgaard (2013) highlights it can be useful to introduce 'the concept of "maybe"... for our more rigid thinkers.... The use of the word "maybe" aims to create flexibility and is more proactive because it does not allow these clients to create just one picture in their heads related to how things are "supposed to go"' (para. 15).

Training above and beyond standard counsellor training is important for counsellors to understand the communication differences of the autistic client group. As Hearst (2014) argues 'we can... see that a condition that affects social relationships would affect therapy... if this condition were not well understood, it would be difficult to conduct therapy effectively' (p28).

Environment/Sensory Input

Rosslyn (2018) explains the autistic client may not have come to therapy for the purposes of forming 'a relationship, but for help – and until they receive some, they will not relax... they may be finding the environment stressful; overhead lights, coloured cushions, diffusers and small noises are all potential sensory problems' (p26-p27). Hearst (2016) adds that it is important to be 'aware of the sensory environment recommending not having clutter and providing 'stim toys' (things to fiddle with)' (para. 4). Nicholson (2017) clarifies that 'autistic individuals lack the ability to adjust to sensory experiences that other people accept as normal' (para 9). Aston (2011) comments that if the client 'is comfortable and relaxed within the environment...' this gives them 'the best possible chance of having a stress-free and beneficial therapeutic alliance' (para. 23).

Boundaries

As well as tending to the environment, boundaries may also need to be modified. Hodge and Rutten (2017) highlight that autistic clients might need 'a high level of consistency around room layout, dates and times... being more flexible about where sessions might take place and in what form... some clients need more frequent, shorter sessions' (pp513-514). However, Nicholson (2017) suggests, however, that they might need longer sessions as 'this extended time period allows for cognitive flexibility and for theory-of-mind deficits' (para. 5).

Furthermore, it appears to be unhelpful for autistic clients to be restricted to the usual offering of six sessions. Research by Blainey et al. (2017) found that an average of twenty sessions would be most beneficial. Further research by Jones (2013) recommends more relaxed boundaries, including 'the use of refreshments, humour and self-disclosure to facilitate the therapeutic relationship' (p197).

The aim in creating these 'friendlier relationships,' Jones (2013) clarifies, is that autistic clients can then 'engage in the therapeutic relationship' (p197). Engagement in the therapeutic relationship can still be a challenge when working with an autistic client due to poor communication skills hampering the development of psychological contact, deemed necessary to form Rogers' first condition of the relationship.

Creative Counselling

Stepankova's (2015) study of 6(N) autistic individuals investigates the use of Prouty et al.'s (2002) Pre-therapy contact reflections. For example, giving a bodily reflection verbally can be useful for autistic clients who are lower functioning and perhaps non-verbal, although this was out of scope for the purposes of this review, which focuses more on higher functioning autistic clients. The principles of pre-therapy to help aid psychological contact can be expanded upon, with creative counselling.

Ross (2018) argues that 'a creative, person-centred, and sensory sensitive approach to working with ASD students is essential... tactile and visual therapies such as drawing, sand-

tray, and small figure work may be useful methods to explore' (p14).

Ross (ibid.) agrees with Nicholson (2017), commenting that it is common for autistic people to 'have a special interest' and it can be 'important to weave it into counselling communications, in order to encourage client engagement' (para 12). Aston (2011) recommends finding out 'from the client how they best prefer to communicate; they may prefer to write things down... to express feelings' (para 12). Abilgaard (2013) further explains that many autistic people 'are visual learners, using visuals is key to helping these clients' (para 5). Additionally, Jones (2013) recommends working in a 'creative and flexible way... to benefit in developing the therapeutic relationship' (p198).

It is hoped that these creative tools will enable the autistic client to enter into a therapeutic relationship with his counsellor where psychological holding is possible, and therapy can take place.

Summary

The qualitative, case study and anecdotal research for this review has highlighted that many adaptations are already being made by PC counsellors. They may include being more aware of differing communication styles, personal language and body language, providing support in the counselling room, for example, being more aware of sensory issues, flexibility around boundaries and providing creative tools to aid in communication to ultimately help in building a therapeutic relationship with adequate psychological holding.

This review has provided evidence that adaptations can and need to be made to PCC to make it 'enough' for autistic clients. However, to make it available to greater numbers of autistic people, it is promising that the UK government propose making autism training mandatory. This will hopefully give a greater number of PC counsellors the training to make them more confident in making the necessary adaptations.

Conclusion

Summary of Main Results

The literature gathered for this review demonstrates that CBT with adaptations can be an effective therapy of choice for autistic clients; however it is not without barriers and is not a panacea for all. This review agrees with Blainey et al. (2017) who recommend 'a parity of choice' (p01483) is given to the autistic client group. Furthermore, there is a need for greater comparisons with other therapies in the future CBT research, and for larger-scale studies.

