

RESEARCH ARTICLE

Clinicians' experiences and perceptions of family therapy in the context of autism

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Abstract

There is a paradoxical paradigm operating in neurodiverse families with autistic children, indicating increased stress alongside enrichment of family life. An emerging body of research has shown that the use of family therapy can improve family functioning and relationships in neurodiverse families. The current study uses constructivist grounded theory to explore clinicians' experiences and perceptions of utilising family therapy in the context of autism. Study findings suggest that clinicians integrate therapeutic techniques from diverse family therapy approaches to improve family relations by bridging different ways of learning and communicating as well as facilitating multiple perspectives. Integrating therapeutic techniques across diverse approaches further encompasses working with the systems around the individual with autism. To adapt family therapy in the context of autism, it is suggested that clinicians examine their own perspectives and beliefs about autism and keep a curious stance during the process.

KEYWORDS

autism, bridging different communication and learning, family therapy, grounded theory, neurodiversity

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Practitioner points

- Clinicians find family therapy helps neurodiverse families bridge different ways (i.e., neurodivergent versus neurotypical) of learning and communicating.
- In adapting family therapy in the context of autism, clinicians should examine their perspectives and beliefs about autism and maintain a curious stance.
- Constructivist grounded theory is theoretically consistent with the practice of family therapy, and is a helpful methodology in exploring experiences and perceptions in family therapy research.

INTRODUCTION

The lived experiences of neurodiverse families, including parents, siblings and extended family, have been explored using qualitative studies. Findings suggest that there is a paradoxical paradigm operating in families with autistic children. On the one hand, families report a heightened level of stress associated with supporting the unique needs of their children, including differences in sensory processing, social communication and relationships, and preferences for routines (Broady et al., 2017; Gorlin et al., 2016). On the other hand, families describe varying degrees of family life enrichment (e.g. family members do more for each other than they do for themselves) and enhanced personal growth (e.g. a greater appreciation of differences between people, an enhanced clarity about what matters in life) related to having family members with autism (Hayes & Watson, 2013; Schlebusch & Dada, 2018).

Over the last few decades, there have been a lot of scientific enquiries into the neurobiological diversity and unique cognitive processing styles of individuals with autism (Dimitrova, 2015; Silberman, 2015). People with autism – like neurotypical people – acquire emotional, social and other adaptive behaviours within their intimate family systems. In other words, the family provides context for the developmental trajectory of autistic children. For example, how parents (and families more broadly) perceive autism, and how they adjust family interactions based on the needs of the child, can have significant developmental implications (Lee et al., 2020; Ravindran & Myers, 2012). While there is evidence for the use of psychological and skill-based interventions to assist autistic individuals with coping and skill acquisition (Whitehouse et al., 2020), most interventions focus on the individual level, overlooking family relations at the system level.

Family therapy is a therapeutic approach underpinned by the systems theory of family relationships. When a family system is stuck on specific relational patterns and resistant to adapt to cope with novel circumstances, various problems (e.g. behaviour, mental health, or physical health) can emerge among family members (Andolfi, 2017; Carlson et al., 2005; Minuchin, 1974). Theories of family therapy entail what clinicians in the field have recognised for some time: that individual change is contextualised, often through systemic changes within the family.

Family therapy has shown some effectiveness in improving relationships among family members and reducing ‘symbolic’ problems; for example, a child’s ‘separation anxiety’ as a ‘symbolic’ problem of parental discord. Scholars have proposed using family therapy to support neurodiverse families (Goepfert et al., 2015; Helps, 2016; Solomon & Chung, 2012; Spain et al., 2017).

Several studies on the use of family therapy in the context of autism have shown improved family functioning and relationships, as well as reduced 'challenging behaviours' (Ma et al., 2019; McKenzie et al., 2020; McKenzie et al., 2021). These changes are possibly facilitated by an increased understanding of each other and autism, and being able to view the autistic individual's needs and behaviours from a broader perspective (e.g., development stages) as opposed to the 'symptoms' of autism referred to by the medical model.

Despite the promising outcome of using family therapy to support families having children with autism, little is known about clinicians' experiences and perceptions about applying family therapy interventions to support families with children with autism. The purpose of the present study is to explore clinicians' experiences and perceptions of using family therapy with neurodiverse families in the context of autism. This study aims to develop explanatory hypotheses based on conceptualisations of clinicians' experiences and perceptions. Constructivist grounded theory (CGT) was chosen to guide the research design on the basis of the researcher's epistemological stance of relativism, in that different perspectives hold value in understanding human experiences.

Grounded theory is an inductive, comparative, systematic method of conducting qualitative research, involving an iterative process of simultaneous data collection, analyses and conceptualisation (Charmaz, 2014). The purpose of applying grounded theory is theory construction (Charmaz, 2014; Glaser, 2016). Glaser and Strauss are known as the founders of grounded theory. While working together in a study examining the experience of terminally ill patients, Glaser and Strauss developed grounded theory, offering an explicit and codified statement of how to analyse qualitative data (Glaser & Strauss, 1967).