There was minimal empirical research exploring the efficacy of PCC for autistic people. This review agrees with Harris et al. (2010) arguing that autism research is still in its 'infancy.' However, promising evidence was available to demonstrate Rogers' core-conditions of PCC; empathy, UPR and congruence as being of therapeutic value to this group. The review also agrees with Knibbs and Rutten (2017) arguing that PCC is an ideal platform for helping autistic people who can be subject to 'heightened conditions of worth' (p2).

Although this review could not say that PCC is enough for autistic clients in its classical form, it has provided evidence that it could be enough with adaptations, such as using creative counselling to aid in forming psychological contact, necessary for forming the vital relationship between counsellor and client, also for the counsellor to be sensitive to sensory sensitivities in the client and differing communication styles. Most importantly, counsellors need to receive adequate training in autism. This review supports the government plans to provide mandatory training on 'learning disability and autism training for health and care staff' (2019).

It is important that all therapy approaches, including PCC, are adapted and made available to the autistic client group, and to not discriminate by excluding any therapy choices from them for reasons of inaccessibility, not least due to poor mental health being more prevalent in the autistic client group. It is unjust that only CBT is currently being adequately adapted to meet the needs of this group. We can however learn lessons from CBT practitioners as to how to standardise research to make the evidence-base stronger in the promotion of PCC and how to more adequately adapt the approach.

Future Research

Although excluded from this review due to the limited word-count, gender differences appear to warrant further research. A recent report by Kirby et al. (2019) highlights that autistic females are three times more likely to commit suicide than neurotypical females. It is important that further research is carried out to understand both the causes of this increased risk, and the mental health issues leading to this tragic outcome. Although the gender split for this review is overall well-balanced at sixty percent male and forty percent female, where gender was disclosed, autism research tends to be heavily male orientated. For example, studies by Blainey et al. (2017) had sixty males and twenty-one females, and Lester (2014) had eleven males and one female. We need to ensure that future research represents females fairly to understand how they can be better supported and to decrease this risk.

Another area excluded from this review, but which requires greater research is autism with ID; most research focussed on high-functioning autism with no ID, despite findings by Russell et al. (2019), which reported fifty percent of autistic people have ID. Indeed, 'Eight out of ten studies demonstrated selection bias against participants with ID' (p1). Further research is required to examine the efficacy of mental health support currently on offer for this group.

This review agrees with research by Buck and Buck (2006), who argue that further research is needed in 'practical therapeutic process to understand how the basic concepts of client-centred theory can be used to describe and understand the experiential world of clients with ASD better, and thus help them to optimise their lives' (p72). This review has highlighted how Rogers' core conditions could be beneficial to autistic clients and there is scope for this to be researched further, particularly if adaptations can be agreed.

Potential Bias

The author of this review is training in PCC. Therefore, there was a risk of what Vossler and Moller (2015) term 'the allegiance effect' (p37) giving a bias towards favouring PCC. This effect was mitigated against by adding a comparison against the greater researched CBT. Both approaches were carefully addressed, scrutinising both benefits and barriers of each.

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Welcoming Conversations

I remember, when I went for therapy some years ago, the therapist didn't even look up from their desk as I entered the room. I said 'hello', which was met with no response. The rest of the session seemed to be about my reaction to not being greeted, how I had felt ignored and how I had expected some acknowledgement of me as a person. Sometime later, while training to be a therapist myself, I realised their response must have been from a psychodynamic 'blank screen' approach. Or maybe it was just someone having a bad day? It didn't work for me, whatever it was. I even went back for a second session, as I did need help at the time, but the second session was similar. A continuation of what seemed like a battle between what I felt was a reasonable way of being, and the therapist's response. I didn't go back again, and I would say that clearly we were not in relationship, which was unfortunate.

I would like to consider the relationship between different modalities in therapy, not necessarily the different theories of practice and models; I want to focus on the relationship between therapists and counsellors who have different ways of being with their clients, and I wonder if we can be more open and learn from each other. I imagine the recent concept of Pluralism in counselling and psychotherapy (Cooper & McLeod, 2011)1 is an opportunity for different schools of therapy and approaches to meet, have a dialogue and begin to be in relationship. The pluralistic perspective on psychotherapy and counselling seems to offer an alternative way of thinking about the client's needs, and may, indeed, be a new way of informing therapeutic practice. I believe that even just being aware of different perspectives, approaches and modalities can only enhance more understanding of practice, which will ultimately benefit the client. I also believe that therapy is a collaborative process, and is always informed by what we know, what the client knows and what we can both learn together, and offers a space where we can explore what we don't know. I wonder, then, if there is similar way of exploring our practice in a conversation with colleagues working across modalities. While there may be differences in our