CGT contains the main foundations set by Glaser and Strauss's (1967) original works but propositions a constructivist view (Charmaz, 2014). Constructivism assumes a relativist epistemology, and views reality as a construction created through the meaning people ascribe to their lived experiences (Charmaz, 2014). CGT acknowledges the researcher and research participants and their multiple realities and standpoints. It adopts a reflexive stance towards the researcher's background, values and relationships with research participants while situating the research in the historical, social and situational conditions of its production (Charmaz, 2014; Charmaz & Thornberg, 2021).

There are some comparable aspects between CGT and family therapy. Both CGT and family therapy focus on the meanings behind actions and words. Both CGT and family therapy recognise the interactive effects of the researcher and the therapist on the outcome. Therefore, both CGT and family therapy propose methods to bring the effects to the foreground. Furthermore, both CGT and family therapy involve an iterative and recursive process in research and therapy. As CGT is theoretically consistent with the practice of family therapy, it is a helpful methodology in family therapy research (Echevarria-Doan & Tubbs, 2005).

METHODS

Selection criteria

The criteria for participant selection for the present study were: (1) the clinicians must have undergone family therapy training (which included theoretical understanding of family therapy), or (2) the clinicians must have worked within a psychotherapy framework and have worked with family dynamic systems for at least 1 year, and (3) clinicians must have clinical experiences working with neurodiverse families with a child(ren) with autism.

Recruitment

The current study employed both purposive sampling and snowball sampling to recruit participants, and five participants were recruited via email contacts from the Australian Association of Family Therapy (AAFT) website, the Psychotherapy and Counselling Federation of Australia (PACFA) website and the Australian Psychological Society (APS) website, and two were recruited through the professional networks of a participant. All participants provided informed consent and the study protocol had full ethical clearance.

Researcher characteristics and reflexivity

The main researcher (CH) has a background in psychology, behaviour analysis and family therapy, as well as extensive experience working with individuals with autism and their families. Having lived in different countries and having been exposed to various cultures facilitated the main researcher's capacity to analyse social interactions and observe unspoken social rules taken for granted for many from that culture. Describing herself as a 'culture chameleon', CH has been taking note of the comparable process of acquiring social competence between people from culturally diverse backgrounds and people with autism. She has been intrigued by the neurodivergent mind along her journey, working with children with autism and their families since 2000.

The researcher has observed various relational patterns within the family, how families celebrate their child's progress and the desperation when they feel stuck in the moment. Nevertheless, she notices the resilience of these families, going through the child's developmental stages. The researcher undertook the postgraduate training of family therapy with Professor Maurizio Andolfi, who endorses multi-generational family therapy. Family therapists utilise a range of interventions; for example, development of genograms to map out familial patterns and narrative methods to explore language, meanings and attributions to assist family members to look for resources to cope with situations that challenge the system (Andolfi, 2017).

During the research process of using CGT, the researcher recognised some parallel processes of her own thinking process both personally and professionally. Questions she often reflected on, such as:

- What is this situation implying? Is there a different way to explain the situation?
- How are these implied meanings connected?
- Why does this situation matter? To whom does this situation matter?

Recognising that the researcher's preconceptions could impact the research process, the researcher paid close attention to the language used in the interview questions, reflected on her thoughts and feelings while analysing data and kept memos and reflexive journals to create a space to obtain an open, analytical view of the data. Regular supervision and check-ins were undertaken with the other researchers.

Data collection

The means of data collection for this study were intensive interviews (Charmaz, 2014). Intensive interviewing emphasised understanding participants' experiences and perceptions,

utilising open-ended questions. For example, 'What do you find helpful using family therapy with neurodiverse families?' and 'When using family therapy with families of autistic children, what are some unique areas of focus compared to families with neurotypical children?' The development of the interview schedule was shaped by the aim of the present study and the existing literature. Interviews were video and audio recorded via Zoom and each interview lasted between 30–45 minutes. Recorded interviews were transcribed and coded using NVivo 12.

Data analysis

Grounded theory utilises an iterative approach, characterised by simultaneous data collection and analysis (Charmaz, 2014). Data analysis commenced immediately after the first interview. Constant comparative method was used through initial coding, focussed coding and theorising of those codes into categories. (Charmaz, 2014; Charmaz & Thornberg, 2021). During the initial coding phase, the researcher labelled words, lines or segments of data, keeping codes as similar to the data as possible (Charmaz, 2014). During the subsequent focussed coding phase, the researcher utilised the most significant and/or frequent codes to sort and synthesise data. Core categories were then established as the researcher refined the analysis (Charmaz, 2014).

While analysing data and investigating 'what the clinician is trying to convey', close attention was paid to the interviewee's use of language and their non-verbal communication (e.g. body postures, pause between sentences, laughing). These pieces of information were carefully incorporated when analysing the meaning of interviewees' discussions. Reflexive journaling and memos were kept throughout the research process, providing a pivotal link of the researcher's analytic thinking process and the relationships being established among categories (Charmaz, 2014). CGT acknowledges the researcher and research participants as well as their multiple realities and standpoints. It adopts a reflexive stance towards the researcher's background, values and relationships with research participants while situating the research in the historical, social and situational conditions of its production (Charmaz, 2014; Charmaz & Thornberg, 2021).

The researcher adopted a self-reflective stance throughout data collection and data analysis. One example is the researcher's perspective on autism and disability, which was documented in the researcher's reflexive journal (dated 21 October 2022). The journal stated, 'The term "disability" is often used interchangeably with "autism" in Sue's (pseudonym) interview. I find two conflicting views on the two terms within myself. First, from a "social constructivist" lens of "disability", autism, like other conditions, requires a degree of understanding from the larger community, and some environment accommodation (e.g. reduced sensory input, clear visual support). Second, unlike other conditions, the cognitive and social communication profiles of autism signify the ambiguous need of support. Some might argue, "why do we have to compromise and take on the other side's perspective?" In this sense, autism has its distinctive context compared to other type of disabilities'.

Another example is the researcher's internal opposing view on autism, documented in her reflexive journal (dated 25 October 2022). It noted, 'When analysing data from John's (pseudonym) interview, I have some internal conflicts, as part of me disagrees with the medical model of disability, yet another part of me uses the same terminology (e.g. restricted repetitive behaviour,

social communication challenges) during clinical practice (i.e. conducting diagnostic assessment). The “diagnostician” part of me is largely sculpted by clinical training and the larger societal system (e.g. National Disability Insurance Scheme eligibility criteria, Disability Confirmation sheet in the education system, and the “diagnostician” title). During therapy sessions, the “interpreter” part of me comes from my personal beliefs, values and family therapy training (which brings my awareness of my “inner self” to the surface).

RESULTS

A total of seven participants across various professional disciplines (one mental health nurse, one nurse practitioner, one mental health occupational therapist, one art therapist and three psychologists) took part in this study. Five participants had more than fifteen years of experience practising within a family therapy framework, including structural family therapy, Milan systemic family therapy and narrative therapy. Two participants had between three and five years of experience. Participants were assigned pseudonyms used in transcripts and excerpts.

Initial coding

Charmaz (2014) explained, ‘coding means categorising segments of data with a short name that simultaneously summarises, and accounts for each piece of data’ (p. 111). During initial coding, the data were broken down into words and sentences to look for meaning (Charmaz, 2014). Initial coding has involved coding each part of the dataset, finding the meaning of fragment of data (e.g. line-by-line, incident by incident). The main researcher focussed on gerund codes to highlight on the process and increased understanding of the meaning.

Thirty-five initial codes were allocated; for example, ‘translating behaviour’, ‘valuing the autistic view’, ‘staying with family across time’, ‘understanding multiple perspectives’, ‘helping family to navigate emotion related to the diagnosis’, ‘looking into intergenerational patterns’, ‘collaborating through the process’, ‘staying at present reframing history’, ‘zooming out and seeing the person within their broader systems can be useful to set up systems around the person’ and ‘working with the person and their environment having a joint understanding of what moving forwards looks like’.

Focus coding

Focus coding involved conceptualising the codes created in the initial coding process (Charmaz, 2014). As there have been some strong analytic directions merging after the initial five interviews, the main researcher started the focus coding process by engaging in deductive, inductive and abductive reasoning. The properties of data are compared not only with each other, but also with the researcher’s personal and professional experience during the data analysis process. For example, derived from the researcher’s family therapy training, the memo ‘Clinicians try to understand multiple perspectives from family members, and work out intergenerational patterns. Intergenerational patterns provide a guide for clinicians to assist

families ...' linked the initial codes 'looking into intergenerational patterns', 'holding the middle ground' and 'understanding multiple perspectives' and raised the 'understanding multiple perspectives' to a focus code.

Decisions were made about which initial codes make the most analytic sense to be raised to focus codes to categorise the data thoroughly. As opposed to initial coding, data were analysed in larger sections. The meanings or categories were compared and contrasted to clarify the theoretical centrality of data (Charmaz, 2014).

Initial codes were raised into nine focus codes: 'facilitating family to get on the same page and create consistency', 'translating the behaviour according to development stages or life cycle', 'understanding multiple perspectives', 'helping family to navigate emotion related to the diagnosis', 'bridging different ways of learning and communicating', 'integrating therapy techniques', 'reflecting', 'using family therapy frequently with clients' and 'working with the systems around the person'.

Theoretical coding

The focussed coding phase involves the researcher with comparing initial codes and attempting to organise them into more concise categories (Charmaz, 2014). Theoretical coding, as defined by Glaser (1978, p. 72), is to conceptualise 'how the substantive codes may relate to each other as hypotheses to be integrated into a theory'. The main researcher aimed to produce theoretical codes that make data analysis coherent (Charmaz, 2014).

Four categories were constructed from the data collected.

1. Facilitating multiple perspectives to create a space for change
2. Bridging different ways of learning and communicating
3. Integrating therapeutic techniques across diverse approaches
4. Working with the systems around the person

Their interconnections are illustrated in Figure 1.

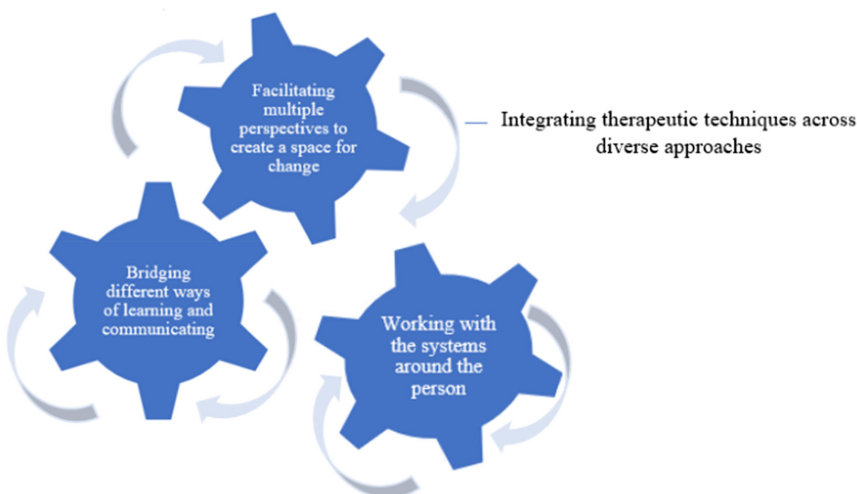


FIGURE 1 Interconnections among the four categories.

Category 1: Facilitating multiple perspectives to create a space for change

Clinicians spoke about trying to understand multiple perspectives from family members and work out family relational patterns. Family relational patterns provide a guide for clinicians to assist families to change; for example, amplifying children's voices; allowing more independence for the adolescent; and questioning the beliefs about each other's intentions. The researcher pondered, 'Whether one could understand multiple perspectives after shifting their positions or one would shift their positions after gaining multiple perspectives is not only a chicken and egg circumstances, but likely a gradual co-occurrence' (Memo). While eliciting multiple perspectives from family members, clinicians also facilitate family members to recognise each other's perspectives. As Sue stated,

I think what I'm using most in practice is understanding multiple perspectives, really, and the family therapy, the training that I've done is very clear on that neutrality whilst you are on the side of your client.

John also emphasised the significance of facilitating an understanding of different perspectives among family members. He noted,

So, the biggest dysfunctional pattern in family circles is there is a misunderstanding before mis-acceptance.

By facilitating multiple perspectives, clinicians help family members to translate the meaning of behaviours within context. In her memo, the researcher noted, 'Clinicians normalise the behaviour [of people with disability] by translating the meaning of the behaviour within context, which is the underpinning foundation of family therapy'. For example, Sue extended the 'absconding' behaviour to the context of 'development stage' (e.g. adolescence) and the adolescent's emotional state. Dan brought forward the concept of family life cycle, and added,

So, the life cycle will help me to understand, particularly with autistic children and adults, and even adults, is that how have your life been impacted at that point in time of transition? To the next stage of their lives.

Uncovering emotions is part of facilitating family members to understand each other's perspectives; for example, complex disenfranchised grief following the diagnosis (i.e. grief unacknowledged or invalidated by social norms), mixed anger and guilt when disagreements arise and worries about the child's future. Clinicians hold the middle ground for family members to process these emotions, creating a space for change to occur. As James said,

Knowing how to balance having, you know, more than one person in a room that ... that's pretty, pretty challenging thing at the best of times and knowing how to hold that middle ground, I think particularly when there are people that you know, might interpret things in a specific way, or they might have a really hard time managing their emotions.

Mary discussed the parents' complex emotions emerging from the beliefs about the child's diagnosis, and how clinicians could help to test these beliefs and create change,

If you have this view, but we've seen these changes, how does your belief align with the changes we've seen? It's just simply exploring that the discrepancy between lived experience and behaviour that's seen by third parties and the parent's own fears.

In reflecting on 'facilitating multiple perspectives to create a space for change', the researcher wrote in the memo, 'Clinicians often feel the pressure that our "performance" is being evaluated by the families in front of us. It takes considerable personal work and professional training, to establish an internal supervisor (i.e. meta-position) in family therapy sessions. The meta-position allows clinicians to join in, be curious about what is happening in the family, and avoids being over involved'.

Category 2: Bridging different ways of learning and communicating

To bridge neurodivergent and neurotypical ways of learning and communicating, clinicians acknowledge neurodiversity and different ways of information processing. The researcher ruminated on the diagnosis, and made some remarks in the memo, 'Who "defines" autistic people? Depending on the clinician's beliefs and perceptions of autism. Perhaps autism represents a diverse cognitive profile, a different sensory processing profile? The diagnosis only provides an incomplete picture of the person, and it is important for the system around the person to become aware of the incompleteness (i.e. the person, not the diagnosis)'. Clinicians need to acquire a level of understanding of autism including being conscious about their own perceptions and beliefs of autism, so they can be more proficient in identifying strengths within the autistic individual and further help the autistic individuals and their families understand the diverging information processing styles. In James' interview, he stated,

I think having all of that knowledge and also understanding, you know, just around the different reasons behind why the family might be really resistant or really restrictive or have very specific interests or, you know, knowing all the sensory things as well.

In terms of understanding autism, Adam talked about it is as a different way of being in the world, highlighting neurodivergence and noting that,

Anything with autism and therapies actually being able to deal with that mindfulness of information processing and thoughts.

Mary agreed upon neurodivergence, and noted,

Actually, I think the other thing about it is valuing the way they experience and see the world and not assuming that they should see the way non neurodivergent people see it.

To bridge different ways of learning and communicating among neurodiverse family members, clinicians utilise the autistic individual's strengths to shift family members' perceptions and create space for connections. For example, Sue gave one example of utilising a teenager with autism's strength of making origami to have her teach family members the craft (i.e. to shift

family members' perception of the teenager's autistic characteristics from problematic to capable of teaching family members the craft activity). This exercise during therapy sessions placed the teenager with autism in the 'expert' position and created space for families to see the teenager with autism through a different lens.

Sue discussed another example where the clinician helped translate a girl with autism's use of metaphor to communicate her love for her mother,

So, the mother was in session with her daughter, and I sort of informed a bit, 'Oh, what's your favourite animal?' Now drawing connections. And she [the autistic girl] was like, 'Oh, I love koalas. My mum's like a koala'. So, you know, in a way, she's saying, I love my mum. Mum didn't hear it, though. So, for me to translate that and say, 'Did you hear that? She [the autistic girl] just said she loves you', you know. But the autistic girl talked in metaphors there, you know. She didn't say, 'I love you, mum'.

In regard to bridging different ways of communication, Nancy also suggested expanding language repertoire to match the communication styles of people with autism:

You kind of have to develop another sort of set of language or a set of questions that I guess is more easily understood and interpreted.

Clinicians also extend bridging different ways of learning and communicating to the larger community, such as schools and the workplace, embedding this ethos when collaborating with the systems around the person with autism. The researcher entered in her memo, 'The perception of the diagnosis from the person and their family is significantly influenced by the community, culture, and the society as a whole'. As Adam pointed out,

If the autistic person in a system, you know, sort of not being mindful of the needs of others, they're not judging them as selfish. They [the system] are able to see that as an area to educate and support rather than punish or exclude on that basis.

Category 3: Integrating therapeutic techniques across diverse approaches

Systems theory is the foundation of family therapy, which consider that the family functioning is influenced by interrelations among various 'parts' of the system (Andolfi, 2017; Carlson et al., 2005; Minuchin, 1974). Carlson et al. (2005) propose that effective interventions take place when therapists have a solid understanding of diverse theoretical approaches (e.g. intergenerational, narrative, solution-focussed and strategic), and can adapt intervention strategies from a range of therapeutic techniques linked to theory to suit individual family needs. Despite the differences in rationale, intervention process and techniques, family therapy theories are similar in that they are all interpersonal models, that individual parts of a system can only be understood within the context of the whole system and that systems tend to seek homeostasis (Andolfi, 2017; Carlson et al., 2005).

In the memo, the researcher wrote, 'To be able to remain open and curious, therapists have to be aware of how our own beliefs and values play a role in the therapeutic process. This is in line with Andolfi's (2022, pp. 154–156) discussion of the central point of the therapist, and

the implicit relational knowledge shared between the therapist and the family in therapy ...'. Neurodiverse families, comparable to neurotypical families, have various relational patterns and family dynamics. Clinicians highlight the importance of having a foundation across diverse theoretical approaches as well as acquiring a broad repertoire of intervention techniques linked to theory, integrating therapeutic techniques across diverse approaches when engaging in assessment of the family system and deciding intervention strategies adapted to that individual family.

Dan's statement reflected how clinicians integrate different family therapy models to meet the client's needs:

I have integrated all my family therapy models into my head. So, to try to come up with a coherent model that fits the client at the time. So, it's not like I will choose one thing, but I'm integrating.

John echoed this technique,

I grab bits of pieces that I find most effective, I'm very well versed with different family therapy models. But I think the biggest issue for me is that you take a non-individual approach.

In addition to integrating therapeutic techniques, clinicians might need to utilise psychoeducation to help family members find resources within the family and learn the skills necessary for changing relational patterns. Sue explained,

I think it all depends on how you explain the intervention that you are offering, you know, how do you explain what you're doing in session.

Category 4: Working with the systems around the person

As families live and function with the larger community, clinicians' roles often extend to working with the systems (e.g. schools, workplaces) around the person. The essence of working with the systems involves zooming out to reflect on the clinicians' position in the systems and zooming in to reflect on how clinicians perceive their roles in working with the systems. Sue posed a couple of fundamental questions regarding working with the systems, for example, 'Whose needs are we meeting? Is it that the needs of the service who's decided that's the best they can give? Or is it really on request of people with disabilities?' Sue noted,

... it's also all the different systems that work with the client and their influence on that and understanding yourself as one of the persons within that system and being able to zoom out yourself even within that system.

John commented on the potential impacts on parents when working with the larger systems,

Systems thinking, seeing the big picture, try to undo a lot of self-doubt on the behalf of the parents thinking that they have done things wrong for years.

In agreeing with the impacts of autistic characteristics on the systems, Adam also commented,

Because you know that that idea that autism pervades, it's that it's not a problem for one person, it's all the systems.

These impacts signify the discordance between autistic features and behavioural expectations from the larger systems set up by neurotypicals and reflect the researcher's belief that autism characterises a diverse information and sensory processing profile. Stemming from principles of family therapy, where the individual with autism might be presented as the main issue, but the focus of therapy is to help the family build functional relations, the emphasis of working with the systems is to help establish justifiable social relations for people with autism in the neurotypical-dominant society.

Focussing in to reflect on not only clinicians' own perception of autism, but also how clinicians perceive their roles in the support structure is another critical aspect when working with the systems. As Mary explains,

Because a lot of awful familial behaviour comes from well-meaning and well-intentioned advice that hasn't been understood and not thought about contextually within this family. ... It's still supplied as a sort of like, every adult, every parent needs to do this with autistic kids.

Working with the systems requires clinicians to bridge perceptions from different stakeholders (e.g. school, family). Disagreements and heightened emotions may arise during the process. For example, there may be discrepancies in the beliefs about the diagnosis, as well as its implication on support and behaviour expectations. These inconsistent beliefs of the autism diagnosis and disabilities, which are rooted in various systems, are likely to influence proposed support and environmental adjustment. Sue noted that parents' hopes are often squashed by the stigma and perception of disability in the community. She went on,

If you really get parents talking because they know their child really well and they do have those sparks of potential that you can tap into.

Nancy talked about the changing needs of the autistic individual, and the necessity to negotiate suitable expectations among stakeholders,

So, you deal with the expectation that he's [the autistic young man] this old and he's leaving school. And also, I guess, needing to reduce expectations as well in terms of what may actually be possible for this young man in terms of leaving school and finding employment and what that's going to look like.

In regard to supporting needs of autistic individuals, the researcher noted in her reflexive journal (dated 1 November 2022), '... the level of need also depends on what the system provides'. Clinicians try to negotiate a joint understanding with the autistic individual and the systems regarding goals and support needed to achieve these goals (e.g. putting support in place in the community, shifting the stigma and perception in the community). Mary stated,

The only question I have is what does the person want? How is it going to be helpful and how do we help the system help them in their change because the system often needs to change, too.

Adam commented on the remedial elements of working with the education system, including translating the autistic person's intention and behaviour. He further noted the preventative elements:

I found that work with systems has that angle of translating the autistic child's behaviour. And the other angle, then it's to, you know, increase predictability into those things that would allow someone with autism to participate. So, there's a sort of two elements in ... in the remedial elements when something is gone terribly wrong and then that area of education or translating autism for them so that they can see it differently and move from, you know

Facilitating multiple perspectives to create a space for change, bridging different ways of learning and communicating and working with the system around the person are like interconnected gears, in which clinicians help spin the gears by using integrated therapeutic techniques from diverse family therapy approaches.

Findings revealed that clinicians integrate therapeutic techniques from diverse family therapy approaches to improve family relations by bridging different ways of learning and communicating as well as facilitating multiple perspectives to create a space for change. For instance, constructing the family genogram (a visual representation of family history and development) together with family members. During the constructing process, clinicians may utilise family members' understanding of each other to help bridge the gaps in communicating with each other (e.g. asking the sibling, 'What does your sister/brother mean when s/he screams?' or asking the child with autism, 'When mum cries, what does everyone else in the family do?'). Clinicians may engage family members in role-playing to facilitate multiple perspectives. Integrating therapeutic techniques across diverse approaches further encompasses working with the system, including schools and workplaces, around the individual with autism.

DISCUSSION

This study explores clinicians' experiences and perceptions using family therapy to support neurodiverse families. Findings from the study align with the principles of family therapy, whereby problems and changes occur within context, in the spaces created between family members. Comparable to supporting neurotypical families, clinicians establish a therapeutic alliance with the family, facilitating families to understand each other's perspectives and creating a space for change. The formation of a therapeutic alliance entails more than therapeutic techniques; clinicians also hinge on their authentic self and relational skills (Andolfi, 2017, p. 67–72). Contradicting views and conflicting opinions are likely to arise as clinicians guide families to explore each other's perspectives. Gripping on an understanding of family dynamics and relational patterns, clinicians embrace families' reactions resulting from contradicting views and conflicting opinions and further navigate ways to spark changes.

Individuals and families change when we go through transitions, such as adolescence, + or the birth of a child. However, these transitions are often accompanied by uncertainty and

heightened stress. Therefore, individuals and families might struggle with changes during these naturally occurring transitions. Combined with neurodiversity, families are often confused by the individuals' need for changes during transitions. In these circumstances, family relational patterns might alter when clinicians assist family members to reframe the individual with autism's behaviours within context.

Complex emotions, such as disenfranchised grief, mixed anger and guilt, might come to the surface while family members attempt to understand each other's perspectives. Recognising the primacy of emotion as an instrument to change, clinicians could use integrated family therapy techniques (e.g. reframing, relational questions, active body movements) to guide families moving towards flexibility and growth. Despite varied views of the positions of family therapists in therapy (e.g. directive, non-directive), it agrees that clinicians should be aware of their own values, beliefs and triggers of personal experience throughout the therapeutic process (Andolfi, 2017; Carlson et al., 2005; Sprenkle et al., 2009). It is likely that clinicians who perceive autism as a disorder would proceed therapy in a different direction than clinicians who value neurodivergence, and/or have one or more family members with autism and/or are autistic themselves.

In contrast with supporting neurotypical families, clinicians supporting neurodiverse families help bridge different ways (i.e. neurodivergent versus neurotypical) of learning and communicating. This is coherent with the researcher's self-reflexivity, as stated in her journal (dated 24 October 2022), 'During therapy sessions, the "interpreter" part of me comes from my personal beliefs, values, and family therapy training (which brings my awareness of my "inner self" to the surface)'. To bridge different ways of learning and communication and support family connections, several scholars suggested that clinicians be equipped with an understanding of autism and a sense of curiosity of the impacts of autism on individual families (Befi et al., 2023; Solomon & Chung, 2012). An understanding of autism extends beyond the explicit knowledge about autism to clinicians' perspectives and beliefs about autism. The clinicians' perspectives and beliefs about autism constitute implicit knowledge during therapy, which inevitably influences the therapeutic process via verbal (e.g. language use) and non-verbal (e.g. facial expression, gesture) communication. For example, when a parent of an adolescent with autism requiring substantial support talks about the adolescent's aggressive behaviour at home, clinicians whose beliefs about autism are founded in the medical model are likely to respond from the deficit lens, discussing possible strategies to assist the parent to manage the behaviour and cope with the associated emotions.

Furthermore, clinicians whose beliefs about autism are founded in the biopsychosocial model are likely to respond from the neurodiverse lens, exploring other contributing factors in the system (e.g. the adolescent's developmental stage, history of the behaviour, perspectives from other family members, sensory processing) and assisting the parent to involve other family members to understand the reason behind the behaviour, share the associated emotions and explore ways moving forward. Grounded in the biopsychosocial view of autism, the researcher noted in her reflexive journal (dated 22 October 2022) that clinicians assist to interpret the individual with autism's communication intent, and the behaviour within context.

Moreover, it is important to address the intersubjective sensemaking when clinicians bridge different ways of learning and communicating between autistics and neurotypicals. Clinicians are often required to incorporate another way of thinking, speaking or judging situations that are taken for granted. The researcher cannot help but wonder how this intersubjective experience compares with the transcultural capability among people from culturally and linguistically diverse (CALD) background (reflexive journal, 22 October 2022). De Jaeger's (2021) idea that making sense of transcultural capability and neurodiversity from an engaged epistemology provides a

glimpse to the question, in which knowing each other's essence will never be complete as the sense-making, keeps on evolving throughout the process.

Like the spectrum of autism, each family with children with autism has its unique composition and dynamics. To be able to know the family in depth and discover hopes and possibilities within the family system, clinicians need to remain curious throughout the therapeutic process. Some families may be aware of the neurodiversity long before the diagnosis, while other families may not be aware of neurodiversity but be given a diagnosis. The researcher wonders whether an awareness of neurodiversity helps families to navigate emotions related to the diagnosis (reflexive journal, 15 November 2022). Throughout the process, clinicians keep a sense of curiosity, noticing the meaning behind words and actions, searching for resources in the family, and actively connecting family members to resources (Andolfi, 2017; Sprenkle et al., 2009). For example, noticing how parents respond when the child with autism engages in their special interests; enquiring who helps the most whenever there is an argument; and exploring possibilities to connect family members through the child's special interests.

Extending from Solomon and Chung's (2012) suggestions that clinicians be equipped with an understanding of autism and a sense of curiosity to support families having children with autism, findings from the present study further propose that clinicians examine their perspectives and beliefs about autism as part of gaining an understanding of autism. In her reflexive journal (dated 25 October 2022), the researcher wrote, 'At times, these two parts [medical diagnostician versus biopsychosocial interpreter] have conflicts, and at other times, they co-exist in harmony depending on which part is required in specific circumstances'. This may bring forward the importance of clinicians recognising their inner perception of autism, even when these values sometimes collide. Critically examining one's own beliefs is an ongoing process. Clinicians are encouraged to reflect on their interactions with people with autism and family members; for example, 'Are there any moments where I felt challenged or uncomfortable?' and 'Why did those feelings arise?' In addition, connecting with other clinicians who work with autistics and neurodiverse families can challenge and heighten learning from each other's experiences. Furthermore, it is proposed that clinicians remain curious throughout the therapeutic process, gaining an in-depth understanding of each family beyond the diagnosis; for example, the natural corollary of having children with autism, the meaning of autism as perceived by family members and the sociocultural perception of autism. Although the autistic individual might be presented as the main issue, the focus is to help the family to build functional relations and routines having the unique autistic profile in mind (Memo).

Another category that is distinct from supporting neurotypical families to an extent is working with the systems around the person. In the memo, the researcher noted, 'The essence of working with the system extends to the roles of clinicians, which involve zooming out to reflect on where we [clinicians] are positioned in the system. The essence of working with the system (following social constructivism) also links clinicians acting as "interpreters" to facilitate understanding from multiple perspectives [among families and within community members], and to normalise communication, intention and behaviour of people with disabilities'. Working with the broader systems around the person can be perceived as an augmentation to supporting the family. Equipped with an understanding of the individual with autism, clinicians could take a consultant role in advocating environment modification (e.g. classroom settings, curriculum, workplace lighting) for the individual with autism, and/or take a curious stance in searching for resources within the broader systems. Clinicians put an emphasis on working with the systems around the person, particularly during transitions (Schall et al., 2012). In addition, clinicians can also assist in dealing with situations

when perspectives from various stakeholders disagree. Should a disagreement arise, clinicians could assist with finding remedial interventions, including consequences understood and justified by all parties involved. Clinicians' own perspectives and beliefs towards autism have a profound impact on neurodiverse families and society at large. Through continuous self-reflexivity and conversations, clinicians can become aware of personal biases about neurodiversity and address interconnected issues within a system.

Misconceptions among clinicians about autism can still remain; for example, believing that people with autism do not show affection or attachment. These knowledge gaps and potential prepossession about autism contribute to stigmas and discrimination (Cleary et al., 2023; Turnock et al., 2022), such as people with autism not being independent or leading fulfilling lives, and the focus on finding a 'cure' for autism. Persistent negative stigmas associated with autism can exert a toll on the well-being of people with autism and their families (Cleary et al., 2023; Turnock et al., 2022).

In accordance with the underpinning of family therapy where therapists maintain a self-reflexive stance while exploring family relations and resources, the researcher has maintained researcher reflexivity through reflexive journalling and memo keeping throughout the research process. The categories in this study, and the theorising about their wider meaning and application in family therapy, were constructed on the basis of the meanings and actions of clinicians with clinical experience working with neurodiverse families. Rather than simply describing the patterns of clinicians' experiences and perceptions, CGT offers a framework to examine the qualitative data systematically, which builds up theoretical concepts 'grounded' in the research materials. The researcher began by finding the meaning of fragments of data (e.g. line-by-line, incident by incident), raised focus codes by constantly comparing similarities and differences among initial codes and constructed emerging categories that link or separate focus codes (Charmaz, 2014). The four categories are results of the systematic CGT research process, specifying the properties between a set of key codes as well as explaining the relations among the set of codes. The recursive cycles built into CGT alongside its proposed systemic methods (i.e. deduction, induction, abduction) to form connections among research categories, are not only congruent with the family therapy process, but also help the theorising processes in social worlds relevant for therapy.

Implications, limitations, and future directions

Findings from the present study suggest that clinicians using family therapy with families who have children with autism recognise neurodiversity within the family and adapt therapy accordingly to support their needs. Specifically, clinicians guide families moving towards change and growth by facilitating multiple perspectives to create a space for change, bridging different ways of learning and communicating, integrating therapeutic techniques across diverse approaches and working with the systems around the person. Our findings are aligned with those suggesting utilisation of family therapy to support neurodiverse families to improve family relational patterns and reduce 'challenging behaviours' (Goepfert et al., 2015; Helps, 2016; Solomon & Chung, 2012; Spain et al., 2017). Extending from Solomon and Chung's (2012) suggestions, it is proposed that clinicians who utilise family therapy in the context of autism gain an understanding of autism beyond explicit knowledge to examine their perspectives and beliefs about autism, as this implicit knowledge and beliefs play an important part not only in the therapeutic process, but also when working with the systems around the autistic person.

Comparable to supporting neurotypical families, Solomon and Chung (2012) suggested that clinicians remain curious throughout the process. During therapy sessions, curiosity can be an aspiration to explore family relational patterns and significant past events, as well as to understand the meanings behind something or someone. Most importantly, curiosity for finding resources and possibilities leads to changes (Andolfi, 2017, p. 84). Through the process, clinicians take the not-knowing stance, and invite family members to consider alternative states of meanings and possibilities, for example, asking the neurotypical sibling, 'What would parents do more if they spent less time helping your [autistic] sibling?' Presenting this curiosity not only allows clinicians to join in the family systems, but also allows family members to reflect on their experience. These findings provide future directions of training for clinicians in implementing family therapy to support families having children with autism.

On the subject of bridging different ways of learning and communicating, the researcher put forward that clinicians should be mindful of the continuing intersubjective experience of making sense of autistics and neurotypicals. It would be beneficial for clinicians to derive an engaged epistemology that acknowledges mutual existence (i.e. autistics and neurotypicals) and the essence of neurodiversity (De Jaegher, 2021). The researcher ponders how this intersubjective experience compares with that of transcultural capability among people from CALD background. Future studies could examine the comparable aspects of intersubjective experience of neurodiversity and transcultural capability and look at bridging different ways of learning and communicating with existing transcultural literature.

Both CGT and family therapy focus on exploring the meanings behind actions and words. Both CGT and family therapy recognise the significance of researcher/therapist reflexive stance and propose methods to bypass potential transactional effects in the research and therapeutic process. Furthermore, both CGT and family therapy involve an iterative and recursive process. Not surprisingly, CGT has been proposed as a helpful methodology in family therapy research (Echevarria-Doan & Tubbs, 2005). The present study demonstrates how CGT can contribute to the explorative field of family therapy, generating theoretical frameworks for future applications (Charmaz, 2014).

Rigour of this research was enhanced by careful co-construction of interview discussions with participants, transparency of research processes and the keeping and sharing of detailed reflexive journal information. To increase the transferability of findings, participant characteristics and the data collection process were documented. Future research might extend from the present study and include clinicians from more diverse cultural backgrounds to address the sociocultural view of autism and family therapy practice in diverse cultures.

CONCLUSIONS

Clinicians using family therapy to support neurodiverse families not only aim to support families to better understand the unique needs of children with autism, but also improve family relations which directly benefit children with autism. In adapting family therapy in the context of autism, it is suggested that clinicians examine their own perspectives and beliefs about autism and keep a curious stance when facilitating families to understand each other's perspectives and bridge different ways of learning and communicating. It is also suggested that clinicians integrate therapeutic techniques across diverse approaches when guiding families and the systems around the person through change and growth. Finally, it is imperative to note that the intersubjective experience of understanding neurodiversity is ongoing throughout the process.

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The authors declare no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

ETHICS STATEMENT

All procedures performed in studies involving human participants were in accordance with National Statement on Ethical Conduct in Human Research (2007, updated 2018). This project has been approved by the Human Ethics Committee at the University of Newcastle (H-2021-0344).

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